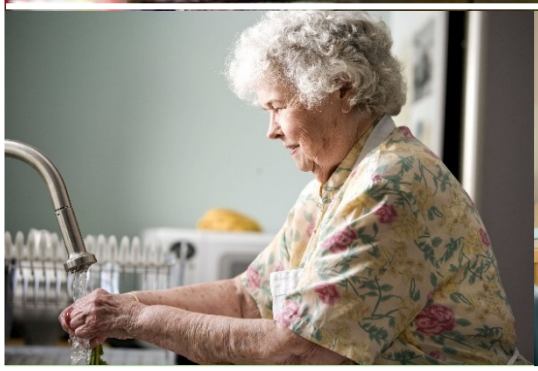


Young, Hip Austin is Getting Old



A New Experiment in Confronting the Challenge

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The University of Texas at Austin
Policy Research Project Report

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Young Hip Austin is Getting Old:
A New Experiment in Confronting the Challenge

Project directed by

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Foreword

The Lyndon B. Johnson School of Public Affairs has established interdisciplinary research on policy problems as the core of its educational program. A major element of this program is the nine-month policy research project, in the course of which one or more faculty members direct the research of ten to twenty graduate students of diverse disciplines and academic backgrounds on a policy issue of concern to a government or nonprofit agency. This "client orientation" brings the students face to face with administrators, legislators, and other officials active in the policy process and demonstrates that research in a policy environment demands special knowledge and skill sets. It exposes students to challenges they will face in relating academic research, and complex data, to those responsible for the development and implementation of policy and how to overcome those challenges.

This report is the product of a policy research project (PRP) conducted in the 2017-18 academic year with client support from St. David's Foundation, Austin, Texas. The tidal wave of graying baby boomers in Austin creates a local imperative to improve available health and social services for the senior population. The project "Young Hip Austin is Getting Old: A New Experiment in Confronting the Challenge" examined one approach to addressing care needs in one of Austin's most needy communities.

As part of this process, the PRP team galvanized support and commitments within the community and The University of Texas at Austin to develop an Age-Inclusive Center to meet the needs of low-income groups. Specifically, the study entailed creating an operational plan and governance model to establish a senior clinic and community center of excellence co-located with affordable housing, employing data from strategic shared stakeholder interviews, focus group interviews, and a market penetration household survey of Rebekah Baines Johnson (RBJ) Senior Living Center and Holly neighborhood residents 65 years and older. Altogether the research and a mini-documentary—intended to sensitize the community to the growing challenge of caring for the most vulnerable seniors—were presented at the Eldercare Summit's Livability and Longevity Symposia in April 2018 at the LBJ School. In addition, the work was featured in a County Connection segment "Aging in Place" on Travis County television (TCTV) Channel 17.

The curriculum of the LBJ School is intended not only to develop effective public servants, but also to produce research that will enlighten and inform those already engaged in the policy process. The project that resulted in this report has helped to accomplish the first task; it is our hope that the report itself will contribute to the second. Finally, it should be noted that neither the LBJ School nor The University of Texas at Austin nor the persons interviewed for this project necessarily endorses the views or findings of this report.

Angela Evans, Dean

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Executive Summary

The coming wave of aging Baby Boomers requires Austin to develop new and innovative ways to improve available health and social services for everyone, including seniors. In 2015, Central Health's *Planning Regions Overview 2014-19* projected a rapidly growing senior population in Austin. This growth includes a significant increase in the number of low-income seniors, most of who struggle to access the health and social services that they need. The 2013 Mayor's Task Force on Aging reported that 40 percent of Central Texas seniors worry about their ability to pay for healthcare expenses.

In response to this challenge, *Young Hip Austin is Getting Old: A New Experiment in Confronting the Challenge*, a Policy Research Project (PRP) at The University of Texas at Austin LBJ School of Public Affairs sought to create a new and innovative model of senior healthcare. This Age-Inclusive Center model ("the Center") expands current public health services to co-locate geriatric primary care and senior services with childcare and an adult day center.

Through a yearlong project funded by St. David's Foundation, the 2017-18 PRP team began to develop a public-private model to address the care needs of one of Austin's most needy areas. The Center model builds on the 2015-16 PRP *A Better Life for Low-income Elders in Austin* funded by Central Health and St. David's Foundation. The 2015-16 PRP identified the Holly neighborhood (located in the 78702 ZIP code) as a diverse community with a rapidly aging low-income population. The neighborhood is also home to the Rebekah Baines Johnson (RBJ) Senior Living Center, an affordable housing apartment complex for low-income seniors. Locating an Age-Inclusive Center in this neighborhood, adjacent to the RBJ Senior Living Center, could serve as a prototype for a new model. The new model would combine senior medical and social services into an all-in-one center that is accessible to those who need services the most and are the least likely to be able to afford them. Additionally, the model incorporates multigenerational services in recognition that strategies that serve the entire community result in better outcomes for all.

In conjunction with community partners, including Meals on Wheels Central Texas (Meals on Wheels) and Family Eldercare, we worked to accomplish the following objectives:

1. Identify specific services and care components for an integrated, age-inclusive center that meets the needs of Austin's senior residents.

2. Develop a model that serves as a prototype for providing identified services and care components to individuals 65 and older, including those with little income and serious health problems.

3. Evaluate market demand and feasibility for locating the Age-Inclusive Center at the RBJ Health Center (15 Waller Street).

4. Evaluate a budget and the financial sustainability of the model.

5. Design a governance model for the Center.

6. Produce a mini-documentary to tell the story of Austin's senior residents that highlights their needs and experiences.

7. Present research and engage with a panel of community leaders and experts as part of AustinUP's Livability for Longevity Symposium on April 10, 2018. Measure project buy-in from the audience through live polling.

The report data come from stakeholder interviews, consumer focus group interviews, a senior household health experience survey in the Holly neighborhood, and other sources such as the American Community Survey. Our team communicated with over 40 stakeholders who represent health administrators, aging-services providers, and political leaders about the PRP proposal's vision and the extent to which they support the proposal.

Focus group interviews with RBJ Senior Living Center residents indicate they were enthusiastic about the location and services that would be offered at the clinic. The convenient location adjacent to their home would increase access to care and wellness services. In general, they did not seem wedded to their current providers and showed high willingness to switch to a more accessible, all-in-one Center. An unexpected level of attention was paid to healthful aging and holistic wellness, which included regular monitoring of blood pressure and glucose levels, advice on diet and nutrition, exercise, and wellness activities, such as yoga and pet therapy. Results from the Senior Household Health Experience Survey reinforced key focus group findings.

Upon meeting with our team, city elected officials, department staff, and other key stakeholders conveyed support for our project and a proposed second phase of the project that incorporates a child daycare center and multigenerational programming. This multigenerational model, based on an approach pioneered by UT Austin's Child Development Center, has been proven to reduce loneliness and social isolation and increase overall health for seniors in adult day centers. Research suggests that the Center would especially help low-income parents who must care for both young children and aging parents.

These insights support the proposal that renovation of the RBJ Health Center be included as a Capital Improvement Project in Austin's 2018 General Obligation Bond Program. We estimate the cost of renovation and interior build of one floor at the RBJ Health Center to be around $3.8 million. The non-city operational expenses of the senior programs (care coordination, adult day center) would be $435,000. Estimates of the senior clinic and day center are, as yet, undetermined.

To advance the implementation of the Age-Inclusive Center, we recommend the following:

- **Identify a non-governmental 501(c)(3) healthcare organization to move the project forward and ensure its sustainability** This entails the creation of a collaborative partnership that is committed to providing high-quality, cost-effective care for seniors, and developing a

shared governance framework that embodies principles of equity and assigns mutual ownership and accountability for decisions.

- **Increase community outreach and engagement to elevate the visibility of the issues confronting senior consumers and their families.** Craft an action plan that offers listening sessions to consumers of care at senior centers, caregiver support groups, and faith-based organizations. Distribute throughout the community the mini-documentary and disseminate the Travis County Television "County Connections" segment "Aging in Place" that features our PRP.

- **Further explore experiential and service learning opportunities at the Age-Inclusive Center for UT Austin students**, including internships, clerkships, residency programs, and graduate education training. We envision that the renovation of the RBJ Health Center could serve as a training laboratory for UT-Dell Medical School students, medical residents, and other helping professionals specializing in geriatric primary care, internal medicine, geriatric psychiatry, and geriatric medicine. Having a teaching hospital that includes rotations at a community clinic serving the frailest and most vulnerable patients is critical given the nationwide shortage of primary care physicians who serve geriatric patients. This initiative would build and strengthen the direct service workforce that provides low-income seniors with the care they need in the community, hospitals, and nursing homes.

- **Evaluate the model for expansion in alternative locations, such as Austin Community College's Highland Campus and the Dove Springs Recreation Center.** Scaling this Age-Inclusive Center model is possible with a systematic impact assessment of the quality of workforce, patient health outcomes, and administrative efficiency. Expansion will further improve care delivery among vulnerable populations.

In summary, this report identifies the challenges and opportunities of establishing a public-private partnership for an age-inclusive model of senior healthcare and multigenerational programs at the RBJ Health Center. In addition, the evidence points to key steps for implementation, best practices, and replication of the innovative pilot across the City of Austin. Taken as a whole, these findings lead us to the conclusion that an Age-Inclusive Center can serve as a model for cities across the United States as a new and integrated standard of providing health services, an adult day program, and community care to older individuals with little income and serious health problems.

Chapter 1.
Introduction: Integrated Care for Seniors in Austin

Background

Our research team is a group of 12 Master of Public Affairs students at the Lyndon B. Johnson (LBJ) School of Public Affairs at The University of Texas at Austin. Students at the LBJ School participate in a yearlong course called the Policy Research Project (PRP), which gives students the opportunity to engage with a client on a consulting project with real-world implications.

Our team's PRP, *Young Hip Austin is Getting Old: A New Experiment in Confronting the Challenge*, builds on research from a 2015-16 PRP, *A Better Life for Low-Income Seniors in Austin*. The client for the 2017-18 PRP is St. David's Foundation, a healthcare conversion foundation based in Austin, Texas. The objectives of the PRP, described in full below and developed in part with St. David's Foundation, focused on developing a plan for an innovative community center where seniors can access preventive care and social services, and participate in community-based activities, as well as raising awareness of the need for such a center in Austin, Texas.

Problem Statement

The proportion of the American population that is 65 and older is rapidly growing. By 2030, the population of seniors, which we define as individuals over the age of 65, will increase by 65 percent.[1] By 2056, the Census Bureau projects that this segment of the population will outnumber the number of people under age 18 and will comprise one-fifth of U.S. residents by 2060. This trend will increase the burden on Social Security, Medicare, and Medicaid as well as various state and local programs. Many seniors already struggle to access and pay for healthcare services, and population growth will only amplify this issue. Austin, a city with a reputation for being young and hip, is not exempt from these age-wave related challenges—its senior population growth has already outpaced the national average and is projected to continue to do so. According to Central Health's Planning Regions Overview, Austin continues to have one of the fastest-growing senior populations in the U.S. As is common to the experience of seniors across the country, 40 percent of seniors in Central Texas as of 2013 worry about the ability to pay for healthcare expenses. Compounding the shortcomings in healthcare access and affordability, seniors and their families are faced with a shortage of supportive programs that foster independence and wellness.

The expected increase in seniors makes improving the availability and quality of senior healthcare and social services a local priority, especially those that serve the most vulnerable seniors, who are low-income or have one or more disabilities. The existing service and funding gaps exceed what the public sector alone can fill. The healthcare needs of seniors going forward can be sufficiently met only through innovative solutions built on the understanding that healthy aging is about more than just going to the doctor. A comprehensive approach to wellness is required that recognizes the full range of physical, social, and economic needs of seniors.

The ideal solution would place health and social services and supports nearby accessible to the homes of seniors who want to age in place, maintain a sense of belonging, and participate in an active and mutually supportive community. Our team sought to create an innovative model of care that includes the co-location of geriatric primary care, social services, and adult day services in a community health center. We have developed an integrated model for an Age-Inclusive Center (the "Center") that serves those functions. We also considered the feasibility of establishing the Center at a specific site in Austin, the Rebekah Baines Johnson Health Center.

Rebekah Baines Johnson Health Center

Before the 2017-18 PRP began, the RBJ Health Center was identified as a potential location for an age-inclusive center by the 2015-16 PRP. The RBJ Health Center is located at 15 Waller Street in the 78702 ZIP code within the Holly neighborhood. Currently, the first floor of the RBJ Health Center is a health clinic that tests and treats patients for sexually transmitted diseases and tuberculosis. Located across the lot is the RBJ Senior Living Center, which houses 250 low-income residents. Ongoing redevelopment of the RBJ Senior Living Center will add 250 additional affordable senior apartment units in the next five years.

The location is an intriguing prospect for the site of the Center for several reasons. It is one of the largest senior housing complexes in the Austin area, and its residents are on average over 70 years of age, with annual incomes of less than $12,500.[2] This complex is located in the midst of a rapidly changing neighborhood where seniors are at risk of losing their connections to the community, and where their particular healthcare needs may be underserved. We believe that the central location of the RBJ Health Center in the city of Austin would allow it to serve as a center of gravity for senior-targeted healthcare and social services in the region and could attract patients and visitors from further afield than the Holly neighborhood. As such, our research objectives, data collection, and proposed models are guided and impacted by the geography and demography of the surrounding area.

Project Objectives

Our team had the following objectives during the 2017-2018 academic year:

1. Identify specific services and care components for an integrated, age-inclusive center.

2. Develop a model that serves as a prototype for providing identified services and care components to individuals 65 and older, including those with low-income and serious health problems.

3. Evaluate market demand and feasibility for locating the Age-Inclusive Center at the RBJ Health Center. Evaluation includes focus groups with residents of the adjacent RBJ Senior Living Center and a survey of residents of the surrounding Holly neighborhood to evaluate characteristics and needs of the population.

4. Evaluate a budget and the financial sustainability of the model.

5. Design a governance model for the Center.

6. Produce a mini-documentary to tell the story of Austin's senior residents that highlights their needs and experiences.

7. Present research and engage with a panel of community leaders and experts as part of AustinUP's Livability for Longevity Symposium on April 10, 2018. Measure project buy-in from the audience through live polling.

Structure of the Report

The report begins in Chapter 2 with a broad review of the literature on the expected needs of seniors, as well as aspects of the inclusive care necessary to address those needs. Based on primary and secondary research conducted by the PRP team, Chapter 3 moves into a more focused presentation of the needs and demands of senior residents in greater Austin and in the 78702 ZIP code. Taken together, the literature review and needs assessment identifies gaps in available senior services and barriers to accessing and using existing and potential services. Chapter 4 presents our proposed solution based on these findings and includes an analysis of the initial financial outlay and continued feasibility of the Center. Chapter 5 summarizes the methodology and results of our team's yearlong extensive engagement with stakeholders. Chapter 6 outlines the principles and structure of our proposed governance model for the Center. Chapter 7 details our team presentation at the Livability for Longevity Symposium, hosted by AustinUP and the LBJ School of Public Affairs, and the mini-documentary entitled *Rebekah Baines Johnson Center* produced by our team. The final chapter of the report offers recommendations to anticipated service needs in Austin, Texas. We also summarize ways in which a community foundation, such as St. David's Foundation, can help establish and support cost-effective models in Austin. Finally, we describe the services that organizations are well positioned to implement and how local policymakers can bolster their impact.

Chapter 2.
Literature Review

Sources of Senior Vulnerability

The coming wave of aging Baby Boomers requires that Austin develop new and innovative ways to improve available health and social services for everyone, particularly for seniors. This chapter summarizes the research on the expected needs of the senior population and key points of consideration for solutions. We consider issues critical to aging successfully and avoiding debilitating health problems in old age. Toward that end, we identify built environment factors that help maintain health and cognitive function as one ages in the community, as well as viable options for cities that seek to become incubators for successful aging (i.e., age-friendly cities).

Depending on their disciplinary approach, researchers tend to focus on either biomedical or psychosocial predictors of healthy aging. Biomedical indicators focus on the absence of disease or functional limitations. Psychosocial indicators include social engagement, voluntary work, life satisfaction, resilience, and extrinsic factors such as finances.

Aging in Place

Many older adults describe a desire to "live in their homes or communities as long as possible," a concept termed "aging in place."[3] In the National Advantage Survey, more than 80 percent of the 1,500 older adults surveyed want to age in place.[4] The rate of older adults choosing to enter out-of-home long-term care has decreased since the 1970s. The number of people 85 and older living in long-term care facilities has decreased from 26 percent in the 1970s to 14 percent today.[5] This is in part due to the increased availability of community-based services. Aging in place is popular with older adults for its benefits in comfort, but it comes with less recognized and anticipated risks.

Place attachment appears to highly influence physical and mental health outcomes for older adults. Familiar environments provide comfort in spatial familiarity, promote feelings of belonging, and induce a sense of personal meaning.[6] Studies show that the longer a senior ages in place, the better his or her perception of stress, health status, and depression.[7] At the same time, aging in place is also associated with negative outcomes, like higher risk of social isolation and loneliness.[8,9,10] A senior's ability to age in place is impacted by the affordability of housing, gentrification trends, and a senior's socioeconomic status. These topics are addressed later in this chapter.

Low-Income Seniors

Approximately 14.6 percent of seniors in the United States are living below the poverty threshold, relying on the shrinking safety net of Social Security as a main source of income and little to no savings.[11] Nearly 10.2 million seniors in 2014 were found to face food insecurity, defined by the United States Department of Agriculture as being in a state of limited or uncertain access to adequate food.[12]

Another risk associated with low socioeconomic status is mental health decline. Dallaire et al. find that "those at the lower levels of socioeconomic status are often most likely to be diagnosed with a psychological disorder."[13] Within the next 25 years, the senior population is projected to experience a significant increase in depression and dementia diagnoses.[14]

Even when seniors qualify for social and healthcare entitlement programs, such as Medicare and Medicaid, they often do not know about or utilize them. Healthcare costs can deter low-income seniors from inquiring about Medicare or Medicaid, and the AARP Public Policy Institute reports that underutilization of recommended preventive services is more prevalent for the uninsured.[15] Further, people of color and individuals of low socioeconomic status are much more likely to be uninsured. As a result, these populations, which are highly concentrated in the Holly neighborhood and surrounding area, experience more risk factors at an earlier age.[16]

Transportation

As they age, seniors often lose independent mobility, defined as "the ability to move oneself (e.g., by walking, by using assistive devices, or by using transportation) within community environments that expand from one's home, to the neighborhood, and to regions beyond."[17] Mobility is impacted by cognitive, psychosocial, physical, environmental, and financial factors. Mobility limitations impact the physical, social, and mental wellbeing of seniors, and are one of the most complex and crucial pieces of a successful strategy to aging in place.

Age-friendly transportation that encourages senior mobility is a top priority for seniors and their caretakers especially in urban communities. Public transportation availability is highly correlated with keeping seniors safe from injury and crime and is a direct determinant of the accessibility of health services and social activities. The World Health Organization's 2007 guide on Global Age-friendly Cities recommends "age-friendly" transportation planning encompass the following:

- **Availability** of different types of transportation, including services and transit vehicle types specific to seniors and those with disabilities;
- **Affordability** of the transit system, including free and reduced fare with low process barriers to qualify and utilize;
- **Reliability and frequency** of service, including increased frequency at night and on the weekends;
- **Travel destinations** on service routes that include a variety of health services, social activity centers, and other non-medical facilities; and
- Senior specific **safety and comfort** amenities on buses and at bus stops, like priority seating, specialized service and routes for seniors.

These considerations build a convenient, accessible, and safe transportation system for seniors in urban areas, particularly for those who are low income, with disabilities, wanting to age in place, or suffering from social isolation.[18]

Gentrification

As discussed earlier, many older adults are not able to continue aging in the same environment in which they have spent most of their lives. Gentrification is one primary cause of an inability to age in place, especially in Austin where new development on the east side is forcing out a large African American and Hispanic community that has deep historical roots to the land. In 1928, the city segregated all African American housing and amenities to land east of IH-35 where the Holly neighborhood now sits.[19] The City's Master Plan stated "it is our recommendation that the nearest approach to the solution of the race segregation problem will be the recommendation of this district [just east of East Avenue and south of the city cemetery] as a negro district; and that all the facilities and conveniences be provided the negroes in this district as an incentive to draw the negro population to this area."[20] Hispanic residents soon followed. Several of the original residents of this neighborhood reside in the same homes decades later, but are being pressured by realtors and developers to sell their homes. Those that sell often must move to more affordable neighborhoods outside of Austin in Round Rock, Pflugerville, or Manor.

Those who are not displaced either remain by choice or by necessity as they lack the economic or other supports required to relocate. Phillipson categorizes these individuals as either "elected" or "excluded."[21] For the purposes of this report, we use Central Health's definition of gentrification: "the process of renewing and rebuilding urban areas accompanied by the influx of middle-class or affluent residents. This process often displaces lower-income residents. The term is not defined by race or ethnicity."[22]

Research shows that older individuals with a lower socioeconomic status who remain in gentrifying areas lose access to "vital networks as others are displaced."[23] While they may stand to gain from improved services, investment and other resources that flow into the area, there has not been enough research to determine how the outcomes for older adults who remain in gentrifying areas compare to those living in non-gentrified areas.[24] The greatest concern is that the gentrifying and gentrified neighborhoods are ill equipped to support the needs of older, economically vulnerable adults who remain.[25] Generally, literature on the subject recommends specific "policies, programs, and infrastructure changes to support older adults who wish to age in place in a gentrifying neighborhood."[26]

Social Isolation

Social isolation is an acute issue for some older adults. Social isolation is defined as "an objective state involving minimal contact and interaction with others and a generally low level of involvement in community life."[27] The effects of social isolation are frequently seen in health outcomes, including a higher risk of mortality, increased risk for falls, heavy drinking, cognitive decline, nutritional deprivation, higher rates of re-hospitalization, and loneliness.[28]

Many factors increase the prevalence of social isolation among older adults. These factors include loss of mobility, transportation barriers, lack of opportunities to participate in the community, and, as mentioned above, gentrification, which severs seniors' connections in a changing neighborhood.[29]

Aspects of Inclusive Care

The following sections present strategies to address complex needs of seniors in a comprehensive, integrated, and innovative way.

Multigenerational Care

Multigenerational and intergenerational care strategies are in their infancy in the U.S., but they show great promise. Multigenerational centers are those that "support programs, events and activities targeted at a wide range of ages, abilities, and community needs through joint partnering of community-based organizations."[30] Examples of program mixes include a childcare center, cafe, art gallery and studio, and a community center room. No full count of operating centers exists, but the number of pilot and new centers is growing. According to Generations United, a nonprofit dedicated to intergenerational programs, policies, and strategies nationwide, approximately 500 mixed-age programs exist around the country.[31] Intergenerational programming provides support that fuses wellness and community into physical spaces, interpersonal relationships, and active lifestyles essential to aging populations. Multigenerational and intergenerational centers are meant to enhance the programs and services that exist in a community and bridge the gap between providers and users.

Providence Mount St. Vincent in Seattle puts this intergenerational strategy into practice. The senior living community has assisted-living and skilled-nursing components, a wellness clinic, and a licensed childcare center called the Intergenerational Learning Center, which began operating in 1991. Children and senior residents interact through visits and activities such as music, games, art, and storytelling. Providence Mount St. Vincent says that seniors and children both benefit from this role-model relationship, and that society benefits through the reduction of "stereotypes and barriers that exist between generations."[32]

Intergenerational interactions benefit both seniors and children. The program was designed to "counterbalance the loneliness and boredom" of a nursing facility and serve as a "jolt back to the world of living." It also enhances "children's social and personal development."[33] Children who spend time around seniors are less likely to exhibit ageism or be uncomfortable around those with disabilities and impairments.[34] According to a 2015 Seattle Times story, the center had a waitlist because it had reached its maximum enrollment of 125 children.

Preventive Care

A focus on effective preventive care is key to improving quality of life and reducing reliance on emergency and catastrophic healthcare, which is often the costliest. Individuals who are of low socioeconomic status or uninsured often treat the emergency room as their primary care because they have no other option. Additionally, individuals with chronic diseases or disability who otherwise face ongoing, burdensome healthcare costs often forgo preventive and maintenance care and rely on emergency room visits to manage their health, which overall leads to poorer health outcomes.

As the number of seniors increases, one concern is the burden that their healthcare costs will place on the system—particularly from the costs associated with nursing home care. In 2015, the

U.S. spent $156 billion on nursing care facilities and continuing care retirement communities.[35] This represents 5 percent of total healthcare spending. These costs not only burden the healthcare system, but also place a cost burden on seniors and their families. The estimated cost of a semi-private room in a nursing home in 2017 in Texas was $4,563; the monthly cost for a private room was $6,053.[36] Medicare generally does not cover long-term stays in a nursing home. Seniors who do not meet income eligibility for Medicaid may be incentivized to spend down their assets and savings until they can qualify for Medicaid.

Providing timely preventive care is one strategy to avoid the high costs of nursing home care. While cost savings are a benefit of preventive care, the true aim of preventive care is to improve quality of life. The literature typically describes three categories of preventive care: vaccinations, screening, and preventive actions such as guidance on exercise and a healthy diet. The type of preventive care appropriate for an individual is determined by his or her life expectancy and current health status.[37]

Though preventive care can improve quality of life, only about two of every five older adults in the U.S. are up to date on the core set of preventive services.[38] Time, cost, transportation, and other barriers often make access to medical care difficult or even impossible. The AARP Public Policy Institute identifies four categories of barriers to the receipt of preventive services: structural, community, organizational, and personal.[39] Chief among the community barriers is that often no single local entity exists to coordinate the wide-scale delivery of necessary preventive services. The personal barriers include sociocultural factors, such as distrust of doctors or the healthcare system at large and low health literacy. In the absence of coordinating and supportive assistance, the barriers often preclude an individual from seeking preventive care.[40]

Integrated Care

Integrated care is an approach to providing care that emphasizes a high degree of collaboration and coordination between a patient's providers. The term can refer specifically to the coordination of physical and behavioral healthcare or take a broader view of the social determinants of health. Integrated care has benefits for seniors, who often have multiple chronic conditions that require them to visit a number of different providers. The literature is in agreement that coordination among these providers can lead to better quality of care and improved client satisfaction.[41] Integrated care may have high costs up front, but studies have found that integrated care can result in long-term cost savings. The cost-effectiveness of integrated programs depends on their specific structure and population served.[42]

Increasingly, research shows that the integration and co-location of community-based health and social services improves the utilization and success of preventive services. AARP Public Policy Institute notes that "the majority of health management takes place outside of the healthcare system and is up to the patient," but patients are often ill-equipped to manage their care. A gap exists in organizations' currently ability to coordinate and manage a patient's care through counseling, education and support services.[43]

Summary

The physical, social, and psychological needs of seniors are manifold, complex, and overlapping. The extent to which these needs are met or unmet contribute to an individual's degree of overall wellbeing. As such, effective solutions to the needs of the aging population need to be flexible, innovative, and expansive enough to address all categories of need.

Barriers to healthy aging and aging in place are fairly well understood and documented, and include built environment barriers, primary biomedical and psychosocial barriers, and primary extrinsic factors. Built environment barriers include gaps in age-friendly transportation and mobility service, social isolation and loss of community, and gentrification. Primary biomedical and psychosocial barriers include distrust of healthcare professionals, concerns about social stigma, chronic disease and disability, and lack of awareness of available health and social programs. Primary extrinsic factors include low socioeconomic status and insurance status.

Because these needs and barriers are so well understood, the focus should be on developing solutions that take various aspects of physical, social, and psychological needs into account. While many programs and services exist, they often address a need in isolation from others and lack appropriate coordination with other service providers, thus making them ineffective in addressing the overall wellbeing of seniors.

Multigenerational, integrated, and preventive care strategies all approach health as a multilayered concept that goes beyond immediate biological needs. They represent the lessons that stakeholders in health and social services have learned that the physical health of patients is deeply intertwined with their social and psychological health.

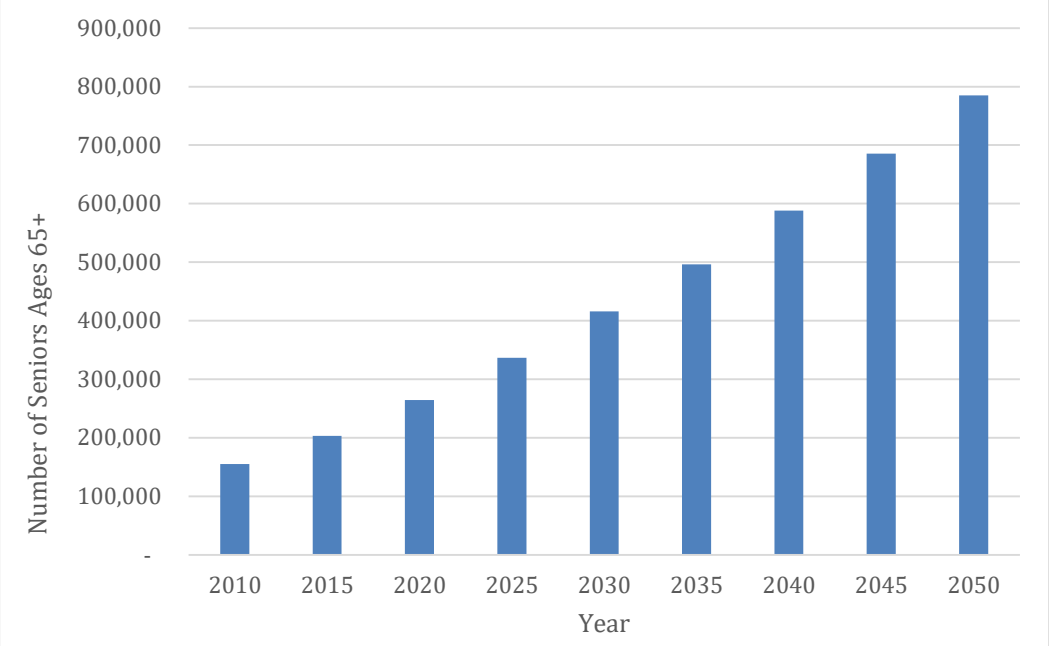
The exact way in which an approach such as these is designed depends on the population it is meant to serve and where it will be located. Chapter 3 presents our team's research on the demographics, existing services and programs, and other characteristics of Austin, and specifically, the Holly neighborhood.

Chapter 3.
Need and Demand for Services in Austin and Holly Neighborhood

Demographics

In Texas, the national trends of increased life expectancy and the aging of the Baby Boomer generation are expected to yield an older adult population of 5.9 million by 2030—19.4 percent of the total state population. Austin will be no exception to this trend. An analysis of data from the Texas Demographic Center finds that the 65+ population in the Austin-Round Rock Metropolitan Statistical Area is estimated to increase by 406 percent between 2010 and 2050. Figure 3.1 depicts this change.

Figure 3.1
Growth in Seniors Aged 65 and Older, Austin-Round Rock Metropolitan Statistical Area, 2010-2050



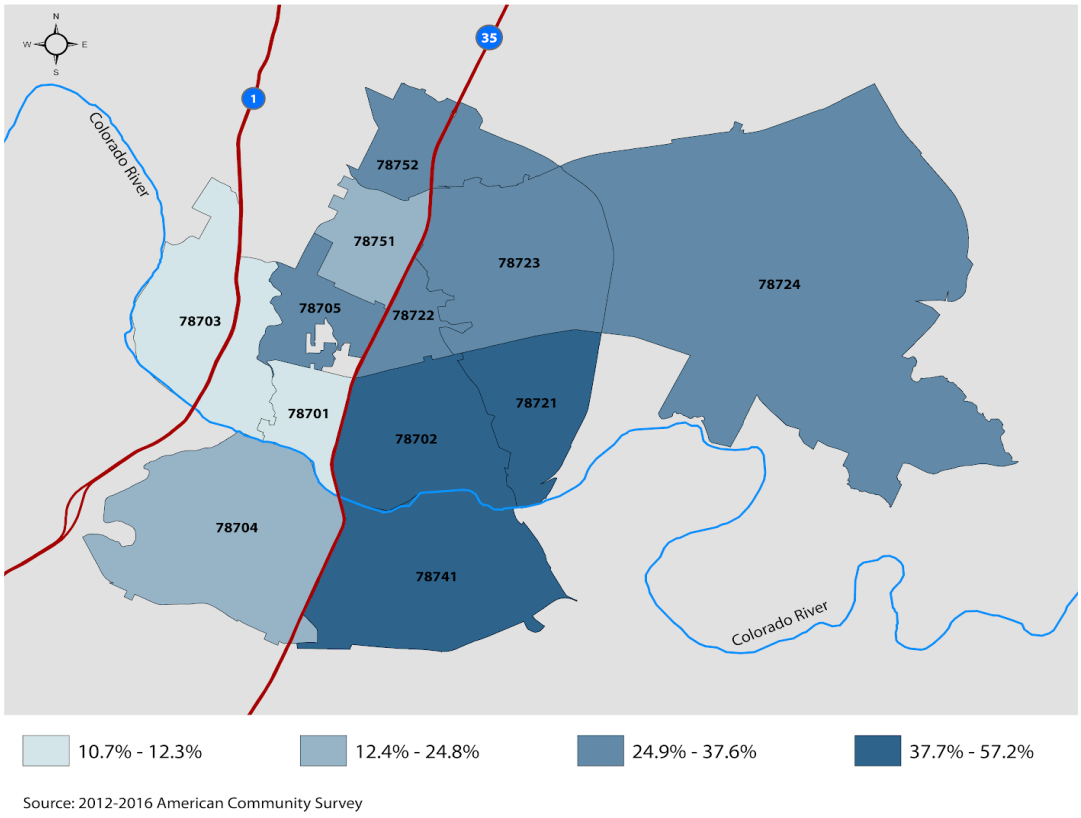
Source: U.S. Census Bureau, "Quick Facts," accessed May 5, 2018, https://www.census.gov/quickfacts/fact/table/traviscountytexas,roundrockcitytexas,austincountytexas,austincitytexas/.

Austin's senior population demographics vary based on location within the city. Our analysis was limited to ZIP codes within the city of Austin as defined by the American Community Survey (ACS). Using data from the ACS, our research focused on three categories of demographic characteristics: income, health insurance, and disability.

Income

Income of potential patients is a primary concern for the design and sustainability of the Age-Inclusive Center. To better represent the reality of living in Austin, we looked at seniors with incomes below 200 percent of the federal poverty level (FPL) rather than 100 percent. An income at 200 percent FPL is currently about $23,000 for a single adult. Data from the 2012-2016 ACS show that one out of four Austin seniors lives at this level of poverty. In the 78702 ZIP code, one out of two seniors lives below 200 percent FPL. Figure 3.2 shows these data points at the ZIP code level in the city of Austin. Seniors in ZIP codes on the eastern side of Interstate 35 are more likely to live below 200 percent FPL than those who live west of IH-35.

Figure 3.2
Percentage of Seniors Aged 65 and Over with Incomes Below 200 Percent FPL, Austin, 2012-2016



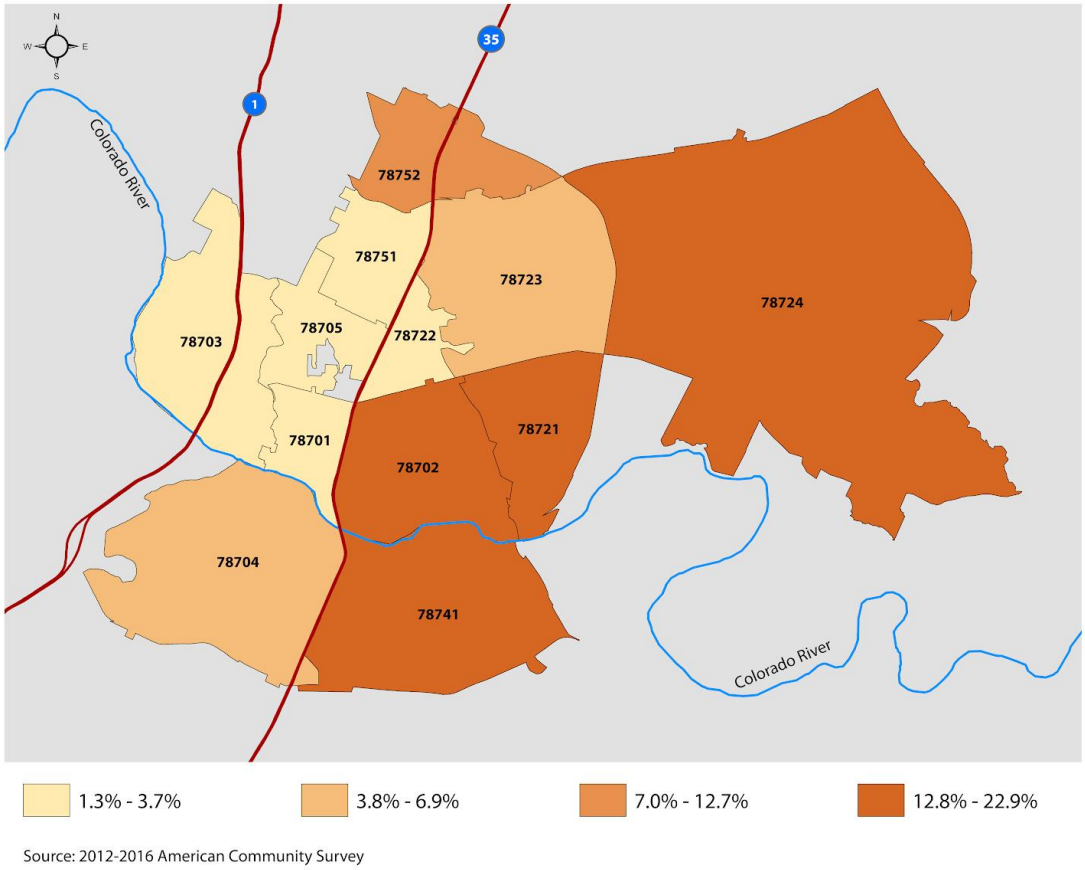
Source: Texas Demographic Center, "2014 Texas Population Projections by Migration Scenario Data Tool," accessed May 5, 2018, http://txsdc.utsa.edu/Data/TPEPP/Projections/Tool?fid=769FF93EC87F4217B059EA587467CC02.

Health Insurance

Health insurance coverage is an important consideration for our proposal's financial sustainability. We isolated the percentage of seniors with both Medicare and Medicaid coverage, (referred to as dual-eligibles) who are Austin's frailest medical populations requiring the most

expensive medical care. Figure 3.3 displays the percentage of dual-eligible seniors. Similar to the ZIP code level figure, this map shows that the city's most vulnerable seniors are concentrated in neighborhoods to the east of IH-35. The 78702, 78741, and 78721 ZIP codes have the highest percentage of dual-eligible seniors.

Figure 3.3
Percentage of Seniors Dually Covered by Medicare and Medicaid, Austin, 2012-2016

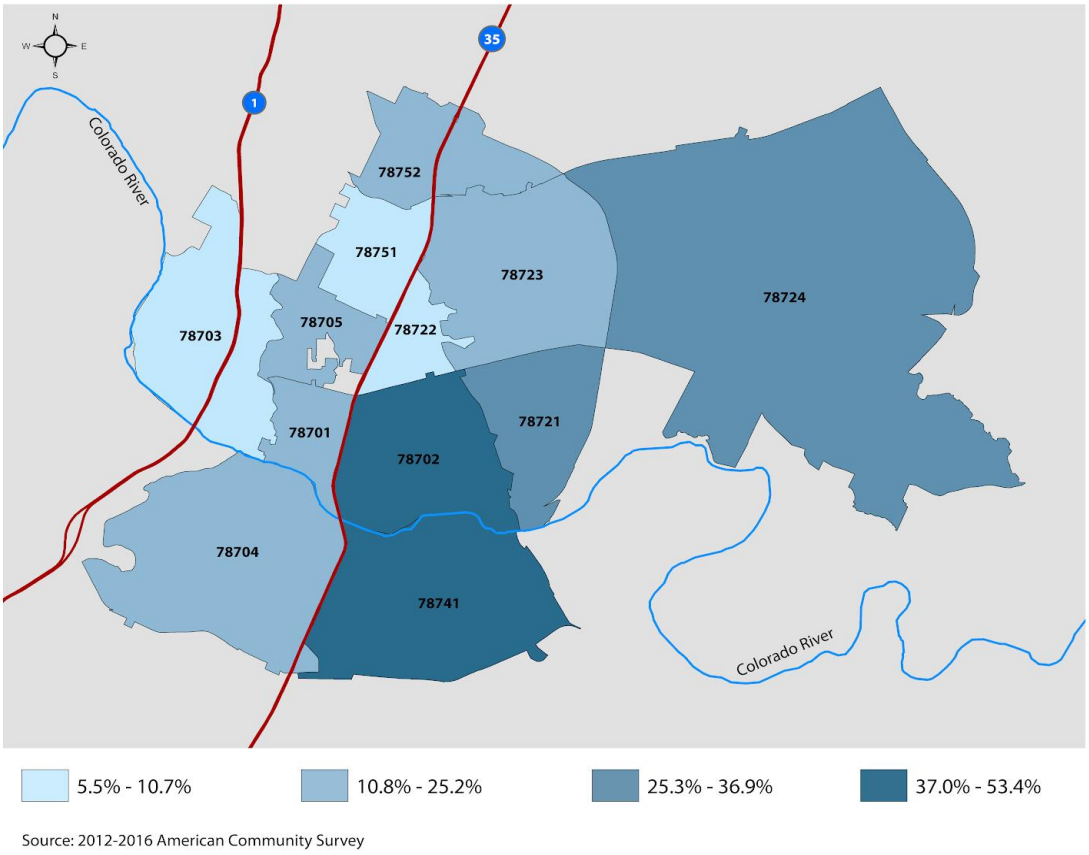


Source: Texas Demographic Center, "2014 Texas Population Projections by Migration Scenario Data Tool," accessed May 5, 2018, http://txsdc.utsa.edu/Data/TPEPP/Projections/Tool?fid=769FF93EC87F4217B059EA587467CC02.

Disability

Disability is a major concern for Austin seniors, and it adds complexity to their health and social service experience. The ACS disability measure captures both physical and cognitive disabilities. One out of three seniors in Austin reports one or more disability. In the 78702 ZIP code and neighborhoods in the 78741 ZIP code, this rate is as high as one out of every two seniors. While the overlap between income and dual-eligibility data is expected due to the income requirement of Medicaid, the mapping for seniors with one or more disability is more striking.

Figure 3.4
Percentage of Seniors With One or More Disability, Austin, 2012-2016



Source: Texas Demographic Center, "2014 Texas Population Projections by Migration Scenario Data Tool," accessed May 5, 2018, http://txsdc.utsa.edu/Data/TPEPP/Projections/Tool?fid=769FF93EC87F4217B059EA587467CC02.

Data Collection Summary

Our primary data collection consisted of two main portions: a focus group and a senior household health experience survey. Additionally, we gathered responses from the audience at our presentation at the Livability for Longevity Symposium, which is discussed in Chapter 7.

In October 2017, the team completed an Institutional Review Board (IRB) application for planned focus groups and surveys. For the application, we completed an online ethics-training program on how to interact with subjects and protect their personal information. We also completed a preliminary outline of the study's scope and implementation that detailed how to handle issues of consent and confidentiality.

The focus groups and survey provided the team with quantitative and qualitative information on senior residents of the 78702 ZIP code and their aging experience. The focus groups, which were conducted in and consisted of residents of the RBJ Senior Living Center, were informal and had

a small sample size (n=10), but the open-ended nature allowed us to capture a broad range of opinions and concerns. The household survey targeted senior residents in the 78702 ZIP code more broadly and was distributed by Meals on Wheels during their service provision. We did not have any contact with survey recipients or request identifying information, which limited the qualitative robustness of responses. The focus group results informed the household survey questions and helped make them more relevant to the concerns of potential respondents.

Focus Group Methodology

The purpose of the focus group was to determine whether RBJ Senior Living Center residents would be willing to switch healthcare providers if an age-inclusive center was located at the RBJ Health Center. Our focus group questions were designed to understand the various factors that affect a participant's willingness, such as the participant's preference for different health and social services, mobility options, and level of satisfaction with their current care provider. The questions were open-ended to facilitate discussion among participants. To broaden the range of feedback received, the moderator encouraged participants to talk about not only their own opinions and experiences, but also those of other seniors that they know. The formal methodology and procedures developed for the focus groups are included as Appendix A.

In total, four one-hour sessions were held, with two sessions held on November 10, 2018, and two held on November 17, 2018. Each group consisted of five participants, all of whom were over the age of 55. One member of the PRP served as moderator for all of the sessions and was accompanied by two additional members to record the responses of the participants. At the end of the focus group session, all participants were given an H-E-B gift card as thanks for their participation.

Focus Group Findings

Overall, focus group respondents were enthusiastic about convenient and coordinated care. They acknowledged that a centralized location with both medical and non-medical services would improve their access to care. Participants expressed willingness to switch providers if a new provider could better deliver the following services:

- **Medical care**, particularly routine wellness monitoring; mental health services (including prevention and depression symptomatic treatment); home healthcare for residents not eligible for Medicaid community-based services; and geriatric providers including physicians, medical social workers, psychiatrists, and behavioral health counselors.

- **Adult day services**, including medication management; dementia and cognitive decline prevention; physical, speech, and occupational therapy; interventions to improve mobility, especially wheelchair transition; cooking classes; gardening; dance and music; and pet care.

- **Wraparound services**, including reliable transportation to medical providers, other non-medical transportation, and coordination of care (insurance, food stamps, etc.) from social workers.

Participants identified gaps in the senior care services at their residence that fell into two categories: services that were formerly provided at the RBJ Senior Living Center but are no longer available (e.g., Zumba and other fitness classes), and existing services with which participants are dissatisfied (e.g., infrequent social worker visits). They also felt as though they lacked information about insurance and existing services, food-sharing networks, and quality transportation options. Participants believed that any new clinic would need robust coordination of these services and better methods of disseminating information than they are currently accustomed to.

Participants most valued the non-medical services within the adult day and wraparound services categories. They wanted affordable programs and services tailored toward wellness instead of illness, such as social activities and healthy pantry food options. Transportation was prominent in focus group discussion, and many participants noted that a lack of reliable transportation to grocery stores and community centers is a consistent pain point. Many participants offered criticism of the Capital Metropolitan Transportation Authority (CapMetro). Further examination of these complaints found that word-of-mouth misinformation concerning route and fare changes seems to be common among residents, despite CapMetro's monthly outreach events at the RBJ Senior Living Center.

Word of mouth also informs decisions on doctors and service providers. For our participants to change service providers, the new clinic will need a superior reputation with compassionate staff where seniors feel respected. To achieve a superior reputation, the clinic should focus on convenience and continuity of services, and must accept both Medicare and Medicaid for a variety of covered services. For detailed focus group summaries, see Appendix B.

Senior Household Health Experience Survey Methodology

A qualitative survey of the 78702 ZIP code was an initial project deliverable for our PRP client, St. David's Foundation. Senior residents of 78702 represent a much larger sampling frame than the focus groups conducted at the RBJ Senior Living Center, and constitute one primary target market for our proposed center due to their proximity. The survey's purpose was to gauge seniors' interest in the following: (1) the RBJ Health Center site as the location for a health and social services center, (2) the range of services that our Age-Inclusive Center would provide, and (3) the prospect of switching primary healthcare providers if a center with such services existed at the RBJ Health Center.

Survey Design

To maximize honest and unbiased responses, our survey was designed to maintain participant anonymity and eliminate in-person contact between the researchers and participants. The design and implementation of the survey was also informed by the IRB process, which sensitized our survey team to data privacy and confidentiality concerns. As a result, we did not collect the health and disability status of respondents, and we did not prompt respondents to provide identifying information such as their name or address.

A draft survey was tested at the RBJ Senior Living Center on February 7, 2018. Three residents were asked interview-style questions from a preliminary version of the survey. They provided

feedback on survey length and question complexity and clarity. Our survey testers found the survey's length and question complexity to be satisfactory. However, a few minor adjustments were made to phrasing to improve clarity.

The senior household survey was limited to the 78702 ZIP code for two reasons: (1) conversations with community stakeholders revealed that less healthcare survey data exists for 78702 than other ZIP codes; (2) the PRP team's limited resources required that we limit our inquiry to the Holly neighborhood, which would provide a strong base of operations for the proposed model.

Survey Distribution

The survey packets included English and Spanish instructions and pre-addressed, pre-stamped return envelopes. The survey was distributed to participants through Family Eldercare and Meals on Wheels, which are local senior service providers. Because we did not ask service providers to provide identifying personal information for those to whom they distributed the surveys, our team was unable to follow-up with individuals who received it.

Of the 250 surveys given to our partners for distribution, 46 were returned (23 percent), 42 of which were in English, and the remaining 4 in Spanish. Our team did not distinguish between the surveys provided for distribution to Family Eldercare and Meals on Wheels, so we were unable to determine the source of completed surveys. Using Google Forms, we generated an electronic spreadsheet of survey results. When respondents included a comment in the margin in lieu of an answer, the response entry was altered to recognize it.

To condition survey respondents to the survey, an introductory page was included that explains who the research team is, who our clients are, what we hope to learn, instructions on how to complete the survey, a note about confidentiality, an invitation to attend the Livability and Longevity Symposium on April 10, 2018, and contact information for the team.

Survey Content

The survey began with a series of demographic questions, including age, sex, race, and marital status. We then asked questions about a participants' housing situation to understand how likely they thought they would continue living in their current residence, and thus whether they expected to be in the vicinity of the proposed center in the future. Specifically, respondents were asked how likely they were to move in the near future and how worried they were about this, whether they owned their home, and how many other people lived with them.

Survey respondents were then asked about their health services use: where they receive their primary care, how often they see a medical professional, how satisfied they are with their care, and how they pay for their care. These questions aimed to gauge how likely respondents are to switch providers. We also asked whether transportation was a barrier to healthcare access. We wanted to get a better understanding of their perception of transportation barriers, as this could influence how convenient the RBJ site would be for them.

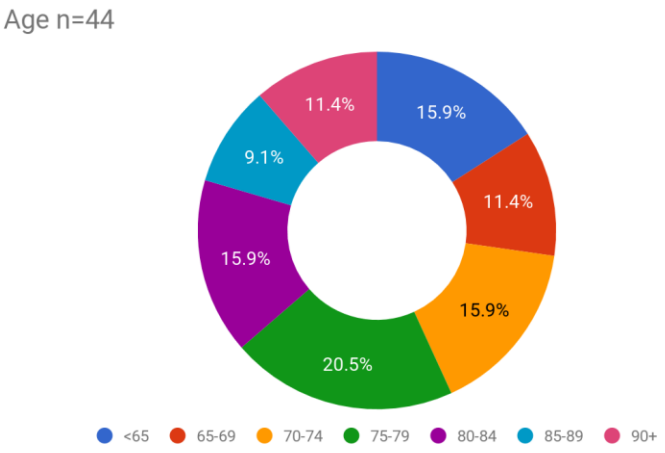
An environmental scan of Austin showed that adult day and wraparound services are not widespread in Austin. To explore residents' desire for these lacking services, we included several questions in our focus group about their merits. Focus group participants reacted negatively to the term "adult day center," yet they were not familiar with the term "wraparound services." Thus, we asked survey respondents if they received these services by providing a description of both. In conjunction with these questions, we asked respondents if they would be interested in any services to which they do not currently have access to gauge the gap between respondents' service needs and desires, and their utilization and satisfaction. In doing so, we avoided providing a list of possible services in order to avoid priming affirmative responses.

Lastly, survey respondents were given a description of the proposed Age-Inclusive Center and asked if they would be interested in using this site. The description included the address (15 Waller Street) and services that may be provided. The survey design did not allow our team to follow up with participants who responded negatively to better understand the circumstances and reasoning that resulted in their response.

A copy of the survey and all attached materials can be found in Appendix C**.**

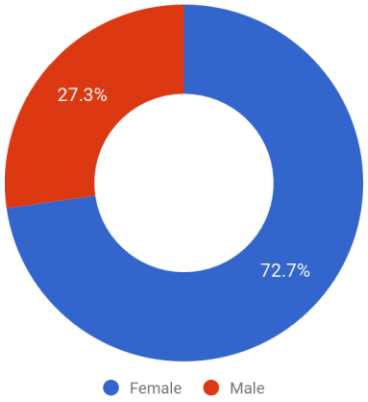
Senior Household Health Experience Survey Demographics

A summary of respondents' demographics is presented in the following figures. Due to the small sample size of returned surveys (n=46), our survey demographics are not reflective of the 78702 ZIP code or the Holly neighborhood, except for respondents' marital status.



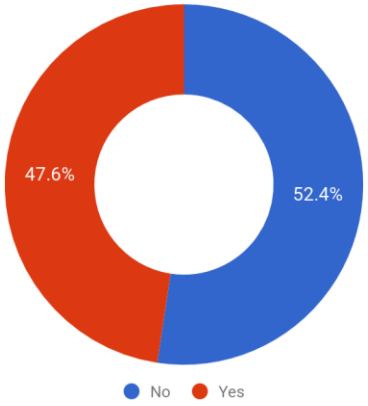
Age:
Our proposal specifically focuses on seniors (adults age 65 and older). The majority (85%) of our survey respondents were 65 and older. However, ACS data shows that 54% of 78702 residents over 50 years old are under 65.

Sex n=44



Sex:
The majority (73%) of respondents were female. This is consistent with surveys showing females are more likely to return surveys.[44,45] This trend is consistent with ACS data that 59% of 78702 65+ residents are female.

Are you of Hispanic, Latino, or Spanish Origin? (n=42)

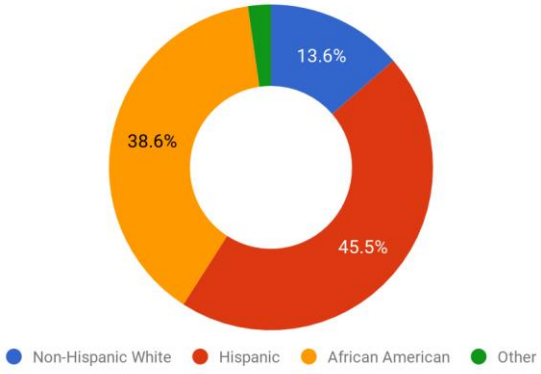


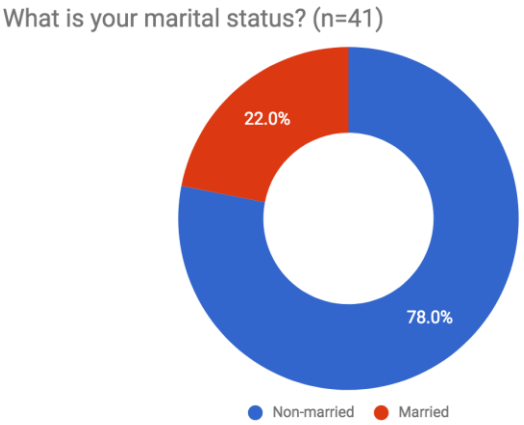
Race:
Slightly under half (48%) of respondents reported being of Hispanic, Latino, or Spanish origin. Just over 50% of 78702 residents report as Hispanic.

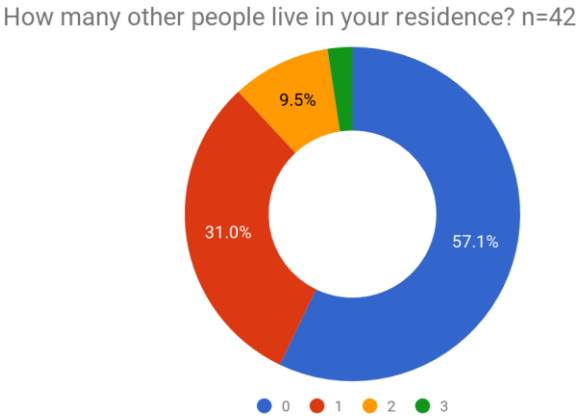
Hispanic made up the largest portion of respondents (45%), followed by African American (39%) and Non-Hispanic White (14%). Two percent of respondents reported as "Other," including but not limited to Asian or Native American.

These results diverge from the neighborhood, which comprises 33% non-Hispanic white, 13% African American, and 2 percent Asian or other races.

Which of the following would you say is your race? Select all that apply (n=44)







Marital Status:
To measure cohabitation patterns, we asked two questions: 1) What is your marital status? and 2) How many other people live in your residence?

Our responses showed a large majority (78%) of respondents were not married, which is representative of 78702 residents.

ACS does not have data on the number of people cohabiting in each residence. Our data shows that 57% live on their own. At least 43% live with one or more person: 31% live with one person, 10% live with two people, and 2% live with three people.

Senior Household Health Experience Survey Findings

The generalizability of the survey results is constrained in several ways, but we still believe that the findings are worth testing in future research. The response rate was lower than desired, which was foreseeable given the design of the survey. Some seniors may have found it difficult to read, comprehend, and resend the survey. They also may have been generally uninterested in responding to the survey, for example because they find it hard to access treatment outside the home or are uninsured. Factors of this nature have an impact on the potential bias of the survey results.

Another area of potential concern was that distributing the survey through service providers such as Meals on Wheels and Family Eldercare limited the scope of respondents to those who already receive services, which could bias the results. At the same time, those who receive services in close vicinity to the proposed RBJ Health Center site may be among those most likely to experience a positive benefit from the development of new services.

Additionally, the fact that some survey respondents are Meals on Wheels service users may affect how representative the sample is of the 78702 ZIP code's senior population. Meals on

Wheels users must meet certain criteria to qualify for their services, possibly including having severe mobility issues. This important characteristic among those users may not apply to the general senior population. However, given that the 78702 ZIP code has one of the highest rates of seniors with physical disability in Austin, we believe that this subset of the senior population to be more representative in 78702 than it would be in other ZIP codes. As discussed in more detail in Chapter 4, for the proposed Center to be financially sustainable, the patient population must include residents from other ZIP codes as well. Thus, further study is necessary to understand demand in surrounding and distal neighborhoods.

A substantial number of respondents did not answer every question on the survey, and given the nature of the survey, we cannot determine why a question went unanswered. They may not have understood the question, may not be certain of the answer, or may have found the question uncomfortable. Each question had at least one non-response and some had as many as eight non-responses. Appendix D presents summary figures for responses in each of the following categories.

Living Situation

For the Age-Inclusive Center to be viable, it must be located where a significant number of seniors reside at the time of its establishment and for the foreseeable future. While the Center will pull from a larger catchment area, having a senior population more proximal will anchor the Center in the community. The survey results indicate that seniors in the sample at least perceive their housing situations to be stable. Almost half of respondents indicated that they were not worried about having to move, despite the rapid gentrification in the 78702 ZIP code.

For those concerned about housing stability, this concern appears to be in the more distant future, as nearly 90 percent did not believe they are likely to move in the near future. Understood definitions of the near future likely vary between respondents, but it is possible that rising rent and property taxes are worrying because of the expenses, but do not reach a threshold where respondents believe they will have to move. The high rate of homeownership amongst this population gives some objective measure of stability beyond perceptions. For 55 percent of respondents, changes in rent prices will not affect housing stability. The property tax exemption for individuals over 65 and with disabilities is particularly pertinent to this demographic.

Medical Care Utilization

The majority of respondents receive their primary care at a doctor’s office or medical clinic, which suggests that demand exists for this form of care even among seniors with mobility restrictions. However, four of the 44 respondents who answered the question receive care in-home and two go to the emergency room, which suggests that a significant part of this population would not be willing to seek preventive care through a clinic going forward.

As may be expected from a population that has a high frequency of health ailments and physical disabilities, the sample of survey respondents are frequent users of healthcare, with over 70 percent receiving medical treatment at least monthly. Going to see a medical professional is routinized for many in this population, meaning that the positive impacts of co-locating other services with healthcare would be amplified. Along with the majority of respondents who pay for

their care through Medicare, the relatively high proportion of dual-eligible respondents (26 percent) in the survey bodes well for the ability of this population to pay for services at the proposed Center.

In terms of satisfaction, 85 percent of respondents indicate that they are at least satisfied with the medical care they receive currently with almost half of those saying they are "very satisfied."

Social Service Use

Demand for wraparound and adult day services in Austin exceeds the capacity of those organizations that provide them, and as expected, most of the survey respondents have not accessed those services recently. While one would presume that this lack of services would demonstrate a need, after being prompted about wraparound and adult day services, a majority still indicated they were not interested in services or supports that are currently unavailable. Some of those who have mobility limitations may presume adult day services to demand a level of physical activity that they cannot do or would not be comfortable with. Some respondents indicated that they received their primary care in-home, which may be comprehensive and preclude a need for additional services.

These results demonstrate a need for coordination. Almost three-quarters of respondents did not visit a wraparound care provider and a majority had not discussed their benefits with a professional or volunteer. Even many who believe that they are taking full advantage of the benefits available to them may not be, and this population of homebound seniors is likely to be eligible for a number of different government programs.

Surprisingly, a majority of respondents do not find transportation to be a problem in getting social services or medical care. This may reflect at present an established routine or use of senior-targeted transportation services. That this population has reliable access to transportation is a positive indication of their prospective ability to access services at the RBJ Senior Living Center campus; however, this answer may only indicate an established routine to a current service location and not other setups. This is in contrast to the focus group findings.

Proposed Center

As has been noted earlier, individuals who are homebound may find it difficult to arrange transportation to a new location, or they may doubt their ability to take advantage of an activity center. In this sense, this result is a very positive indicator for interest in the site. At the same time, one can also question its validity—respondents could see answering "yes" as lending general support to researchers who are considering providing senior-targeted care, even if the individual respondent would not change providers in actuality. It also is not necessarily clear to respondents what getting services at the new Center would entail—it is possible that some would only make the shift if their current provider operated the Center. An alternative approach may be possible in future research to avoid this form of bias.

Themes and Summary

We focused our data collection in the 78702 ZIP code due to this area's dense low-income, dual-eligible, and disabled older adult population.

The data collection consisted of two elements: (1) focus group interviews with RBJ Senior Living Center residents and (2) a survey of service recipients throughout the neighborhood. Though we have concerns about the generalizability of these studies, we believe that they capture the feelings of subpopulations in need and bring various themes to light. The results of the qualitative and quantitative research stress the need for more extensive research on gaps in and demand for senior-targeted services in and near 78702, as well as the need to replicate such research on more distal Austin neighborhoods. While the data give a deeper look at a small subset of Austin, understanding the experience of seniors across Austin is imperative to the overall development of Austin as an age-friendly city.

While a wide array of services targeted towards seniors exists in Austin, focus groups suggested that many who these services are meant to serve either do not know about them, do not know if they are eligible for services, or have trouble getting to where they are provided. This highlights the need for care coordination and co-location. In our focus groups, participants indicated a willingness to switch providers given that they provided these services, and in our survey, most respondents indicated interest in the proposed Age-Inclusive Center that contains these elements. However, for those respondents who report a higher satisfaction with their current provider, likelihood to switch may be lower.

Chapter 4.
Proposed Solution: Age-Inclusive Center

As outlined in Chapter 1, Austin's senior population growth outpaces the national average, a trend that is concentrated in the 78702 ZIP code. In this area, roughly half of senior residents have incomes below 200 percent of the poverty level, and half of the residents 65 and older report at least one disability. The PRP team developed objectives in conjunction with our client, St. David's Foundation, that included proposing a service model to address the particular needs of this population.

Solution

Based on our environmental scan, focus groups, and survey responses, we propose creating an Age-Inclusive Center at the RBJ Senior Living Center campus consisting of three essential components: a senior health clinic, adult day services, and wraparound services. The proposed Center would be located in the RBJ Health Center due to its proximity to a large concentration of low-income seniors, enabling them to age in place.

In Chapter 2, we outlined the literature pertaining to the needs of aging adults and some possible solutions. As a result of this research, we believe that the ideal Center would co-locate health and social services under one roof and provide multigenerational, preventive, and integrative care. This Age-Inclusive Center will be anchored by stakeholders and service providers from the public, private, and nonprofit sectors, as outlined in Chapter 6.

The Center will provide valuable services to RBJ Senior Living Center residents as well as to the people of the surrounding community. Additionally, the Age-Inclusive Center will serve as a model for more such centers in the Austin area and beyond as a new and integrative way to provide health, social, and community-based services to seniors and those age 55 and older with little income. The Center's complete plan will also incorporate multigenerational services and care, such as childcare and community outreach, in recognition that intergenerational strategies result in better outcomes for all.

Implementation and Sustainability

The city of Austin, which owns the RBJ Health Center, would provide the space to a newly formed organization meant to operate the proposed Age-Inclusive Center. This space would undergo renovation and reconfiguration to make it amenable to the proposed Center. A cost analysis is provided in the next section.

The array of services provided by the proposed Center is stated in a broad manner to allow for flexibility in fulfilling roles. Although some service providers have expressed interest in joining the partnership, or have fully committed via a letter of intent, finalization of partners should be made by the entity that takes responsibility for the Center's initial establishment.

Budget Analysis

Our budget analysis is in large part derived from the work and estimates of other organizations that offer similar services. Our format and expense budgets rely on pro forma documents from Programs of All-Inclusive Care for the Elderly (PACE). We examined the 2016 financial pro forma from Bienvivir PACE Program in El Paso extensively to give the groundwork and basic understructure to our cost estimates.

The costs of our proposed services at the Age-Inclusive Center are below. These costs cover renovating 11,700 square feet of the City of Austin-owned RBJ Health Center building at 15 Waller Street, but do not include operational expenses These renovation costs were estimated with advice and personal interviews with Seton Healthcare Family design and construction team members, who recently completed a significant project associated with construction and operation of the Dell Seton Medical Center at The University of Texas. For the sake of budgeting and without access to City of Austin project management and construction staff, we divided the physical space into two distinct categories: clinic space and mixed-use space. Clinic space is estimated to be $300 per square foot to convert and renovate and mixed-use space, here including all non-medical associated spaces, are estimated at $150 per square foot.

Based on advice from Mayor Steve Adler, our team pursued the option of including the conversion and renovation costs of the RBJ Health Center building in an upcoming City of Austin bond measure. A delegation of the team and PRP director Jacqueline Angel met with the Reinvestment in Facilities & Assets Recommendation Working Group of the 2018 General Obligation Bond Election Advisory Task Force (BEATF) to propose adding renovation costs to the 2018 bond package. The attendees of this meeting reported that the project's goals were met with enthusiasm from the task force due to a lack of senior-focused projects on their list of recommendations. Due to the project's late start in the process, however, it was not selected for inclusion in the working group's recommendations, nor in the BEATF's recommendation on budget priorities to the Austin City Council.

Project members continued to explore options for general obligation bond financing through meetings with city council members and their staff. The team met with all 10 city council members or their staff between February and April 2018. Each expressed a general interest in the inclusion of a senior-focused bond item, and most expressed that the proposed amount would not be too large a sum to add to the bond. However, some noted that inclusion would be difficult due to the late nature of our meetings.

General obligation bond financing would align with the City of Austin's interest in renovating and preserving existing city-owned structures and institutions rather than funding the construction of brand-new facilities. Bond financing also allows the city council and its constituents the opportunity to support the project's aims and mission through the established good credit of the city and the council's jurisdiction to tax real property. The current total recommendation, as of April 2018, from the Task Force represents $851 million in bond funding.[46] Including the Age-Inclusive Center's renovation budget in the bond would have a negligible overall effect of the tax rate impact with a taxpayer burden of an additional 0.000083

cents per $1000 of taxable assessed value. Seeking the Council's approval of the project's inclusion in the bond package remains an ongoing effort as of this writing.

The calculations below are based on the PACE pro forma model from 2016 with an assumed and calculated annual inflation rate of 3 percent applied for three calendar years.

Operating cost commitments were obtained from core service lines and are noted below. Our team did not estimate revenues and department incomes. As a clinical partner has yet to be determined, attempting to estimate reimbursement rates and cost capturing can widely vary between service and governance models. Once the project is taken up and operational partners are solidified, each will need to estimate costs and conduct their own cost-effectiveness analysis for each service proposed.

Table 4.1
Cost Calculator for Age-Inclusive Center

	Start Up – Year Zero	Operating – Year 1
Renovation and Build-Out		
Renovation		
6,000 sf. clinic ($300 per sf.)	$1,800,000.00	
5,700 sf. mixed use ($150 per sf.)	$855,000.00	
Equipment	$663,750.00	$33,745.92
IT infrastructure	$112,486.40	$11,248.64
Subtotal	**$3,431,236.40**	**$44,994.56**
Operating Costs		
Medical Staff		
Salaries and Benefits	$147,402.18	$335,955.26
Medical Malpractice Insurance		$8,998.91
Continuing Medical Education		$3,374.59
Nursing		
Salaries and Benefits	$20,186.81	$208,762.38
Social Services		
Salaries and Benefits	$13,883.07	$130,726.07
Other Expenses	$1,124.86	$4,859.41
Center Support		
Salaries and Benefits	$11,498.36	$220,503.72
Other Expenses		$30,371.33
Pharmacy		
Salaries and Benefits	$3,250.86	$81,163.44
Fraud Waste and Abuse Monitoring		$28,121.60
Part D Premium Actuarial Expense	$21,934.85	$22,947.23
Non-Covered Part D Drugs		$24,297.06
Covered Part D Drugs		$294,601.88
Routine Specialists (Dentists, Psych)		
Purchased Service		$32,193.61
Outpatient Services		
Purchased Services (Radiology, Lab, Dialysis, etc.)		$282,804.31

Summary

The estimates above were determined from the independent service lines of other established institutions and organizations. The innovation of our project relies on the coordination of previously disparate entities coming together to co-locate those service lines for patient and user ease. The project is not intended or designed to be a reoccurring financial burden to the City of Austin. With the exception of the initial renovation of the city-owned space, the partnered organizations would maintain their own budgets and finances. The estimates above were intended to give a vision for the scale and possible costs for the operation of the Age-Inclusive Center. Our proposed solution requires the involvement of an array of stakeholders, as well as a system to ensure effective governance between the Center's service providers. The next two chapters of the report delve into such issues.

The integrated and comprehensive structure of the Age-Inclusive Center is intended to be adaptable and iterative. Austin, and indeed the Holly neighborhood, is an excellent site to test the practice and operations of the integrated services. The need is clear, and the opportunity is clearer: the Holly neighborhood and the City of Austin can be leaders in addressing the acute needs of this highly at-risk population by supporting and committing real resources to the proposed Age-Inclusive Center.

Chapter 5.
Stakeholder Engagement and Analysis

Based on the overall project objectives, we developed a Stakeholder Engagement Strategy to identify and engage parties as potential stakeholders to build a network of support for our project and to advance our research and project outcomes. We use the term "stakeholder" to mean any person or entity that has an interest in the success or failure of our project. Stakeholders include residents, politicians, clinicians, funders, and service providers who are actively engaged in senior-oriented advocacy and work. Our stakeholder engagement strategy and the summary of our work are detailed below.

Stakeholder Qualifications

Persons or parties with potential interest in our project were identified through an online scan, faculty member suggestions, and suggestions from our client, St. David's Foundation. To formalize an individual or entity's willingness to participate, we discussed our vision in in-person meetings with each stakeholder, and then asked for structured and unstructured feedback on our vision in a questionnaire named the "Strategic Shared Vision."

We categorized parties as primary or secondary stakeholders. We consider primary stakeholders to be any party directly involved in the approval process, financing, or operation of the Center. Secondary stakeholders are parties willing to support our proposal with primary stakeholders or provide supportive services to the Center. We approached primary stakeholders during fall 2017, then shifted our focus to secondary stakeholders. See Appendix E for a full list of stakeholders.

Primary Stakeholder Analysis

The primary stakeholder group is anchored by St. David's Foundation, Central Health, Meals on Wheels Central Texas, Community Care Collaborative (CCC), Seton Healthcare Family, CommUnityCare, and Family Eldercare. Below are brief descriptions of each organization and its level of commitment to aging in place and the Age-Inclusive Center.

St. David's Foundation

St. David's Foundation reinvests profits from St. David's HealthCare into community health programming for Central Texas and engages with over 60 nonprofit partners to do so.[47] In 2017, the Foundation awarded over $75 million in grant funding to these partners. St. David's Foundation identified three core objectives for its 2017-19 funding cycle, Healthiest Places, Healthiest People, and Healthiest Care.[48] The Foundation states that "Aging in Place" is one of its top four priorities under the "Healthiest People" mission. This priority centers on expanding geriatric-focused services across five Central Texas counties that allow Medicaid-eligible and other low-income patients to stay in their homes as they age.[49] As part of this priority, St. David's Foundation plans to increase access to adult day services, supplementary nutritional services, in-home care services, and more. The Foundation also promotes multigenerational

solutions for aging in place. St. David's Foundation funds programs from which our team has received or seeks support, including Meals on Wheels, Family Eldercare, Drive-a-Senior, and People's Community Clinic.[50] St. David's Foundation is the primary client of the PRP and granted our team the funds necessary to conduct our project. Our hope is that this project will offer the Foundation new opportunities to meet the objectives outlined in its 2017-19 priorities.

CommUnityCare

CommUnityCare was founded in 1970 and runs 19 locations across Travis County. CommUnityCare is a Federally Qualified Health Center (FQHC) and is the largest provider of safety net primary care services in the Austin area.[51] CommUnityCare serves over 88,000 vulnerable patients annually and provides "outpatient primary healthcare, dental care, limited specialty care, lab, radiology including mammography, a full-service pharmacy, and behavioral health services."[52] CommUnityCare recently partnered with the Dell Medical School to pilot a simpler colorectal screening program for patients 50 and older, which represents their particular interest in Austin's aging population.[53] Its team stated an interest in exploring what services or interventions CommUnityCare can add to senior patient offerings, whether through our proposed Center or another entity.

Central Health

In 2004, Travis County residents voted to create a hospital district, which became Central Health. Central Health collects property taxes from Travis County residents and uses the revenue to purchase care for low-income and uninsured residents of Travis County. In 2015, Central Health funded more than 376,000 primary care visits. As data in this report show, the aging population of the 78702 ZIP code resembles Central Health's target population. Sherri Greenberg, LBJ School professor and vice-chair of the Central Health Board of Directors, provided feedback throughout the project and participated in a PRP-led panel during the Livability for Longevity Symposium presentation. Stephanie McDonald, Chief of Staff for the president of Central Health, met with the team and provided feedback on the project proposal. CommUnityCare is a component unit of Central Health, and Central Health in turn has some financial control of CommUnityCare.

Seton Healthcare Family

Seton Healthcare Family (Seton) was formed by the Daughters of Charity of St. Vincent de Paul in Austin in 1902 to operate a small hospital. In 1999, the Daughters of Charity National Health System merged with the Sisters of St. Joseph health system to create Ascension. Ascension is the largest healthcare nonprofit system in the country. Ascension's values include a commitment to serving people of lower socioeconomic status. The local arm of the merger, Ascension Seton, operates the Dell Seton Medical Center at The University of Texas. Dr. Erica Garcia-Pittman, Dell Medical Geriatric specialist and Outpatient Clinic Director for Seton Mind Institute, described the model that she felt best meets the needs of Dell Medical School and the Holly neighborhood. She explained that current research showed that older adults were increasingly asking for choice and independence. She also described how Dell Seton Medical Center has increased its focus on improving the mental health of aging seniors. Dr. Garcia-Pittman also

explained how a lack of mental healthcare is a barrier to aging in place and that Dell Medical Center is committed to reducing this barrier through psychiatry.

Community Care Collaborative

The Community Care Collaborative, founded in 2013, is a public-private partnership between Central Health and Seton created to "better manage the health care of low-income and uninsured residents" in Travis County.[54] Integral Care is also part of the collaborative and provides behavioral and mental health services. The CCC is an Organized Health Care Arrangement, which is an "organized system of health care in which separate health care providers and plans can participate in joint activities, such as quality improvement or payment activities to share patient data."[55] The CCC is supportive of the proposed Center. Throughout the project, CCC leadership, Larry Wallace, Dr. Mark Hernandez, and Greg Hartman served as advisors for the project.

Meals on Wheels Central Texas

Founded in 1972, Meals on Wheels Central Texas is one of the largest meal-delivery organizations in the state of Texas, "distributing 3,000 meals each business day to homebound older adults and people with disabilities."[56] Meals on Wheels believes in "holistic case management" and offers a number of services in addition to meal delivery, including home repair, grocery shopping assistance, veteran services, Alzheimer's respite care, and behavioral health services. Many of Meals on Wheels' clients, especially homebound seniors, stand to benefit from access to the Center's adult day and wraparound services.

Meals on Wheels could play a prominent role as the adult day services provider at the Age-Inclusive Center. President and CEO Adam Hauser expressed strong interest in filling this role. Additionally, Meals on Wheels provided invaluable assistance to the project, helping administer the Senior Household Health Experience Survey discussed in Chapter 3.

Family Eldercare

Family Eldercare was founded in 1982 and provides an array of wraparound services including money management, healthcare consulting and referral assistance, and in-home care and respite services. Family Eldercare maintains a robust volunteer network to provide these essential services.

Family Eldercare could play a prominent role as the wraparound services provider at the Age-Inclusive Center. Family Eldercare also provided invaluable assistance to the project, helping administer the senior household survey discussed in Chapter 3.

Stakeholder Outreach Strategy

Our outreach strategy and its results are detailed in the following sections.

Strategic Shared Vision

With the guidance of Deloitte consultants, our team developed a strategy to better align our vision with stakeholders' based on our understanding of their priorities. Based on best practices, we prepared a short summary of our goals and asked stakeholders to answer questions about these goals as they compared to their vision for the project. This "strategic shared vision" proved to be an effective way to establish a baseline position for each stakeholder. Our team captured this composite vision in a single-page summary, shown in Appendix F.

During the first four months of the project, our team reached out to over 40 confirmed or potential stakeholders to share our initial vision of the Center. This outreach consisted of several steps. If a stakeholder was interested after initial contact, we followed up with a more detailed explanation of our PRP. We asked them to: (a) commit to publically voicing their support for the Center when it is closer to implementation (our desired level of support varied per stakeholder, but generally included a verbal or written statement to decision makers), and (b) respond to the following four questions regarding our strategic shared vision:

1. In your own words, what is your end goal for our project?

2. In your own words, how would you describe our proposed solution and steps involved?

3. Does our proposal align with your own vision?

4. In your opinion, what are our greatest barriers to this challenge? What are our greatest assets?

We used these questions to build a broader narrative of support for the Center and clarify each stakeholder's interests, priorities, or vision for the Center. It allowed us the opportunity to solicit new ideas to shape the age-inclusive care model, and better understand healthcare, aging policy, and the needs of the population. In total, we received responses from over 30 key stakeholders. The following list summarizes the central strengths of our proposal that stakeholders expressed in their Strategic Shared Vision responses.

1. A clear need exists for expanded senior services in the City of Austin, including holistic wellness that goes beyond acute care.

2. There is widespread support for a proposal that co-locates multiple services, including a clinic, mental health care, a day center, and wraparound services. The age-inclusive model would create a sense of community for participants.

3. Strong partnerships with operational and political entities provide extra support for the feasibility of our proposal. These partners include a major medical foundation, two senior service providers, and Luci Baines Johnson, daughter of former President Lyndon B. Johnson.

Stakeholders noted that the largest barriers are funding for start-up costs and sustainable operations, rehabilitation of the building, and a business model that allows all partners to work

together without conflict. Stakeholders expressed concern about the financial sustainability of our proposed Age-Inclusive Center due to its location in an area with increased gentrification.

Beyond contributing to our composite shared vision, these interviews also helped build community support for the project. Interviewees were asked to help our team mobilize support among policymakers and other individuals. Almost all contacted stakeholders offered support by identifying and introducing other potential stakeholders. The results of our primary stakeholders outreach are summarized below. Secondary stakeholder interactions are also presented in subsequent sections.

UT Austin Community Support and Experiential Learning Opportunities

In addition to soliciting feedback on a strategic shared vision, our team engaged with the broader University of Texas at Austin community on areas for potential collaboration. Because the RBJ Health Center is approximately two miles from UT Austin, we see our initiative as a chance to expand service-based experiential learning for UT students in a variety of fields. Experiential learning provides opportunities for students to participate and assignments and activities based on real-life situations and primary research.[57]

We met with the deans of four UT Austin schools, including the McCombs School of Business, the Moody College of Communication, the Steve Hicks School of Social Work, and the School of Nursing. Each was considered a secondary stakeholder and was presented with our strategic shared vision and corresponding questions. At the end of each meeting, the dean or the respective representative committed to some level of collaboration. Most schools committed to allowing students to participate in a service learning position throughout the creation and operation of the Center. The four schools are interested in amplifying capacity and providing expertise, and have offered to help draft formal financial statements and a governance model.

McCombs School of Business Commitment

Our team met with representatives of the dean's office in October 2017, including Director of the Masters in Public Accounting Program Jim Franklin and Healthcare of Business Certificate Professor Dr. Kristie Loescher. Dr. Loescher raised concerns about the sustainability of the health clinic portion given Medicaid/Medicare reimbursement rates in Texas, lack of primary market demand research, and a reduced catchment rate due to gentrification.

Both Dr. Loescher and Franklin saw value in the initiative from a student learning perspective. They committed to involve McCombs students in the creation of the Center's business plan and in the creation and administration of market demand surveys. They also offered to provide students for service learning opportunities in accounting, marketing, and other disciplines once the Center is operational. Six of Dr. Loescher's students joined our team in January 2018 to create a social media engagement strategy for our presentation during the Livability for Longevity Symposium and to analyze primary data from our senior household survey.

Steve Hicks School of Social Work Commitment

Our team met with representatives from the Steve Hicks School of Social Work for an introductory lunch, during which we introduced our proposed model. Dean Luis Zayas, Assistant Dean Sarah Swords, and Assistant Dean for Field Education Tanya Voss attended the meeting. During the lunch, they reiterated the Hicks School's support for aging initiatives, and explained the criteria necessary to allow student field placement at the Center. If the requirements were met, the Grace Program would place one or more students at the site. The Grace Program is a field-based program funded by St. David's Foundation that promotes social workers serving older adults. The Grace Program is able to fund students' placements and offers stipends, in support of its mission to serve older adults.

In addition, a team member met with Dean Zayas separately to complete a stakeholder survey. The stakeholder survey expanded into recommendations for how to best interface with Dell Medical School. Dean Zayas described the innovative work that Dell Medical School is doing with interdisciplinary teams. Dell Medical School is seeking to transform medical services from a hierarchal system lead by a doctor, to a democratic system lead by a team composed of doctors, social workers, pharmacists, and mental health professionals. He further explained that our model could work well with an interdisciplinary practice approach, with minor changes. The model would need to incorporate a formal method for medical and wraparound providers to collaborate.

School of Nursing Commitment

We met with Dean Alexa K. Stuifbergen of UT's School of Nursing, who was receptive to our proposal. The school has a gerontology program for Advanced Practice Nurses (APN), and graduates 12 APNs a year. Dean Stuifbergen expressed interest in placing resident learners at the clinic, who could then serve as clinicians upon graduation. Expanding the School of Nursing's clinical presence in the community is a clear benefit for Dean Stuifbergen and the school.

Moody College of Communications Commitment

Members of our team met with Mike Mackert, the Director of the Center of Health Communication and Associate Professor at the Moody College of Communication in October 2017. Mackert was interested in the concept. He offered to advertise future internships to Moody students, who could help develop an advertising strategy for the Center.

Austin Political Outreach Summary

The Center will ideally receive verbal support from political leaders and some public funding for capital outlays or operations. Our team believed it was necessary to build support amongst local and state elected officials. Local politicians and their staff are also gatekeepers to accessing public funding and for including this project in the 2018 General Obligation (GO) Bond Program. Additionally, these leaders often hold significant influence over the decision making of our operational and funding partners. Therefore, we identified and engaged political entities that would become a decision maker or gatekeeper for funding, building, or maintaining the Center.

We initially contacted each political stakeholder by phone or email to set up a meeting, where we presented our project proposal, strategic shared vision and corresponding survey. If they showed preliminary interest, we then walked them through research showing the need for geriatric services in East Austin and discussed their constituents' needs as related to the Center's services. This approach led each political actor who we contacted to pledge some level of support for a senior center at the RBJ Health Center.

Austin City Council Engagement

Upon invitation from Luci Baines Johnson, PRP team members presented our project proposal to Austin Mayor Steve Adler in January 2018 at Austin City Hall. Mayor Adler voiced his support, suggested that we focus on private or operational donors for capital outlay startup costs, and recommended that we work with Janine Clark, the Mayor's Office Policy Aide, and Austin Public Health to recommend the project for inclusion in the 2018 GO Bond Program.

Following our meeting with Mayor Adler, we met with Austin City Council members and staff to explain our project and gauge their level of support for the Center. We also sought their strategic advice on advancing a recommendation for inclusion in the bond proposal. Further conversations with council members showed several were intrigued by the multigenerational childcare component of our model. In fact, one council member encouraged us to consider adding both the senior and multigenerational components into the bond proposal instead of completing them in phases, as had originally been considered.

Travis County Judge Sarah Eckhardt

Travis County Judge Sarah Eckhardt responded to our emailed inquiry via email. She noted that our partnerships with multiple service providers offer a unique opportunity for development of lacking elderly services. However, she cautioned against relying too heavily on a brick-and-mortar format due to an increasing population shift out of the downtown Austin area. She suggested that funding from earned revenue may be sparse due to lower Medicare/Medicaid reimbursement rates, and that grant funding from state and national sources is dwindling.

Travis County Commissioner Jeff Travillion

Commissioner Jeff Travillion contributed to our strategic shared vision and met with our team to discuss the project. He was supportive of our proposal and offered his office as a potential resource. He also agreed to write a public letter of support for our project.

Texas State Senator Kirk Watson, District 14

We met with Sandy Guzman, legislative director for Senator Kirk Watson, to discuss Watson's involvement in the creation of Capital City Innovation, a new medical innovation zone in downtown Austin, discussed further in Chapter 6. Guzman noted that she believed Senator Watson and the Capital City Innovation team would support the idea if operationalized by a Federally Qualified Health Center partner. On Guzman's recommendation, we also met with Watson's District Director Stephanie Chiarello-Noppenberg. Chiarello-Noppenberg expressed an interest in expanding our services research among the proposed catchment ZIP codes. She also

believed that our suggested costs are understated and suggested that we work with an architect to establish more accurate estimates.

Julián Castro, former Secretary of the U.S. Department of Housing and Urban Development and former Mayor of San Antonio

Secretary Julián Castro, Dean's Distinguished Fellow and Fellow of the Dávila Chair in International Trade Policy at the LBJ School of Public Affairs, met with our team several times. During our first interaction, we briefed him on our strategic shared vision, and asked him questions about his work with aging residents as mayor of San Antonio. Secretary Castro offered his support in name, and to introduce us to his contacts involved with the San Antonio 2020 program, the city's comprehensive plan. We then conducted an on-camera interview with Secretary Castro about the needs of seniors and his opinion on our project. Secretary Castro lastly offered to write a letter of support to or call the Austin City Council members if the proposal came before them for approval and inclusion in the bond package.

Summary

Our team encountered widespread support amongst the public, private, and nonprofit sectors for an Age-Inclusive Center. We received commitments and letters of support from numerous entities and persons and believe we are in a position to capitalize on the broad public support. As the project moves forward, we must continue to engage stakeholders across the community, especially in city government, and work to identify and confirm service providers.

Chapter 6.
Governance Model for the Age-Inclusive Center

A governance model is a framework for implementing the decision-making processes of a board of directors. It is used to institutionalize the management, responsibilities, and operations of the Center. Our proposal calls for the involvement of public, private, and nonprofit entities, which necessitates a flexible and balanced governance model to encourage inclusive decision making and collaboration, and resilience when responding and adapting to unique challenges. Based on research and interviews with Austin-based healthcare organizations, we developed a governance model that would best fit the needs of both the Center and the service providers.

Our team reviewed the governance model of several stakeholders, including St. David's Foundation, Community Care Collaborative, Seton Healthcare Family, and Central Health. We also looked at other local organizations, including Capital City Innovation. Two models in particular, utilized by Capital City Innovation and Seton, stood out. The general principles of our governance model and the two specific models are discussed at length below.

Overview of Proposed Structure

Implementing any governance model at our proposed Center will require an implementing organization (the "implementer") to create a new nonprofit entity to coordinate all partners and activities. Creating a new firm ensures that our proposed public-private partnership operates without biased reliance on the management of a single, existing firm. This new nonprofit firm, named "The Age-Inclusive Center" for the purposes of this report, will run the Center through coordination with a managerial team and service providers, such as an FQHC and care coordination teams. The nonprofit's leadership board, henceforth referred to as "the Board," will make all financial investment decisions, conduct audits of the Center, approve operational decisions made by service partners, and oversee hiring decisions. The Center will sit under the governance of the Board. However, it will have its own governance structure with an Executive Director that reports to the Board, a limited managerial team, and committees for each type of service. These ideas will be expanded upon later in this chapter.

First, however, it is important to understand how we developed this structure. Our proposed governance model is based on two theories of management—collaborative and shared governance. The merits of each are explored below.

Collaborative Governance Model

The first model in which we were particularly interested is built on the concept of "collaborative governance." Collaborative governance takes a broad, stakeholder-centric approach to organizational leadership and seeks to create long-lasting, operational partnerships between entities with a shared mission. It transforms formal operational agreements between partners into a strategic partnership that breaks down sector silos for interdisciplinary collective action.

A recent study conducted by the American Hospital Association Center for Healthcare Governance presented the many benefits that result from a collaborative governance model. AHA's report "Learnings on Governance from Partnerships that Improve Community Health" concluded that the model has "potential to accelerate the transformation of health care from a system of organizations working in silos to a system focused on multi-sector collaboration to improve community health and well-being."[58] A collaborative governance model, the report argues, provides the necessary fluidity and flexibility needed to engage a diverse set of stakeholders.

In addition to helping foster long-term sustainability, the report argues that collaborative governance models are ideal for hospitals and healthcare organizations because "it holds the potential to accelerate change by encouraging organizations with sometimes conflicting agendas to work together for the common good."[59]

In addition to reviewing literature on collaborative governance, we conducted in-person interviews with organizations that have applied different governance models, namely Capital City Innovation.

Capital City Innovation

Capital City Innovation, Inc., is a 501(c)(3) nonprofit that was formed in March 2016. Capital City Innovation is an innovation district, which hopes to become a nexus of activity where businesses and start-ups can become further incorporated into the health ecosystem surrounding the new Dell Seton teaching hospital.

The district physically links Dell Medical School, Central Health, and Seton. The 14-acre district includes three medical school buildings, including Dell Seton Medical Center and Central Health's Brackenridge campus. Additionally, UT's School of Nursing will play a role in the development of the district.

The PRP team first became aware of Capital City Innovation when meeting with Adam Hauser from Meals on Wheels. We conducted further research by interviewing Sandy Guzman, the legislative director for Senator Kirk Watson, who helped bring the project together.

Senator Watson has long been associated with the innovation zone. In September 2011, he introduced to the community "10 Goals in 10 Years," an economic development and healthcare plan for Austin. Included in this plan were calls for a medical school and new opportunities for healthcare innovation. In coordination with Senator Watson, then Austin Mayor Lee Leffingwell created an "Innovation Zone Working Group" to study how best to implement an innovation zone in Austin. Following the release of this study in 2016, Capital City Innovation was created.

Capital City Innovation's mission is to "provide for and support the creation, growth and sustainability of an Innovation Zone that enhances Austin's unique cultural, community and economic assets. A primary purpose of the Innovation Zone is to foster healthcare transformation that will serve the entire community."[60] Capital City Innovation hired its first executive director in July 2017.

Capital City Innovation's governance board is comprised of its three founding members; two ex-officio members representing the City of Austin and Travis County; and four additional seats that have yet to be filled. The three founding members were each asked to contribute $250,000 in seed funding to hire an executive director, develop a strategic plan, and begin developing the organization's infrastructure.

Benefits

For the purposes of establishing a governance model for the Age-Inclusive Center, there were several attractive aspects of Capital City Innovation's example:

1. Creating a new umbrella organization was an effective way of balancing stakeholder interest. Every entity has a seat at the table. We appreciated that while the stakeholders have primacy in determining the future direction of Capital City Innovation, an independent executive director runs the day-to-day management. This seems like an effective way to balance the interests of the stakeholders.

2. Our team appreciated that Capital City Innovation provided us with a local example that is already working. In a sense, we would not have to be reinventing the wheel—the prospective stakeholders are already familiar with this type of governance model.

3. A collaborative governance model seems to be the most effective way of fostering long-term, big-picture collaboration between the public and private sectors. By institutionalizing collective decision making in the governance model, we believe that each service provider would be better equipped and empowered to contribute.

4. Additionally, we believe that a collaborative governance model would be the most effective way of fostering consensus among the service providers.

Challenges

Perhaps the biggest challenge to a collaborative governance model is buy-in. A successful governance model would be dependent on shared vision and commitment to collaboration. If certain stakeholders are resistant to co-ownership or possible imbalance in contribution of resources, it could lead to tension or dissolution. University of California Berkeley's Chris Ansell and Allison Ash write that successful models are dependent on "time, trust, and interdependence."[61] If these conditions are not met by all of the stakeholders involved, then one runs the risk of an unsuccessful governance model. Therefore, the implementer of the Age-Inclusive Center would need board members to commit to the idea of collaborative governance to ensure success.

Shared Governance Model

In contrast to the external view of collaborative governance, shared governance zooms in to examine how employees interact within and are empowered by a firm. According to the Shared Governance Task Force, this model represents "a dynamic staff-leader partnership that promotes collaboration, shared decision making, and accountability for improving quality of care, safety,

and enhancing work life."[62] This decentralized leadership style aims to engage all stakeholders in the workplace and empower them to voice their concerns for the betterment of the organization. The shared governance model is a derivative of Socrates' pedagogical method of encouraging students to teach themselves through answering questions posed to them.[63] Over time, the Socratic method morphed into the idea of representation through democracy in government and then business management. The healthcare industry began adopting the practice in the 1970s due to medical organizations' varying roles and quantities of employees.

A literature review identified three versions of shared governance.[64] The first, the Councilor Model allows a council to interpret and integrate joint staff and managerial decisions through subcommittees. The second, the Administrative Model, splits management and staff into two different committees to come up with policies. Lastly, the Congressional Model creates a group setting where all representatives, both managerial and staff, have the power to voice proposals and vote on policies as one group. The Congressional Model seems to be the most widely adopted among studied nursing organizations.

Benefits

Shared governance is shown to be quite effective in increasing employee buy-in. An organization using shared governance can expect to reduce turnover by an average of 11 percent. Communication rates also improved, with one study reporting a 6 to 7 percent increase in timely communication within the nursing staff. Cost savings are another benefit of shared governance. One study found that a medical center can save over $6 million due to fewer trainings, while another found that non-salary costs are expected to decrease by an average of 1.5 percent.[65]

Challenges

Although the shared governance model is acclaimed for its employee engagement tactics, there are a few drawbacks to consider. First, freedom to constantly innovate leads to lack of clarity in role perception.[66] In fact, about 21 percent of nurses in one study reported never being told of changes that affect their work. Too many decision makers can cause frustration or a stall in progress, causing some leaders to quit their participation. In addition, one study reported an 8 percent decrease in job satisfaction among nurses engaging in shared governance.

Despite these concerns, the acclaimed benefits of shared governance found in similar organizations with team members in different fields of practice lead us to believe that it will create a beneficial culture of engagement and innovation. To combat role confusion, we recommend that the implementer ensure that each employee is offered monthly feedback sessions with peers and direct supervisors, during which they could ask for clarification and voice their concerns. We also suggest that the implementer and the Board create a policy of sharing committee minutes with all employees within one day of meetings to avoid miscommunication.

Ascension Seton Nursing

Seton Healthcare Network in Central Texas states that its shared governance model empowers frontline staff nurses to actively participate on policymaking bodies that determine the

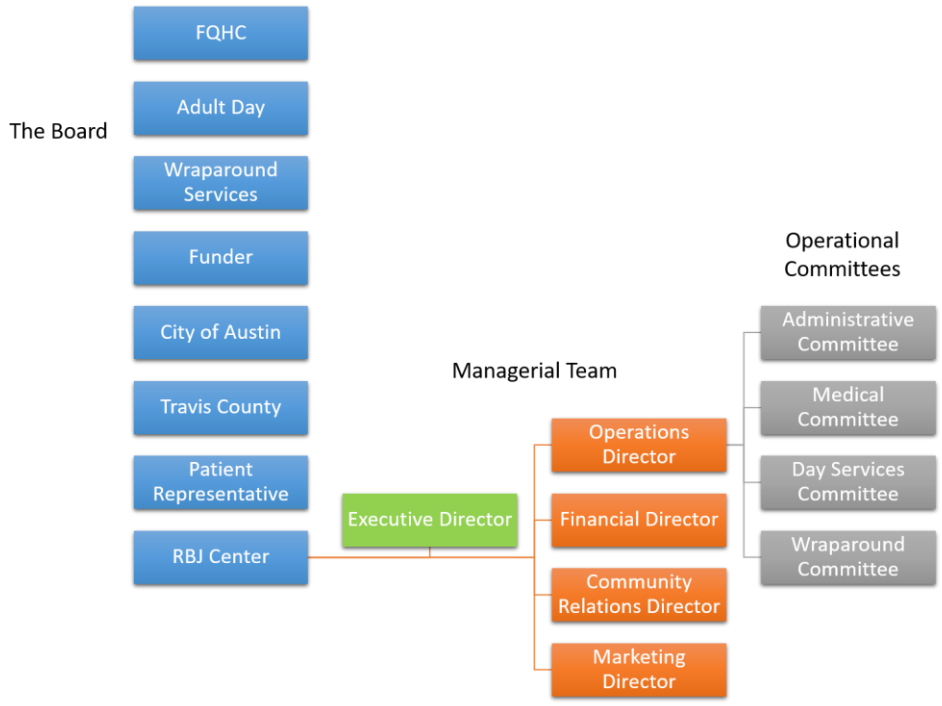
professional nursing practice environment.[67] A 65-member nursing congress defines, promotes, and evaluates nursing practice and assures consistent nursing practice, standardization, and redesign across the network of Seton hospitals. All nurses are eligible to participate and self-nominate themselves. Because Seton works intricately with Dell Medical School and CommUnityCare, we envision that both partners will be familiar with this model.

Our team met with Jonathan D. Hecht, an advanced practice nurse supervisor at Dell Seton Medical Center, to learn more about the implementation of this model. Mr. Hecht observed that the shared governance model increases decision makers' use of evidence-based over eminence-based decision making.[68] Because decision makers are often veterans of not only the practice but also the organization itself, they are prone to rely on previous practices over innovating. Mr. Hecht stated that medical centers can encourage innovation through shared governance by giving patient-facing nurses the chance to introduce ideas based on their current work. In addition, Mr. Hecht mentioned that the model works best among his team when the individuals are previously engaged in their work. Because employees are not compensated for their participation on one of the councils, and changes decided upon in the council take time to be implemented, it is easy for volunteers to become discouraged.

Our Proposed Governance Model

Using the theories of shared and collaborative governance, our team developed a new model for the management of our proposed Center, shown in Figure 7.1 and expanded upon in the following sections.

Figure 7.1
Governance Model



Board of Directors for the Age-Inclusive Center

The Board, in contrast to managerial or operational roles, will not be made up of new faces. Instead, this entity will include a seat for one representative of each operational, financial, or managerial partner, as well as one patient representative and two political appointments. The Board will approve budgets, proposals for service changes, and new partnerships from the executive director. They will also be expected to conduct a yearly audit of the Center's financial statements in coordination with an independent auditing firm. The board will have decision-making authority over employment of the executive director and may be responsible for representing the Center in public. They will also be tasked with ensuring the financial sustainability of the Center.

There will be eight seats total, with two seats open for a city and county official to better ensure that the broader stakeholders' concerns are met. This is large enough to encourage innovation and prevent groupthink from influencing the group in one direction, yet small enough to full engagement from the members.

To ensure equal representation for each partner, the chair position will rotate once every year to a new seat. For instance, if the representative from Central Health acted as the inaugural chairman in 2020, they might pass the position to St. David's Foundation, the next organization in line, in 2021. Allowing each partner to represent their interests on a board instead of in a management position ensures that each of their voices is equally heard.

Management and Operational Committees

The Center will use shared governance within the operational divisions to encourage employee leadership, engagement, and innovation. An executive director will work with four managerial directors to head strategic planning and certain administrative tasks. The financial director will manage investments, bookkeeping, payments, and other concerns related to finances. The marketing director will head service identification and adjustments, advertising, and branding. The community relations director will manage relationships with political entities, clients, their families, and the broader community. This job may be combined with marketing during the initial years of operations. The operational director will manage supply orders, scheduling, and transportation. We also envision the operational director managing employee committees.

To implement shared governance within lower levels of the organization, employees will be asked to self-nominate themselves or other team members to one of four operational committees: Medical Care, Wraparound Care Coordination, Day Center Activities, or Administrative Duties. Members of these committees will create and share best practices during once-a-month brainstorming sessions. These committees will then share their practices with each other during quarterly meetings, as well as propose organizational improvements to the executive director or to the board of directors.

Service Providers

The Age-Inclusive Center has received pledges of service provision or funding from the following stakeholders, all of which we expect to become a part of our governance structure

outlined above. Letters of commitment from certain service providers can be found in Appendix G.

Meals on Wheels Central Texas

Meals on Wheels has signed a letter of commitment to provide adult day services at the Center, including day activities and tele-behavioral health services customized to participants. They will establish an accredited social day center that includes classes, games, field trips, exercise, and more. Their letter of support commits an operating sum of $225,000 to this venture's programming each year, as well as an unspecified number of staff members to run the programming. Meals on Wheels plans to provide one meal and one snack daily to participants and behavioral health services. The St. David's Foundation funds this program and is committed to providing further funding for the Center through expanding Meals on Wheels' capabilities.

Family Eldercare

Family Eldercare has signed a letter of commitment to provide wraparound services for the Center's participants. We expect wraparound services to include medical case management, legal references, guardianship for seniors without the bill payer and financial management services, and transportation coordination.[69] Family Eldercare is also funded by the St. David's Foundation, who is committed to providing funding to further expand their services.

Steve Hicks School of Social Work

The Steve Hicks School of Social Work verbally expressed interest in expanding its Gerontology Resources and the Aging Community in Education, or GRACE program, to the Age-Inclusive Center. Dean Sarah Swords communicated this interest over several meetings in fall 2017. The GRACE program funds the residency of social work students at The University of Texas at Austin who specialize in gerontology, as well as a resident social worker at the site who supervises the students.[70] These students would work closely with Family Eldercare to provide care coordination to the participants of the adult day center. The Center will house at least two students. The St. David's Foundation also funds the GRACE program and would be interested in funding scholarships for the student residents.

McCombs School of Business

The McCombs School of Business verbally committed to providing the Age-Inclusive Center with operational marketing and financial management services from students in its Business of Healthcare Certificate Program. These upperclassmen will engage in service learning with an operational function of the venture that is relative to their studies, adding to the Center's sustainability and enhancing their education. This commitment comes from Dr. Kristie Loescher of the Business of Healthcare Certificate Program and Jim Franklin of the MPA program. Dr. Loescher solidified her involvement by allowing five of her students to volunteer with our team in spring 2018.

Senior Clinic (FQHC) Operational Partner

Perhaps the largest service role that an implementer will need to fill is that of the Federally Qualified Health Center (FQHC). The participating FQHC will run a small, non-emergency clinic for geriatric patients in coordination with possible residents from Dell Medical School. Our team worked with leadership at both CommUnityCare and the People's Community Clinic to gauge the feasibility of their participation. While both service providers are supportive of the concept and potentially are interested in filling this role, neither has confirmed their involvement as an operational partner as of this writing.

Dell Medical School

The Age-Inclusive Center will offer innovative learning opportunities for medical students and residents from Dell Medical School. We propose that the implementer create a geriatric specialty residency for at least one student at our Center. Other medical students will use it to observe and practice primary care visitations. This partnership will help ensure the sustainability of senior care in the area. We do not have a formal partnership at this time, but Dr. Erica Garcia-Pittman of Dell Medical School expressed interest in developing a geriatric residency program once the Center is operational during a meeting with our class in fall 2017.

Funders

Letters of commitment for each funder can be found in Appendix G.

The Carl C. Anderson Sr. and Marie Jo Anderson Charitable Foundation

The Carl C. Anderson Sr. and Marie Jo Anderson Charitable Foundation (The Anderson Foundation) supports existing programming for vulnerable youth, disabled persons, and the elderly across the state of Texas.[71] The average grant size is $25,000. With over $1.3 million in funding, Anderson Foundation strongly supports Meals on Wheels, Family Eldercare, and People's Community Clinic, three organizations that we propose as operational partners. The Foundation is also familiar with our proposed location and the surrounding community's needs; it recently invested over $200,000 into elevators at the RBJ Senior Living Center. In a letter of support, the Foundation indicated that they would be willing to become a financial supporter of the clinic or day services portion of the Center.

Austin Geriatric Center

The Austin Geriatric Center is the managerial entity that operates the RBJ Senior Living Center.[72] As this nonprofit makes decisions for our proposed target market, they would play a key role in both pushing for any redevelopment in the adjacent Austin Public Health-owned building and in marketing our services to RBJ Senior Living Center residents. The Austin Geriatric Center sent our team a letter of support stating its desire for our proposed services to come to fruition.

Vacant Roles

Based on the Center's proposed services and the above audit of the expected services to be provided by partners, we have identified several key roles that will need to be filled in the Age-Inclusive Center's management. First, the Center requires an executive director to manage the day-to-day operations, and an operations manager to care for the facilities, arrange any transportation, and schedule events. A head care coordinator is also required to solicit and organize services from partner organizations. This role will be in charge of scheduling and expanding services based on patient needs, as well as creating special programming.

Conclusion

In summary, through research and personal interviews, our team concluded that a collaborative governance model would be the best fit for the Center's board of governance and developed a model that reflected the best practices from other boards. We also identified many of the potential service providers as well as potential funders. As the project moves forward, we must continue to engage with these confirmed or potential partners, as well as work to identify new institutional partners.

Chapter 7.
Presentation of Research and Community Connections

Introduction

As the 2017-18 academic term neared its end, our team worked to give the PRP public exposure. We did this for many reasons. First, engaging with the community provides a platform for critical feedback to improve our model. The critique and insight of outside stakeholders and experts can only improve the design and feasibility of our proposed solution. Second, presenting our research in a public forum raises the visibility of the project and allows us to connect with individuals and organizations with whom we have not previously engaged. It can also lead to potential partnerships and funding opportunities for future work. Finally, the PRP project is limited to the 2017-18 school year, but we believe that this problem deserves ongoing attention and enthusiasm. By bringing awareness to both the challenge and possible solutions, we hope to extend the lifespan of the project, and inspire individuals or organizations to build on the foundation that we have built.

Livability for Longevity Symposium

AustinUP and the PRP team, as representatives of the LBJ School of Public Affairs, partnered to host the Livability for Longevity Symposium to bring together community stakeholders to discuss and develop meaningful solutions for Austin's aging population. To develop the Symposium sessions, AustinUP and the PRP team met with representatives from Family Eldercare, ACC/AARP Back to Work 50+, Aging 2.0, Austin Commission on Seniors, Meals on Wheels Central Texas, Austin Area Aging, and AARP Texas. The Symposium included a keynote conversation, an economic and workforce development panel, and a housing and community solutions panel. As part of the Symposium, our team presented our research during a 90-minute session. The session comprised a mini-documentary (discussed below), a presentation of the problem and proposed solution, a Q&A session, and an expert panel session.

Community stakeholders described current Austin Aging Solutions. A current CommUnityCare patient described how uninsured older adults could obtain healthcare in Austin. She described her personal experience from finding community care to seeing a specialist. Stakeholders shared current projects. The symposium showed audience members the state of aging in Austin. The audience and community stakeholders shared information about aging in Austin throughout the symposium. Audience members asked the PRP team detailed questions. Austin Public Health asked the PRP team about barriers to service engagement. Some seniors shared their lived experience; for instance, one audience member from the Holly neighborhood stated she was afraid of losing access to transportation with the planned CapMetro service changes. See Appendix H for the full program and details of the symposium.

Audience members took part in a live-polling exercise during our presentation. We asked questions to gauge audience opinion on aging in Austin. Appendix H includes more details about this segment, including questions asked and results.

Mini-Documentary

Our team produced a mini-documentary, *Rebekah Baines Johnson Center,* which focuses on RBJ Senior Living Center residents' personal perspective on wellness and the ecosystem of senior care. Taylor Barron, a local filmmaker, generously assisted us in filming and editing the footage for its final presentation at the symposium. The documentary provides additional qualitative research to complement the research methodology presented in Chapter 3. We aimed to share a narrative on the life of Austin's senior residents for viewers to better understand the problem statement and goals of our project. The documentary amplifies the voices of the individuals at the heart of our project and highlights the specific location of our project's proposal.

The film features interviews with three residents—Bill Kretschmer, Barbara Faeyermuth, and Martha Pacheco—who were recruited with the help of Helen Varty, Executive Director of the RBJ Senior Living Center. Prior to filming on March 13, 2018, we provided each individual with predetermined interview questions that were focused on the residents' concept of "healthy aging." Barron filmed the interviews while PRP member Robert Epstein asked the prepared questions. Each interview lasted approximately one hour. Examples of the questions include:

- Why is wellness meaningful to you?
- How do you think of or define "wellness?"
- When have you felt like you have had "community"?
- Can you share a story about an experience you had with community at RBJ?
- What are services that you wish were available at or near RBJ?
- What are things you value at RBJ?
- What are things you wish you could change or adjust?

The final documentary also includes footage from a previous interview with Julián Castro, former Secretary of the U.S. Department of Housing and Urban Development, conducted on February 22, 2018, with Barron, PRP member Madison Gove, and Professor Jacqueline Angel. This interview delved into the broader concepts of aging in place and housing for seniors with questions like:

- During your time as mayor of San Antonio and as HUD Secretary, what did you see as the largest challenges faced by low-income seniors?
- How do you think a senior center that includes healthcare, wraparound, and adult day services would affect a senior's ability to age in place?
- Can you talk about any experiences with seniors in your life that inspired you or impacted your perspective on aging?

The documentary opens with Martha Pacheco in her apartment overlooking IH-35. She states that wellness to her is security, happiness, and being surrounded by friends, like she has been for decades at the RBJ Senior Living Center. The documentary then transitions to Secretary Castro's experience with the obstacles that his grandmother and mother faced aging in place. We pan to Bill Kretschmer who discusses living and working at the RBJ Senior Living Center, and how different his life would be without it. He knows he would be living in Section 8 Housing, that his mobility would be defined by bus schedules, and that he would be without the flexibility and autonomy that living at the RBJ Senior Living Center provides. The documentary ends with Barbara Faeyermuth, librarian and Zumba enthusiast, who explains her fulfilling time at the RBJ Senior Living Center. Barbara shares her love for the library and dance classes as well as her passion for nutrition and health classes. In less than six-and-a-half minutes, the documentary powerfully presents the experiences of senior residents at RBJ in their own words—voices that are so often missing from the conversation about their own wellbeing.

PRP Newspaper Op-Ed

Professor Jacqueline Angel and PRP member Andrew Scoggin co-wrote an op-ed as part of the project. The *Austin American-Statesman*, *Houston Chronicle*, and Fort Worth *Star-Telegram* picked up the op-ed in April 2018. Angel and Scoggin wrote about the growing senior population in the U.S. and how Texans can "set an example for others to follow" by making changes that benefit people of all ages. An image of the op-ed as it appeared in print is included in Appendix I.

Chapter 8.
Conclusion and Recommendations

Austin demographic data and projections make it clear that the city is in need of an innovative solution to address aging-related challenges. Our literature review presented a more nuanced description of the issues that aging and aging in place present. Building on the 2015-16 PRP, we developed a plan for an Age-Inclusive Center in the Holly neighborhood. Focus groups and surveys informed plans for the Center. The Livability and Longevity Symposium in partnership with AustinUP gave our team an opportunity to share our research and gain feedback.

Our team received support for an Age-Inclusive Center through engagement with a wide variety of stakeholders including aging-services providers, public officials, members of The University of Texas at Austin community, and other interested parties. Throughout the year, our work followed multiple, parallel tracks. We conducted a stakeholder analysis, created a proposed governance model, and worked to mobilize members of the community on behalf of the project. As the project moves forward, the entity that implements our proposal must continue to engage stakeholders across Austin, especially in city government, and work to identify and confirm service providers.

Focus group respondents from the RBJ Senior Living Center were enthusiastic about models of care based in a centralized location with medical and non-medical services. In particular, respondents showed interest in routine wellness monitoring, mental health services, medication management, activity classes, and non-medical transportation. They indicated a willingness to switch providers if the Center provided these services and was accessible.

Though only a small sample, the senior residents surveyed from the 78702 ZIP code indicated a lack of available adult day and wraparound services in Austin, and a majority of respondents stated interest in the proposed Age-Inclusive Center that contains these elements.

The Livability for Longevity Symposium provided an opportunity to present the project goals, findings, and proposed recommendations. In conjunction with other community organizations focused on aging in Texas, the symposium was a daylong event with speakers and panels focused on development, housing, and aging. Our presentation showcased our work over the past year and encouraged engagement with the audience through a documentary viewing and live polling.

Recommendations

Although more research is needed to refine the needs of seniors in the 78702 ZIP code, our research points to a need for senior care all in one place. We recommend creating an Age-Inclusive Center using a collaborative government decision-making structure.

More comprehensive market research of the 78702 ZIP code and the greater catchment area is required given the small size and scope of research done by the PRP team to date. Future research should be attuned to gauging interest in the program offerings of specific service

providers as well as the perceived accessibility of a finalized location, particularly among those who face acute mobility challenges.

Our solution addresses the problems associated with aging, those of social isolation, difficulty coordinating health decisions and needs, and an ever-increasing reliance on the support of others. By creating and operating a single space that contains the essential and holistic needs of seniors, we can close the gaps that aging residents face. As the community rapidly changes around them, the Holly neighborhood's at-risk population can benefit and thrive with the assistance of our place-based initiative. The city's commitment of that place, a single floor of a five-story property, would enable the already multiple successful community-serving organizations with the tools and location to base their services and operations. The RBJ Health Center building is adjacent to a rapidly growing community of at-risk seniors and is a viable location to implement our strategy for addressing those needs.

Adding a multigenerational component to the Age-Inclusive Center creates a symbiotic relationship between the community's children and seniors. This place, renovated by the City of Austin to accommodate the geriatric primary care clinic with adult day and childcare services, along with firm commitments from Family Eldercare and Meals on Wheels, can soon demonstrate the City's commitment to its seniors and its commitment to innovation and creativity. The budget we propose is the beginning of the conversation. The costs associated with the renovation of the space are not insignificant at an estimated $3.4 million dollars. However, with partner organizations firmly committed to the project, its aim, and its successful operations, the investment made by the city and its tax base would be rewarded with the opportunity to have a real and lasting effect on the growing needs of our seniors.

Our team proposes a collaborative governance model for the Center. This would involve creating a new umbrella 501(c)(3) organization administered by an independent executive director. Each service provider, along with ex-officio members representing the city and county, would comprise the governance board. Our team felt this model would ensure that everyone had a seat at the table. Furthermore, a collaborative governance model is the most effective way of fostering long-term, big picture collaboration between the public and private sectors potentially represented on the board. By institutionalizing collective decision making in the governance model, we believe that each service provider would be better equipped and empowered to contribute.

Glossary

Activities of Daily Living (ADLs). Basic tasks performed in the course of everyday life, such as eating, bathing, dressing and using the bathroom.

Acute Care. Medical care for an immediate illness or serious injury. Treatment is typically short-term and provided in an emergency department or hospital.

Ambulatory Care. Outpatient medical care. Patients are usually discharged on the same day they receive treatment, which is typically provided in doctors' offices, clinics or hospital emergency departments

American Community Survey (ACS). Ongoing survey that provides information on a yearly basis. Topics include demographic characteristics and health insurance.

Behavioral Health. An umbrella term that includes mental health, substance use disorders and behaviors that contribute to chronic medical illnesses.

Care Coordination. Efforts to better coordinate the care of patients, including facilitating communication between healthcare providers, assisting patients with creating self-directed care plans and providing education and self-care techniques.

Case (Care) Management. A patient-centered process used by public and private health insurers and providers to manage the care of high-cost, high-need individuals.

Centers for Medicare & Medicaid Services (CMS). The U.S. Department of Health and Human Services agency responsible for the federal administration of Medicaid, Medicare, and the Children's Health Insurance Program.

Chronic Care Management. The coordination of healthcare and support services to reduce costs and improve the health of patients with chronic conditions, such as diabetes and asthma. These initiatives focus on evidence-based interventions and education to improve patients' self-management skills.

Colocated Care. Healthcare delivered by different types of providers, such as physical health and behavioral health clinicians, who have offices in the same building.

Dual Eligible. People who are eligible for both Medicaid and Medicare. Because they are eligible for Medicaid, they are generally low-income. As Medicare clients, they are older than 65, blind, or have disabilities.

Durable Medical Equipment (DME). Medical equipment provided to individuals with limitations due to physical or mental conditions or recovering after discharge from a hospital. Examples include modified shower equipment, walkers, wheelchairs, and hospital beds.

Emergency Medical Services (EMS). Services provided by first responders, such as ambulance crews, firefighters and police officers, in medical emergencies.

Federal Poverty Level (FPL). Annually updated guidelines established by the U.S. Department of Health and Human Services to determine eligibility for federal and state programs. The FPL for a family of four was $24,600 in 2017.

Fee-for-Service (FFS). A payment method in which an insurer reimburses a physician or hospital for each service provided according to a fee schedule.

Health Disparity. A difference in health status that is closely linked with factors such as race/ethnicity, religion, socioeconomic status, gender, mental health, sexual orientation, geographic location, or disabilities. People negatively affected by health disparities may experience greater social and economic obstacles to health.

Health Literacy. A person's capacity to obtain and understand basic health information, related to both health insurance and healthcare, in order to make appropriate decisions.

Home and Community-Based Services (HCBS) Waiver. Under this waiver approved by the federal government, long-term services and supports can be provided in a home or community setting instead of an institutional setting for Medicaid beneficiaries. The goal of this waiver program is to meet the physical health, functional, and behavioral health needs of low-income seniors and disabled individuals who otherwise would be eligible for placement in an institutional setting, such as a nursing home.

Independent Living Center or Center for Independent Living (ILC or CIL). A nonprofit agency that assists people with all types of disabilities. These agencies are consumer controlled, meaning clients make decisions regarding their own care, providers, and living arrangements.

Integrated Care. A patient-centered approach to healthcare provided by a multidisciplinary team of clinicians. This care may address physical health, oral health, mental health, substance use disorders, health behaviors, and more.

Long-Term Services and Supports (LTSS). Healthcare, personal assistance, and other supportive services provided to people who are unable to care for themselves, often seniors or those with disabilities. LTSS may be provided in facilities, the home, or community-based settings. Medicaid is the largest payer of LTSS, followed by Medicare.

Managed Care. A health delivery system that seeks to control access to and use of healthcare services to limit costs and improve the quality of care. Managed care arrangements typically rely on primary care physicians to act as gatekeepers and manage the care their patients receive.

Medical Home. An increasingly popular model of primary care that is team-based, often in the office of the primary care physician, and coordinated across the care system, including specialty care, hospitals, home health care, and community supports. The team oversees all of a patient's healthcare needs, with a focus on preventive care.

Medicare. A national insurance program created in 1965 to provide healthcare coverage for people over 65, regardless of income. The program has expanded to cover younger people with permanent disabilities and those with end-stage renal disease. Part A covers hospital care and Part B covers medical care, generally outpatient. Part C, known as Medicare Advantage, is a plan offered through a private insurer that contracts with Medicare. Part D, the most recent addition, offers a subsidized prescription drug benefit.

Medicare Advantage. A health plan offered by a private company that contracts with Medicare to provide Part A and B benefits. Medicare Advantage Plans include health maintenance organizations, preferred provider organizations, private fee-for-service plans, special needs plans and Medicare medical savings account plans.

Medicare Supplemental Insurance (Medigap). Health insurance sold by private insurance companies to fill some of the payment and benefit gaps in Medicare coverage.

Out-of-Pocket Costs. Healthcare costs, such as deductibles, copayments, and coinsurance that are not covered by an insurance policy. Out-of-pocket costs typically do not include premiums.

Patient-Centered Medical Home (PCMH). A healthcare delivery model that emphasizes care coordination and communication to enhance a patient's care. Usually, a patient's primary care provider is considered the medical home and the provider coordinates care with other providers, including specialists. The aim is to provide better care, lower costs, and improve the patient experience.

Population Health. The health outcomes of a group of people, often a community, rather than one person. Population health considers the social, economic, personal, and environmental factors that influence health.

Premium. Amount paid to an insurance company for providing healthcare coverage for benefits specified in a policy.

Preventive Care. Healthcare that emphasizes the early detection and treatment of diseases. Prevention is intended to keep people healthier, reducing healthcare costs.

Primary Care. Medical care provided by physicians and other health professionals such as advanced practice nurses, physician assistants, and certified nurse midwives. It is geared toward prevention, early intervention, and continuous care for basic healthcare services. Primary care includes pediatrics, general, internal, and family medicine, and obstetrics and gynecology.

Social Determinants of Health. Personal, social, economic, environmental, and other circumstances that contribute to a person's health.

Social Security Disability Insurance (SSDI). Federal cash payments to people who have worked for a specified time and paid payroll taxes to the Social Security Trust Fund. These people have a disability severe enough to keep them from working in regular paying jobs for at least 12 consecutive months.

Supplemental Security Income (SSI). A federally funded cash assistance program to help low-income seniors and people who are blind or have other disabilities to meet their basic needs of food, clothing, and shelter. People eligible for SSI are also eligible for Medicaid.

Telehealth: Harnessing information technology to remotely connect healthcare providers with patients for a wide array of health services.

Underinsured. Having public or private insurance that does not cover all necessary healthcare services, resulting in out-of-pocket expenses that may affect a person's ability to obtain healthcare.

Uninsured. People who lack public or private health insurance coverage.

U.S. Department of Health and Human Services (HHS). Manages programs that impact health, public health and human services. HHS oversees Medicare, Medicaid, the Children's Health Insurance Program, and the health insurance marketplaces.

Appendix A.
Focus Group Methodology

Focus Group Methodology Interview Guide

1. Procedure
    a) Informed Consent: confidentiality, time commitment, incentive, follow up
    b) Create a free-flowing and comfortable environment intended to encourage candid discussion among participants
    c) Introduction: purpose of group interview
2. Guide
    a) Do you think people like yourself would be willing to leave their present doctor for care adjacent to RBJ?
    b) Let me mention a few additional services that might make it more likely that someone would use the new clinic.
    c) Which of these do you think would make it more probably that someone would switch from his or her old source of medical care to the new clinic?
        a. If transportation [where to?] were offered?
        b. If daycare [described in more detail] was offered?
        c. Wrap-Around: if a multigenerational program that connects residents to economic supports was offered?
            1. If legal services, (bill paying)
            2. If health insurance
            3. If food assistance
            4. If utility assistance
            5. What if crafts, cooking, and field trips were offered?
            6. List as many as you wish.
3. End with an open-ended question like: Is there anything I have missed that you think would make it more likely that someone would want to switch to the new clinic?

Adult day care facilities can provide a variety of services and activities, including:

1. Assistance with eating, taking medicines, toileting, and/or walking
2. Counseling
3. Educational programs or mental stimulation
4. Exercise programs
5. Health monitoring (e.g., blood pressure, food or liquid intake)
6. Podiatry care
7. Preparation of meals and snacks
8. Social activities
9. Therapy (occupational, physical, speech, etc.)
10. Transportation services

Social activities in adult day care centers can include:

1. Crafts
2. Cooking
3. Exercise
4. Field trips
5. Games
6. Gardening
7. Holiday parties
8. Music therapy
9. Pet therapy
10. Relaxation techniques

Source: http://www.caregiverslibrary.org/caregivers-resources/grp-caring-for-yourself/hsgrp-support-systems/what-is-adult-day-care-article.aspx.

Appendix B.
Focus Group Summary

Focus Group Summary

Lyndon B. Johnson School of Public Affairs
The University of Texas at Austin

Session 1: November 10, 2017 1:00 PM
Session 2: November 10, 2017 2:00 PM
Session 3: November 17, 2017 1:00 PM
Session 4: November 17, 2017 2:00 PM

Focus Group Research

Questions

to determine the receptiveness to a proposed new clinic located adjacent to the RBJ Center

- What is and isn't working?
- Factors that would make people likely to switch to new clinic + follow-ups such as:
  - Wrap-around services
  - Social services
  - Social activities
  - Mobility

Methodology

Two focus groups sessions help on 11/10 and 11/17.
Each session interviewed groups of 5 RBJ residents aged 65+ with one facilitator and two notetakers. The facilitator explained the purpose of the focus group and obtained informed consent.
The atmosphere was relaxed in all sessions.

Focus Group Outline

Residents had strong feelings about:

- Having all services in one place for convenience and continuity of care
- Transportation options and quality
- Lack of understanding insurance networks and constrained choice
- Getting compassion

Residents were indifferent about:

- Not much

The most valuable services to residents were:

- Non-medical services that promote overall wellness

Key Takeaways

Working

- **Social workers** at RBJ are well received by the community, but needs more
- **Sharing food** helps with monotony and burden of cooking
- Transportation options, though service quality needs work

Needs Work

- The term **"Adult Day Care"** triggers feelings of disrespect
- Care services should be tailored towards **wellness, instead of illness**
- **Affordable healthy options**
- More **social activities and services**
- **Information about insurance and existing services**

Factors for Change

- Doctors are found mainly through **word of mouth**
- Changing doctor's offices usually results from feeling **disrespected**
- Multiple services in one place to get **continuity of services and convenience**
- **Acceptance of both Medicare and Medicaid**

Focus Group Details

November 10, 2017

Session 1 & 2

Key Takeaways - Session 1 & 2

Working

- **Social workers** at RBJ are well received by the community
- **Sharing food** helps with monotony and burden of cooking

Needs Work

- The term **"Adult Day Care"** triggers feelings of disrespect
- Care services should be tailored towards **wellness, instead of illness**
  - **Affordable healthy options**, instead of free sugary foods
  - More **social activities and services** to combat social isolation
- **Communication of existing care services**
  - Update 20 -year-old directory of services
  - Transportation updates
  - Coordination and explanation of medical services

Factors for Change

- Doctors are found mainly through **word of mouth**
- Changing doctor's offices usually results from feeling **disrespected**
  - Residents are looking for **people who listen**
- Preference for multiple services in one place to get **continuity of services**

Session 1

General feelings:

- Frustration with too much change that does not result in services that cater to elderly needs
- Main pain points were lack of transportation and healthy food options

Session 1 participants felt

- Basic medical care
- Transportation
- Non-medical care
- Respect

were the main areas of concern.

"There are so many rumors going around and they are all different."

Is Basic Medical Care, Like Dental, Too Much to Ask for?

"Insurance is such a problem for us. Medicare doesn't want you to see, chew, or hear. They won't cover any of it."

"Two of my teeth had cavities. They wouldn't fill them due to insurance."

"It is doctor's responsibility to give prescription that does not interact badly"

- All in one place - convenience
- Lack of doctors who take medicare and medicaid
  - Choice/cost prohibitive
- Prescription explanation
  - Interactions and side effects
    - H-E-B Pharmacy
- Need medical instruments on site
- Dental, optometrist, and other peripheral medical services

Why Are They Taking Away My Transportation Options?

"Only 10% of 250 residents have a car."

"There are so many rumors going around [about transportation]; they are all different."

- Senior Ride
  - Months to get off wait list
  - 1 month to get interview
- Service Changes
  - Grocery bus taken away in 6 months
  - "21/22 routes going away"
- Unused bus service - frustration
  - Shuttle bus lacks capacity
- Residents unable to take common buses
  - "Some people here cannot ride with general public on normal buses"

We Would Benefit Greatly From Additional Non-Medical Services.

"Sweets are a weakness of everyone here. But, most people are overweight, have diabetes, or have heart problems"

"You have to realize in this building there isn't enough income to buy healthy foods. They take what is donated."

- Exercise classes
  - Zumba/yoga
  - Fall prevention
- Food - free & meal prep
  - Free meals from pantry, but not always healthy
    - More affordable fruits and veggies
  - Willingness to pay for pre-made meals
- Music Therapy
- Social workers
  - Explain medication
  - Understanding insurance
  - Middleman to call doctors and nurses

Can We Get Some Compassion?

"We have a nutrition class coming up. But it's designed for elementary students."

"Some people bring us coloring books. They don't realize that just because we are old does not mean we are incapable of thinking."

"My doctor and nurse scared me to death. Would not tell me what was going on. I need a doctor that will be honest with me and not scold me."

Session 2

General feelings:

- Frustration with confusion on available services through insurance and in the area
- Main pain points were lack of financial security and non-medical services

Session 2 participants felt

- Basic medical care
- Transportation
- Non-medical care
  - Financial Security
- Respect

were the main areas of concern.

"The things that go with old age – vision, teeth, and hearing – not covered by Medicare."

Is Basic Medical Care, Like Dental, Too Much to Ask for?

"The things that go with old age – vision, teeth, and hearing - not covered by Medicare."

"I like one doctor. One primary care you can deal with instead of being switched around all the time. It really is frustrating."

"I cannot stress enough how important the dental part is. We are limited to what we can eat. People are not going to eat good foods if they cannot chew them."

- All in one place - convenience
  - Continuity of care
- Wellness clinic
- Therapy
- Medical instruments
- Urgent care
- Dental
- Mental health
- "Well-educated doctors"

Why Does It Take Me So Long to Access Transportation Services?

"People on STS might need to wait years before being approved."

"It's aggravating to call and find my ride and have to wait at least an hour before they will take you somewhere else. You get kind of tired."

"If you are lugging groceries from one bus to another it does not work."

- MetroAccess service
  - Getting approved is a long process.
  - Long delay between call and pickup
  - Plan in advance
- Impending 2018 route changes
- Transfers are cumbersome
- Confusion about senior-targeted programs

We Would Benefit Greatly From Additional Non-Medical Services.

"I would want a professional yoga instructor and somebody that understands how to eat and cook healthily."

"Let's get people out of the building!"

"I have always felt that we need dental care desperately. We have a lot of people that sit by the shop and only eat Twinkies. They cannot eat regular food because it's too expensive."

- Exercise + equipment + space
  - Yoga
  - Catered to abilities
- Healthy eating
- Garden/outdoors
- House cleaning
- Understand health insurance
- Communication - understand services available
- Language services
- Social workers to help understand insurance and section 8

Jobs Could Help Alleviate Financial Insecurity.

"Average income in RBJ is like 1000-1300 a month. Once you pay rent, groceries, bills, medications not much is left."

"I always make a drop more than the poverty level and never qualify for anything."

"Get us jobs! We got paid $100 for going to computer school. The old people get paid to be a guinea pig"

Can We Get Some Compassion?

"I would like someone who specializes in geriatric care. They need to be understanding, patient, and show respect."

"I am disabled, I am not stupid."

"I don't want to take any medications for diddly squat. I want to be healthy. I think we need to think about improving health. There is a disrespect to seniors."

November 17, 2017

Session 3 & 4

Key Takeaways - Session 3 & 4

Working

- Transportation options, though services need improvement
- Services available, though need to be explained and expanded

Needs Work

- **Social workers needed** for care coordination
- Information **explanation for insurance and services available**
- **Social activities** that promote social interaction
- **Basic equipment to monitor health** onsite

Factors for Change

- Preference for multiple services in one place to get **convenience of services**
- **Accept both Medicaid and Medicare**

Session 3

General feelings:

- Enthusiastic and grateful for services offered, disappointed at losing services due to budget cuts
- Wants to understand how to navigate existing insurance and care services

Session 3 participants felt

- Basic medical care
- Transportation to YMCA
- Non-medical care
  - Care coordination
  - Accident prevention

were the main areas of concern.

"We have a lot of things offered here and we are fortunate."

Basic Medical Care, Like Dental, and a Doctor Would Be Great

"I don't do doctors a lot. It would be great for residents here."

"We just lost dental."

"They are taking a lot of services away from the elderly."

- Basic equipment for monitoring blood pressure
- Losing services, like dental, is inconvenient
- Variety of services needed to fit diversity of needs of the community
- Clinics that accept both Medicaid and Medicare
- If can't have it all in one place, try visiting doctors and nurses

Transportation Services Are Sometimes OK for Some

"I can't go anywhere. I'm stranded all the time."

"It's painful and unaffordable."

"I have no problem with transportation."

"I have no problems. I'm too healthy"

- "Drive A Senior" service
  - Utilized for medical appointments like primary care physician and cardiologist
- Not as big of a worry currently, but could become one with age
- YCMA offers exercise classes but inaccessible

Much Needed and Wanted Non-Medical Services Are Being Cut.

"They don't know how to use services that are available."

"I know that some of these people don't eat."

"I am worried about having to take ambulance again. Last time I went to the ER, the bill was so high, I could not afford it."

- Food bank
  - Healthy foods needed
- Exercise classes
  - Yoga
- Social workers very necessary
  - Care coordination
- Wellness for accident prevention

Session 4

General feelings:

- Concerned about lack of understanding amongst residents on existing information
- Wanting to dance, and other social activities to avoid depression

Session 4 participants felt

- Basic medical care
- Transportation
- Non-medical care
  - Understanding information

were the main areas of concern.

"(Residents) don't know where nothing is. They are not informed."

Medical Care Shouldn't Just Be Pills and ER Visits

"A lot of doctors, all they want to do is give you a pill. Anything is better than taking a lot of pills."

"A lot of them are hooked and it is the doctor's fault I've seen it here a lot."

"An ambulance comes to RBJ every single day

- Variety of doctors
  - Chiropractor
  - Physical therapist
- Too much pills
- Food where medical services live

There Are Options for Transportation But Services Can Be Improved

"Having improved transportation would be very helpful."

"I can't get on a regular bus with my wheelchair."

- Some have cars
- Private insurance coverage of transportation
- MetroAccess
- Comfort Care
- Taxi vouchers for emergencies
- Social worker coordinated grocery trips

Non- Medical Services Should Help Us Feel Alive

"I don't know if they want mental health services, but they certainly need it."

"Eldercare is understaffed. They are bogged down. They don't have time. We need more."

"We need to go out in public."

- Therapy for health
  - Mental health
  - Physical therapy
  - Speech therapy
  - Pain management
- Extra services at RBJ
  - Pet care
  - Interpreter
  - Cafe
  - Convenience store
- Medicine management
  - Addiction management
- Food pantry very helpful
- Social workers
  - Coordinate and explain information
  - Insurance information
  - Grocery trips
- Dances

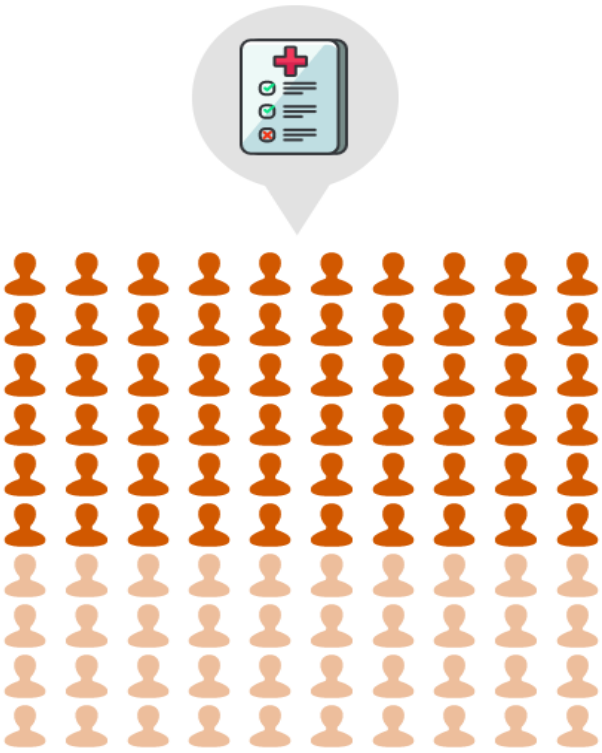
Help Me Understand What Is Available to Me

"I don't care what they told me, I could not wrap my head around it. There wasn't enough information and I was confused."

"We don't know where we can go to get answers."

"I've lost some benefits…not getting help in time."

Appendix C.
Senior Household Health Experience Survey Materials



We care about your wellness!

A quick 10 minute survey can shape the conversation on the senior health care you need in your neighborhood and the City of Austin!

Graduate students at the University of Texas at Austin are conducting a study on behalf of St. David's Foundation about senior health services in your community.

Thank you for taking the time to fill out this survey and participate in our study!

We are students at the LBJ School of Public Affairs at the University of Texas at Austin, and we are conducting a study on behalf of St. David's Foundation about senior health services in your community.

We are particularly interested in learning more about you and your health care experiences. We also want to learn your thoughts about a possible Senior Center, a place where people could go to see a doctor for primary care and receive other senior services.

Whether you choose to participate in this survey will not affect your relationship with the University of Texas at Austin or any of your healthcare and social service providers in any way. Any responses will be kept confidential.

When answering a question, please circle the corresponding letter or fill in the provided space. If you do not know the answer to a question or prefer not to answer a question, you may leave the response portion unmarked. This survey is estimated to take about 10 minutes to complete.

Thank you!

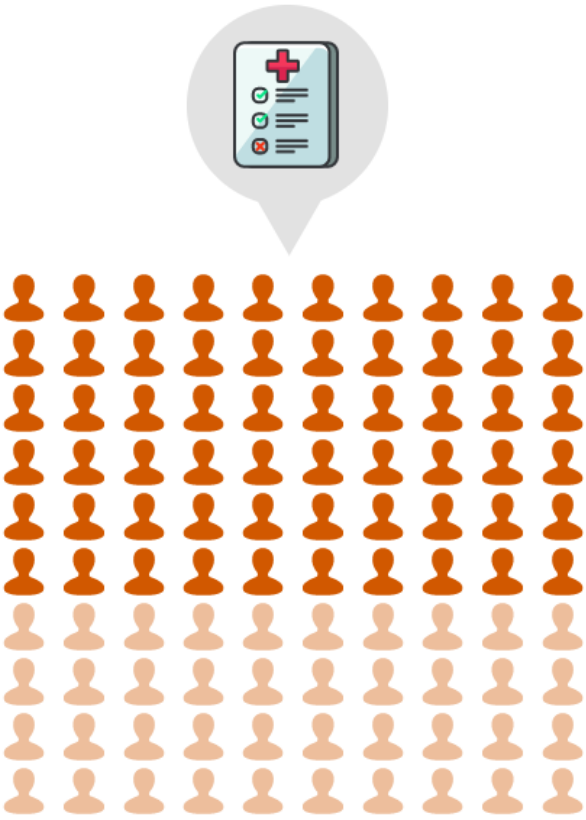
Please join us at the Senior Care Summit on April 10, 2018 from

9 am to 5 pm at the Bass Lecture Hall in the LBJ School of Public Affairs, where survey findings will be summarized.

If you have any questions, feel free to contact:

Phone number: (956) 410-1448

Email: angelprp2017@gmail.com



¡Nos importa su salud y bienestar!

¡Esta pequeña encuesta de menos de 10 minutos puede marcar la diferencia en las necesidades de salud pública de su comunidad y la Ciudad de Austin!

Gracias por tomarse el tiempo de participar en esta encuesta y ser parte de nuestro importante estudio.

Somos un grupo de estudiantes del Colegio de Relaciones Publicas en la Universidad de Texas en Austin, que de parte de la Fundación St. Davis estamos llevando a cabo una investigación acerca de los servicios de salud en su comunidad para gente de la tercera edad.

Estamos interesados en aprender más sobre las necesidades de su comunidad en materia de salud pública y servicios de salud. En particular, acerca de un posible Centro de Salud, donde adultos mayores podrían acudir para recibir atención médica esencial entre otros servicios especializados para adultos mayores.

Al responder las preguntas, por favor circule la letra correspondiente o escriba su respuesta en el espacio provenido. En caso de no saber la respuesta, o prefiera no contestar, deje esa pregunta sin respuesta. Esta encuesta tomara aproximadamente 10 minutos.

¡Gracias por su apoyo!

Por favor acompáñenos a la Conferencia de Cuidado de Adultos Mayores el 10 de abril, 2018 en la escuela LBJ de Relaciones Publicas, donde las recomendaciones de esta encuesta serán resumidas

Si tiene cualquier pregunta contáctenos al:

Teléfono: (965) 410-1448

Correo electrónico: angelprp2017@gmail.com

Senior Household Health Experience Survey (English)

Please tell us about yourself. Fill in the blank or circle the applicable answer.

1. Age: _____

2. Sex:
   a. Male
   b. Female
   c. Prefer not to answer

3. Are you of Hispanic, Latino or Spanish origin?
   a. Yes
   b. No
   c. Prefer not to answer

4. Which of the following would you say is your race? Select all that apply:
   a. White
   b. Black or African American
   c. Native American or American Indian
   d. Asian / Pacific Islander
   e. Other
   f. Prefer not to answer

5. What is your marital status?
   a. Married
   b. Non-married (includes divorced, widowed)

6. How many other people live in your residence? _____
   What are their ages? _____

7. Do you own your own home?
   a. Yes
   b. No

8. Are you worried about having to move because of rising rent or rising property taxes?
   a. Not worried
   b. A little worried
   c. Worried a great deal

9. Are you likely to move from your current residence sometime in the near future?
   a. Yes
   b. No

Health Service Use

1. When you want help with or care for health problems, where do you usually go for primary care?
   a. Nowhere
   b. Doctor's office (WellMed, Austin Diagnostic Clinic, etc.)
   c. Medical clinic
   d. Hospital emergency room
   e. Other: _____

2. Approximately how many times in the past 12 months have you visited with a medical professional?
   a. Once a week
   b. Monthly
   c. Once a year
   d. Never

3. Overall, how satisfied are you with the medical care you receive?
   a. Very satisfied
   b. Satisfied
   c. Dissatisfied

4. How do you pay for your medical care? Are you covered by (circle all that apply):
   a. Medicare (from Social Security)
   b. Medicaid
   c. Other public welfare programs that pay all or part of your medical care, such as the Medical Access Program
   d. TRICARE (military coverage formerly known as Civilian Health and Medical Program of the Uniformed Services (CHAMPUS))
   e. Other: _____

5. In the past 12 months, have you visited a center that provides supportive services such as transportation, hot meals, medication management, and social activities such as cooking classes, dances, and music?
   a. Yes
   b. No

6. In the past 12 months, have you visited a service provider that helps you coordinate your care and social needs, including transportation or medication management?
   a. Yes
   b. No

7. Are there any services or supports that would be useful to you that are not available or you cannot get to?
   a. Yes
   b. No

If you answered yes, please explain in the space provided below:

_____
_____

8. Has a professional or volunteer sat down with you to review your benefits?
   a. Yes
   b. No

9. Is transportation a problem in getting the social services or medical care you need?
   a. Yes
   b. No

Senior Clinic and Community Center

1. Would you go to a Senior Center where health and social services are located in one place? The center would be located at 15 Waller Street in the Holly neighborhood and include: primary care, a care coordinator, and an adult activity center that provides meals and helps people remain active in the community.
   a. Yes
   b. No

Thank you for participating in our survey! If you have any questions or concerns, please call (956) 410-1448.

Senior Household Health Experience Survey (Español)

Por favor díganos sobre usted. Por favor escriba o circule la respuesta que mejor le corresponda.

1. Edad: _____

2. Sexo:
   a. Masculino
   b. Femenino
   c. Prefiero no responder

3. ¿Usted es de origen Hispano, Latino o español?
   a. Si
   b. No
   c. Prefiero no responder

4. ¿De que raza se identifica principalmente? Circulé todas las que le correspondan:
   a. Blanca
   b. Negra o Afro-Americana
   c. Nativo Americano o India Americano
   d. Asiática / de las Islas del Pacifico
   e. Alguna otra
   f. Prefiero no responder

5. ¿Cuál es su estado civil?
   a. Casado/ casada
   b. No casado/casada (incluye divorciado/ divorciada, viudo/ viuda)

6. ¿Cuantas personas viven con usted en su hogar? _____
   ¿Que edad tienen? _____

7. ¿Es dueño/ dueña de su hogar?
   a. Si
   b. No

8. ¿Le preocupa tener que moverse de su hogar por incrementos al costo de su renta o incremento de impuestas a la propiedad?
   a. No me preocupa
   b. Me preocupa un poco
   c. Muy preocupado/ preocupada

9. ¿Es posible que se mude de su hogar en un futuro cercano?
   a. Si
   b. No

Para uso de Servicios de Salud

1. ¿Cuando necesita ayuda o tiene problemas de salud a donde va usualmente por atención medica?
   a. A ningún lugar
   b. Oficina de medico (WellMed, Austin Diagnostic Clinic, etc.)
   c. Clínica medica
   d. Sala de emergencia del hospital
   e. Otro lugar: _____

2. ¿Aproximadamente cuantas veces en los últimos 12 meses ha visitado a un profesionista medico?
   a. Una vez a la semana
   b. Una vez al mes
   c. Una vez al año
   d. Nunca

3. ¿En promedio que tan satisfecho/ satisfecha esta con el cuidado médico que recibe?
   a. Muy satisfecho/ satisfecha
   b. Satisfecho/ satisfecha
   c. Nada satisfecho/ satisfecha

4. ¿Como paga por su cuidado médico? Esta cubierto por (circule todos los que le correspondan):
   a. Medicare (del Seguro Social)
   b. Medicaid
   c. Otro programa público que paga todo o parte de su cuidado médico, por ejemplo, Medical Access Program
   d. TRICARE (cobertura militar antes conocido como Civilian Health and Medical Program of the Uniformed Services (CHAMPUS))
   e. Otro programa: _____

5. ¿En los últimos 12 meses, ha visitado un Centro de Salud que proporcione servicios como transportación, platillos completos de comida, ayuda con medicamentos, y actividades sociales por ejemplo clases de cocina, baile, y música?
   a. Si
   b. No

6. ¿En los últimos 12 meses, a visitado una proveedora que le ayude a coordinar su cuidado medico y necesidades sociales, incluyendo transportación o ayuda con medicamentos?
   a. Si
   b. No

7. ¿Hay algún servicio o ayuda que le beneficiaria a usted que no le ofrecen o no puede obtener?
   a. Si
   b. No

Si contesto Si, por favor explíquenos en el espacio disponible: _____
_____

8. ¿Alguna vez un profesionista o voluntario se ha sentado con usted para explicarle todos sus beneficios?
   a. Si
   b. No

9. ¿El transporte a servicios sociales y médicos que usted necesita es un problema?
   a. Si
   b. No

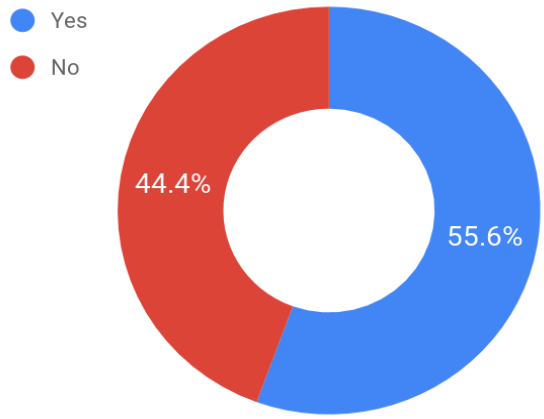
Clínica de Adultos Mayores y Centro de Comunidad

1. ¿Usted acudiría a un Centro de Adultos Mayores que ofrezca servicios médicos y sociales en la misma ubicación? El centro estaría ubicado en el barrio Holly en 15 Waller St. he incluiría: atención medica básica, coordinadores de cuidado, y un centro de actividades que le proporcionara con comida y ayuda para que usted se mantenga un miembro de la comunidad activo/activa.
   a. Yes
   b. No

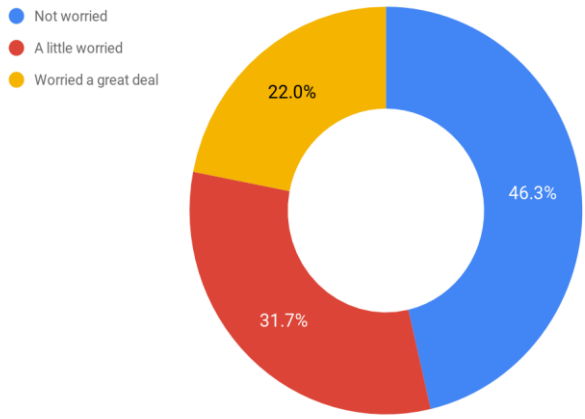
¡Gracias por participar en la encuesta! Si tiene cualquier pregunta o comentario, por favor llame al (956) 410-1448!

Appendix D.
Senior Household Health Experience Survey Responses

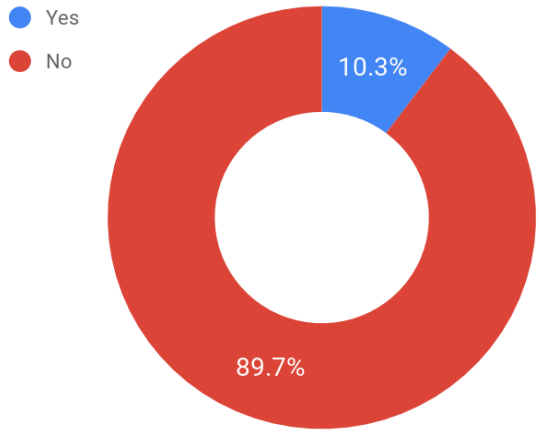
Living Situation



Do you own your own home?



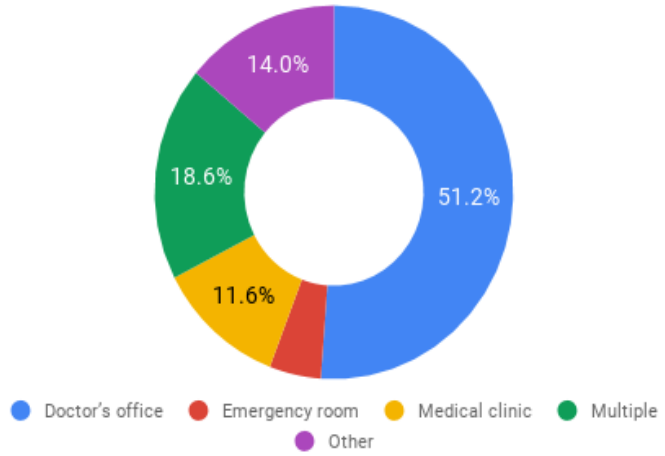
Are you worried about having to move because of rising rent or rising property taxes?



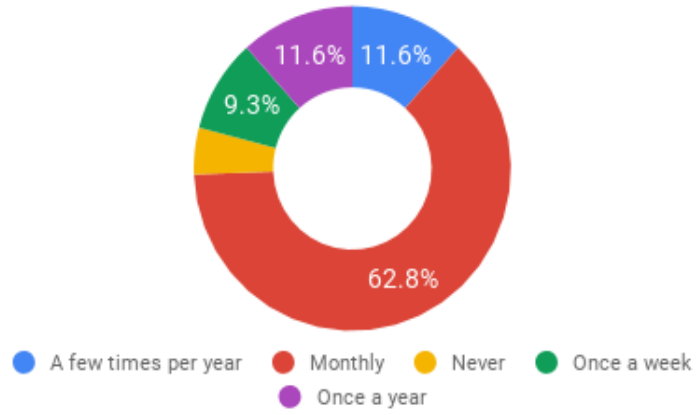
Are you likely to move from your current residence sometime in the near future?

Medical Care Utilization

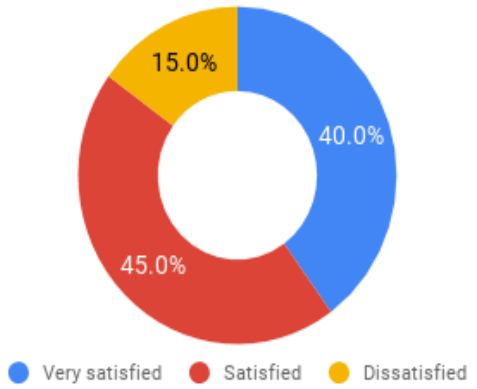
When you want help with or care for health problems, where do you usually go for primary care?



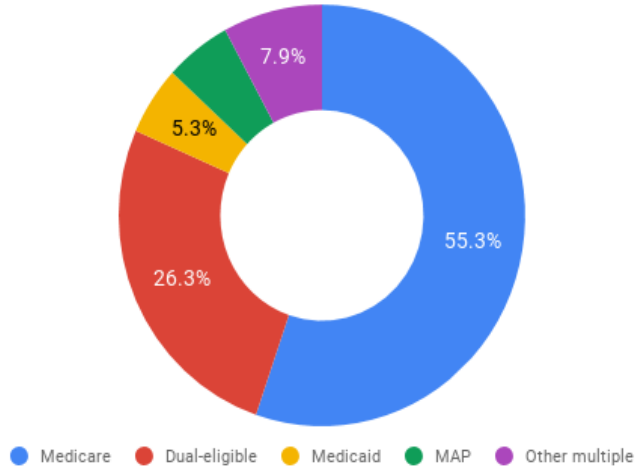
Approximately how many times in the past 12 months have you visited with a medical professional?



Overall, how satisfied are you with the medical care you receive?

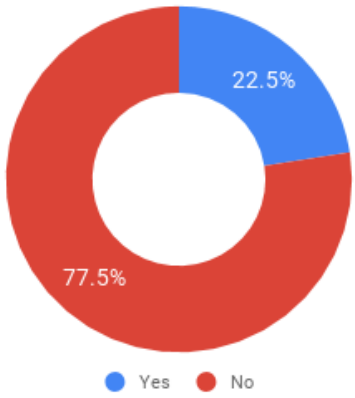


How do you pay for your medical care? Are you covered by:

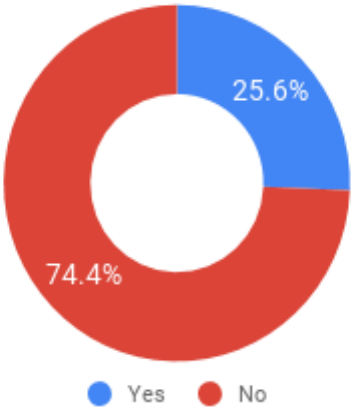


Social Services

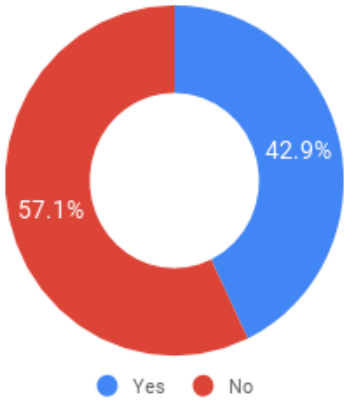
In the past 12 months, have you visited a center that provides supportive services such as transportation, hot meals, medication management, and social activities such as cooking classes,



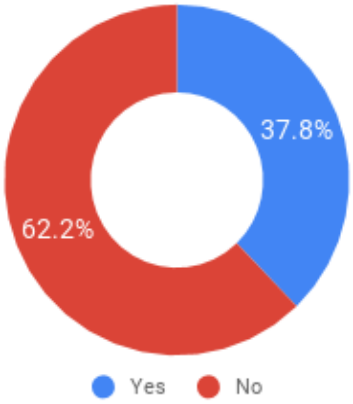
In the past 12 months, have you visited a service provider that helps you coordinate your care and social needs,



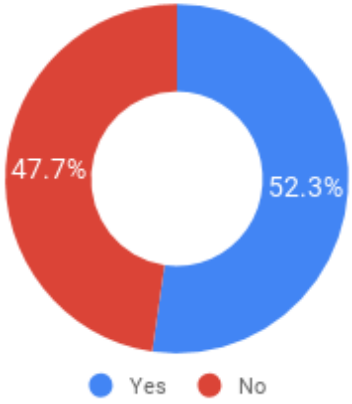
Are there any services or supports that would be useful to you that are not available or you cannot get to?



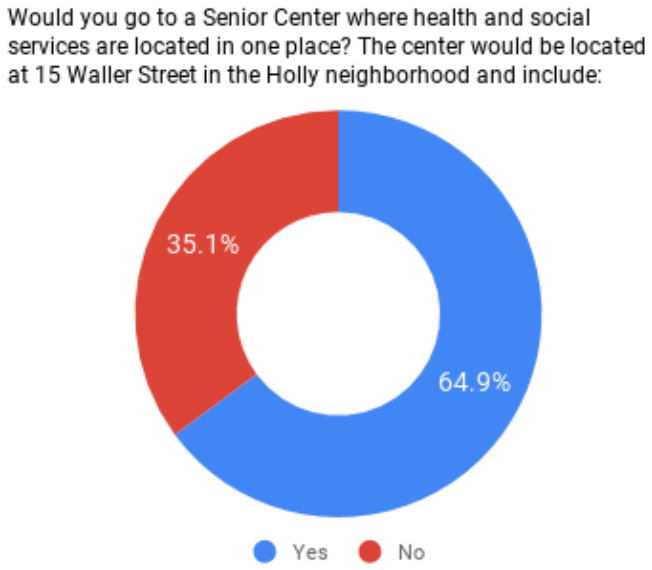
Is transportation a problem in getting the social services or medical care you need?



Has a professional or volunteer sat down with you to review your benefits?



Proposed Center



Appendix E.
Primary and Secondary Stakeholder List

List of Engaged Primary Stakeholders

- Jésus Garza, Former Chief Executive Officer, Seton Healthcare Family
- Jon Weizenbaum, Commissioner, Texas Department of Aging and Disabilities (retired)
- Adam Hauser, President and Chief Executive Officer, Meals on Wheels Central Texas
- Kent Herring, Chief Executive Officer, Family Eldercare
- Mark Hernandez, Chief Medical Officer, Community Care Collaborative, and Medical Director, Seton Healthcare Family
- Larry Wallace, Enterprise Chief Administrative Officer, Central Health
- Gregory Hartman, President of External and Academic Affairs, Seton, Ascension
- Andrew Levack, Senior Program Officer for Healthy Aging, St. David's Foundation
- Helen Varty, Executive Director, Rebekah Baines Johnson Center
- Sly Majid, Chief Services Officer, City of Austin Mayor's Office
- Stephanie Hayden, Interim Director, Austin Public Health
- Filip Gecic, Manager, Austin Public Health

List of Engaged Secondary Stakeholders

- Kristie Loescher, Healthcare Management Professor, McCombs School of Business, The University of Texas at Austin
- Jim Franklin, MBA Professor, McCombs School of Business, The University of Texas at Austin
- Sarah Swords, Dean, Hicks School of Social Work, The University of Texas at Austin
- Alexa K. Stuifbergen, Dean, School of Nursing, The University of Texas at Austin
- Mike Mackert, Director for the Center for Health Communication and Associate Professor at Moody College of Communication, The University of Texas at Austin
- Juan Campos, Videographer, Travis County Television

- Erica Garcia-Pittman, Geriatric Specialist, Dell Medical School, The University of Texas at Austin
- Sarah Eckhardt, Travis County Judge
- Teresa Ferguson, Executive Director, AustinUP
- Ora Houston, City Council District 1
- Delia Garza, City Council District 2
- Sabino “Pio” Renteria, City Council District 3
- Gregorio “Greg” Casar, City Council District 4
- Ann Kitchen, City Council District 5
- Jimmy Flannigan, City Council District 6
- Leslie Pool, City Council District 7
- Ellen Troxclair, City Council District 8
- Kathie Tovo, City Council District 9/Mayor Pro Tem
- Alison Alter, City Council District 10
- Julian Castro, former Secretary of Housing and Urban Development
- Steve Adler, Mayor of Austin

Appendix F.
Strategic Shared Vision

To: Senior Center of Excellence Stakeholders
From: LBJ Policy Research Team
Subject: Strategic Shared Vision
Date: 10/7/2017

Problem Statement

Austin's low-income senior population is rapidly growing and expected to double within the next thirty years. The population lacks access to affordable healthcare and social services with 40 percent expressing concerns regarding how they will pay for their care. They prefer to avoid nursing home admission, but there are several obstacles to aging in place, including locating doctors, securing transportation to appointments, attending rehabilitation, and finding mental health services. These barriers lead to decreased mobility, increased number of hospital visits, and overall higher mortality.

Proposed Solution

Previous research shows that combining access to healthcare and wraparound services with affordable housing alleviates the above adverse health outcomes in an affordable way. Our proposal is to create a ***Senior Center of Excellence*** (the "Center") that provides an array of services delivered by a variety of healthcare providers. These services include **primary care services, wraparound services, and adult day care services**. The Center will be established through public-private partnerships between interested providers including the Community Care Collaborative (a partnership between Seton and Central Health), the St. David's Foundation, and The Dell Medical School. The Center will provide geriatric-specific care, and will also have the future capacity to branch into select multigenerational services.

We propose placing the Center near the Rebekah Baines Johnson (RBJ) Senior Living Center, an existing affordable housing complex in Austin's Holly neighborhood (78702).

Our Role

Our main deliverable will be an operational business plan for the Center by the beginning of May 2018. To formulate this plan, we will:

1. Define the demand for services and potential service delivery gaps and other obstacles by surveying Holly area seniors and caretakers;

2. Explore transportation options for future clients;

3. Assist ongoing efforts to obtain a ground lease for the five-story building at 15 Waller Street (directly across from the RBJ Senior Living Center) from the City of Austin;

4. Determine how the Center will become sustainable, and
5. Foster public-private partnerships to secure seed funding and other needed resources.

Appendix G.
Letters of Commitment and Support

MEALS on WHEELS
CENTRAL TEXAS

April 6, 2018

City of Austin
Financial Services
Attn.: Greg Canally, Interim Chief Financial Officer
301 W. Second Street
Austin, Texas 78701

Dear Mr. Canally:

As you know, Meals on Wheels Central Texas (MOWCTX) seeks to nourish and enrich the lives of seniors in our community and gladly participates in collaborative efforts to do so. We support and appreciate the City's efforts to create an integrated community health center for low-income senior residents at the RBJ Health Administration Building. The community's need for geriatric primary care, social services, and adult day programs will only continue to grow, and the City's proactive approach to meeting this need is a great opportunity for supportive and health care services to collaborate and meet this challenge. MOWCTX is excited about this opportunity and looks forward to assisting the community achieve its vision for providing senior services.

MOWCTX is committed to supporting the activities described in the LBJ School of Public Affairs' document outlining the bond proposal for the RBJ Health Administration Building, including the recommended timeline for construction and opening of a space for community-based agencies like MOWCTX to provide services. To ensure the success of this project, MOWCTX is willing to absorb the estimated operational costs of $225,000/year and provide its own staffing for the programs it expects to operate at this location. The funds to support our program(s) are expected to be available no sooner than January 2019 and sometime during the Meals on Wheels Central Texas Fiscal Year 2018/2019. We look forward to supporting our share of the envisioned programs at the RBJ Health Administration Building.

Thank you for the leadership on this important issue confronting our community and its low-income, aging citizens.

Respectfully,

Adam I. Hauser
President and CEO
Meals on Wheels Central Texas

cc: Jacqueline L. Angel, Ph.D., LBJ School of Public Affairs
Margaret Shaw, City of Austin, Economic Development Dept. Program Manager

3227 East 5th Street, Austin, Texas 78702 • 512-476-6325
www.mealsonwheelscentraltexas.org

family ELDERCARE
At home with changing lives.

April 5, 2018

City of Austin
Financial Services
Attn.: Greg Canally, Interim Chief Financial Officer
301 W. Second Street
Austin, TX. 78701

Dear Mr. Canally,

Family Eldercare strongly believes in community collaborations in efforts to leverage the talents and funding resources that each organization, both government and private offer to provide services to the people of Austin. Family Eldercare has a rich history of high-quality evidence based outcomes in providing case management and "wrap-around" services to seniors and adults with disabilities. We are excited and honored to participate in the collaborative effort in working with the City of Austin, the University of Texas LBJ School of Public Affairs, the Rebecca Baines Johnson (RBJ) staff, and the other partner organizations. The community's need for geriatric primary care, social services, and adult day care programs will only continue to grow, and the City's proactive approach to meeting this need is a great opportunity for the community's healthcare providers, social service providers, and housing providers to collaborate and meet this challenge.

Family Eldercare is committed to working with The City of Austin and supports the activities described in the LBJ School of Public Affairs' document outlining the bond proposal for the RBJ Health Administration Building, including the recommended timeline for construction and opening of a space for community-based agencies like Family Eldercare to provide services. To ensure the success of this project, Family Eldercare is committed to absorb the operational costs which will include salaries, benefits and all required payroll taxes. This total will be approximately $210,000 annually. Family Eldercare is committed to provide the funding and the funding will be available at the beginning of the fiscal year, e.g. October 1, 2018 and our commitment in long term.

Thank you for your leadership and willingness to work with such a diverse and committed group in an effort to provide much needed services to our low-income seniors.

Respectfully,

Kent Herring
Chief Executive Officer
Family Eldercare

cc. Jacqueline L. Angel, Ph.D. LBJ School of Public Affairs
Margaret Shaw, City of Austin, Economic Development Dept. Program Manager

Austin Location: 1700 Rutherford Lane / Austin, TX 78754 **Georgetown Location:** 805 W. University Avenue / Georgetown, TX 78626
p. 512.450.0844 f. 512.459.6436 FamilyEldercare.org

CARL C. ANDERSON SR.
& MARIE JO ANDERSON
Charitable Foundation

April 9, 2018

Mr. Greg Canally
Interim Chief Financial Officer
City of Austin
301 W. Second Street
Austin, TX 78701

Re: RBJ Health Administration Building Bond Proposal

Dear Mr. Canally,

I write today on behalf of the Carl C. Anderson Sr. and Marie Jo Anderson Charitable Foundation in support of the RBJ Health Administration Project. We strongly support the addition of needed supports for the current and future vulnerable senior residents of the Rebekah Baines Johnson Center residential tower as well as the low-income residents in the surrounding area.

The Anderson Foundation's mission is to support: programs that work to meet the essential needs of vulnerable children and programs that enhance the lives of individuals with disabilities and vulnerable seniors. We have been a strong supporter of the RBJ Center, Meals on Wheels Central TX, Family Eldercare, AGE of Central TX, and People's Community Clinic awarding grants of over $1.3 million since 2011, including a $200,000 grant for new elevators at the RBJ Center.

In 2013, we asked Dr. Stephen Bekanich, MD, a Palliative Medicine Physician, to visit the RBJ tower to meet some of the residents and conduct an informal review of residents' needs. His number one area of concern was **residents are profoundly lonely**. Other identified needs: residents were taking too many medications; safety evaluations for fall risks were needed in each apartment; transportation; healthcare literacy; and advanced care planning. Additionally, he felt that having an on-site medical clinic or urgent care facility would help to improve the overall health of residents but would also reduce the daily 911 calls made from the tower. **The proposed development of an integrated community health center including geriatric primary care, social services, adult day services, and early childhood education/day care facility would go far to reduce, if not eliminate, the issues identified by Dr. Bekanich five years ago.**

While the Anderson Charitable Foundation is unable to commit to a certain dollar amount to support the RBJ Health Administration Project at this time, please know that we wholeheartedly support this effort and have every expectation that once the project is operational, we will be a financial supporter as well.

We look forward to working with you and other partners to provide vital services to low-income vulnerable senior citizens in Austin.

Sincerely,

Brad Robb
Executive Director

Cc: Margaret Shaw, City of Austin, Economic Development Department Program Manager and Jacqueline L. Angel, University of Texas at Austin LBJ School of Public Affairs

114 W. 7th Street ▪ Suite 1200 ▪ Austin, Texas 78701
Tel: (512) 458-2285 ▪ Fax: (512) 452-9055
www.theandersonfoundation.org

Austin Geriatric Center, Inc.
d/b/a Rebekah Baines Johnson Center
21 Waller Street
Austin, Texas 78702

February 16, 2018

Jacqueline L. Angel, Ph.D.
Professor of Sociology and Public Affairs
The University of Texas at Austin
LBJ School of Public Affairs
SRH 3.239
P.O. Box Y
Austin, TX 78713

Dear Dr. Angel,

I first want to thank you for your long-time interest in gerontology and all the nationally recognized efforts by you and your students to create a plan for essential services needed by seniors in Austin, including those who reside at Rebekah Baines Johnson (RBJ) Center and in the surrounding neighborhood. I am aware that you have been working with community leaders to locate a medical clinic, adult day care, and additional social services in the City of Austin owned building, across from RBJ Center, that could be a great asset for all the seniors in the area.

At Wednesday's board meeting of the Austin Geriatric Center (AGC), which owns and operates the RBJ Center, I was made aware of your request that we consider adding these services into the RBJ re-development plan for additional low-income housing we have been working on for ten years. Our board had a thoughtful discussion about this possibility but concluded that we are at the point where we cannot interrupt or delay, for any reason, our own plans to break ground in April of this year on our project to build safe, supportive housing for our current residents and those who need the new housing we will create.

With this letter, the Austin Geriatric Center Board wants to express our support for the work you and others are doing to bring additional services to the area. We know that such services would be of great benefit to the RBJ Center residents we serve with housing and for other residents who live in the community. The people affiliated with the RBJ Center who have been working with you on your project will continue to do so. We look forward to the day when we have our housing project completed and hope the support services you envision will also be a reality.

Sincerely,

Clarke Heidrick
Chairman of the Board
Austin Geriatric Center

3294204.v2

St. David's FOUNDATION

1303 San Antonio Street, Suite 500
Austin, TX 78701
stdavidsfoundation.org
p. (512) 879.6600
f. (512) 879.6250

April 9, 2018

Mr. Greg Canally
Interim Chief Financial Officer
City of Austin, Financial Services
301 W. Second Street
Austin, TX 78701

Dear Mr. Canally,

St. David's Foundation is deeply committed to supporting highly-vulnerable, low-income seniors as they age in place in Austin. In 2018, St. David's Foundation plans to allocate $6.7 million to serve the needs of seniors in Central Texas. We will do so by supporting several organizations whose missions are focused on improving the lives of low-income seniors in our community.

St. David's Foundation would like to express our support for the potential renovation of the RBJ Health Administration Building to serve our community's seniors. The renovations at the RBJ Health Administration Building will house critical services for low-income seniors residing in the RBJ Residential Development, as well as vulnerable seniors living in nearby East Austin neighborhoods.

St. David's Foundation provides significant funding each year to Meals on Wheels Central Texas and Family Eldercare to serve seniors in Austin. Both of these organizations plan to serve vulnerable seniors at the newly renovated RBJ Health Administration Building. Meals on Wheels plans to create a new state-licensed Adult Day Health Care site at the RBJ Building. Currently, Austin only has only one licensed Adult Day Health Care facility in the entire city which serves fewer than 70 clients. St. David's Foundation is extremely dedicated to increasing Adult Day Health Services and sees this as a unique opportunity to do so. Meanwhile, Family Eldercare plans to offer case management (wrap-around) services for seniors at RBJ. This service is a critical component of St. David's Foundation's Aging in Place strategy, and one that the Foundation currently funds Family Eldercare to provide. The Foundation is deeply committed to expanding case management services to reach more seniors in Austin.

The Austin community has a unique opportunity to leverage all its resources to collectively create an innovative service site that will reach a critically underserved population. St. David's Foundation would welcome the opportunity to engage in a public-private partnership to help make Austin the healthiest community in the world for our seniors.

Sincerely,

Earl Maxwell

Earl Maxwell
Chief Executive Officer

cc: Margaret Shaw
Jacqueline Angel

RECOMMENDATION

Commission on Seniors

Recommendation Number: 21071011-4D Supporting the Rehabilitation and Redevelopment of the Rebekah Baines Johnson Center (21 Waller St) to Increase Affordable Housing for Seniors and Recommending the City of Austin Study the Feasibility of Providing Multi-generational Programming and Services at the adjacent City-owned building

WHEREAS, the Commission on Seniors serves as an advisory board to the Austin City Council concerning the quality of life for senior citizens in the Austin area and to help ensure older adults are productive, independent, and healthy; and

WHEREAS, according to information provided by the City Demographer, the fastest growing age group in the Austin area are people aged 55 and older, increasing from 8 percent of the area population in 2010 to nearly 20% of the population in 2040. Seniors are often among the poorest in Austin, with the median household income for seniors aged 65 and older $44,251 compared to $55,744 for all households; and

WHEREAS, the City of Austin Age Friendly Action plan adopted by Council in November of 2016 calls for innovative models to serve the needs of Austin's senior population, increasing the amount of affordable housing for seniors, increasing multigenerational programs in parks and city facilities, and developing health outreach programs and community care clinics in neighborhoods with dense populations of older adults; and

WHEREAS, on October 19 the Council will conduct a public hearing and consider a resolution for an application to be submitted to the Texas Department of Housing and Community Affairs by the. Austin Geriatric Center, or an affiliated entity, for the rehabilitation of the senior housing units in the Rebekah Baines Johnson Center and the development of additional new affordable senior housing at the site, located at 21 Waller Street.

WHEREAS, the proposed rehabilitation and redevelopment of the RBJ Center will improve existing housing units and increase the number of affordable units available to seniors, including low income and disabled seniors; and

WHEREAS, the City of Austin owns 8.98 acres adjacent to the RBJ Center, including dedicated parkland and a 5-story building housing the RBJ Health Center (Austin Public Health offices), Austin-Travis County EMS offices and a Sexually Transmitted Diseases Clinic.

WHEREAS, in conjunction with the redevelopment of the RBJ Center the City of Austin has the opportunity to establish an innovative public-private partnership at the city-owned building that is both adjacent to the RBJ Center and located in an underserved neighborhood; and

WHEREAS, A University of Texas at Austin LBJ School of Public Affairs Policy Research Project led by Professor Jacqueline Angel (a member of the Commission on Seniors) is developing a public-private operational plan for a RBJ-Holly Neighborhood Clinic and Community Center that would provide an integrated care model that consists of geriatric primary care as well as a multi-generational care program and wrap-around services, and this study is supported by St. David's Foundation and pending from Central Health, as well as other organizations that express interest in results.

NOW, THEREFORE, BE IT RESOLVED that the Commission on Seniors

- Supports the application to the Texas Department of Housing and Community Affairs for rehabilitation and redevelopment of the RBJ Center;
- Recommends the Council direct staff to explore using some or all of the city-owned building to provide a range of social services and health care, including multi-generational services, to residents of the RBJ Center and surrounding neighborhoods; and
- Recommends the Council direct staff to consider the RBJ Health Center for a potential public-private partnership to establish a Neighborhood Clinic and Community Center and collaborate as appropriate with the Policy Research Project at the LBJ School of Public Affairs, the neighborhood and other stakeholders.

Date of Approval: October 11, 2017

Record of the vote: 13-0-1 abstaining (Garcia-Pittman)

Attest: Janee Brase

Appendix H.
Symposium Live-Polling Exercise

After our symposium presentation and Q&A with our panelists, we used live-polling technology to gauge audience opinion on aging in Austin. The following section describes the process, questions, and responses from the audience.

Poll Methodology

We asked the audience three questions. Audience members used iClicker devices to give their response. These clickers had A, B, C, D, and E buttons to give their responses that would be auto-populated on the projector screen by the iClicker software. The results were shown to the audience on the presentation screen after a short period of time given to answer each question. We asked the following three questions:

1. How would you rate the quality of life of seniors in Austin?

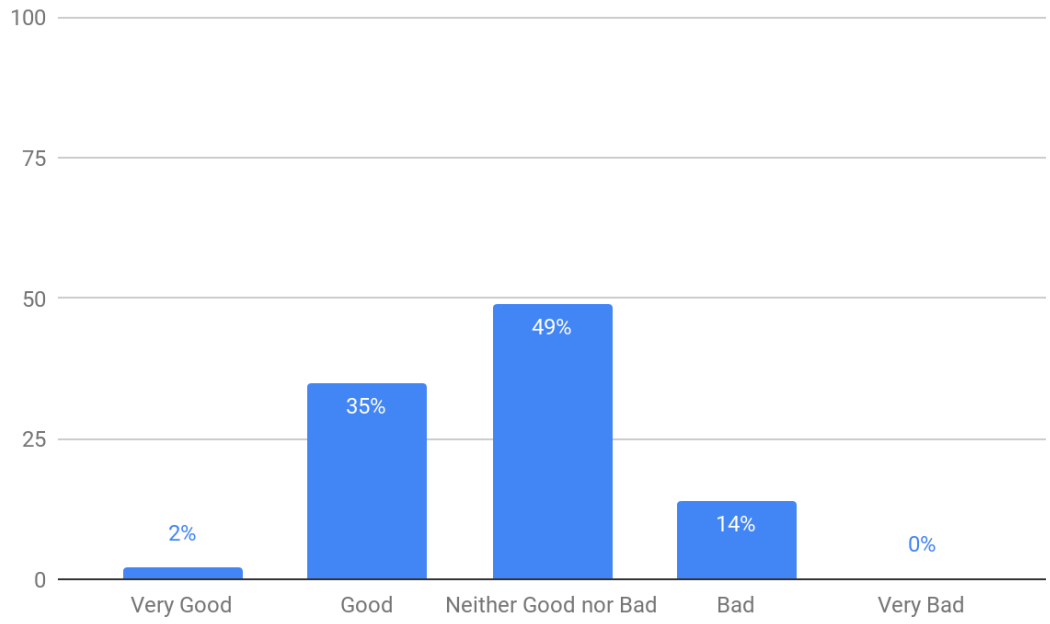
2. How would you rate the job Austin is doing in improving deficiencies in seniors' quality of life?

3. Do you think younger generations show support and concern for older adults more or less than when your generation was their age?

Polling Results

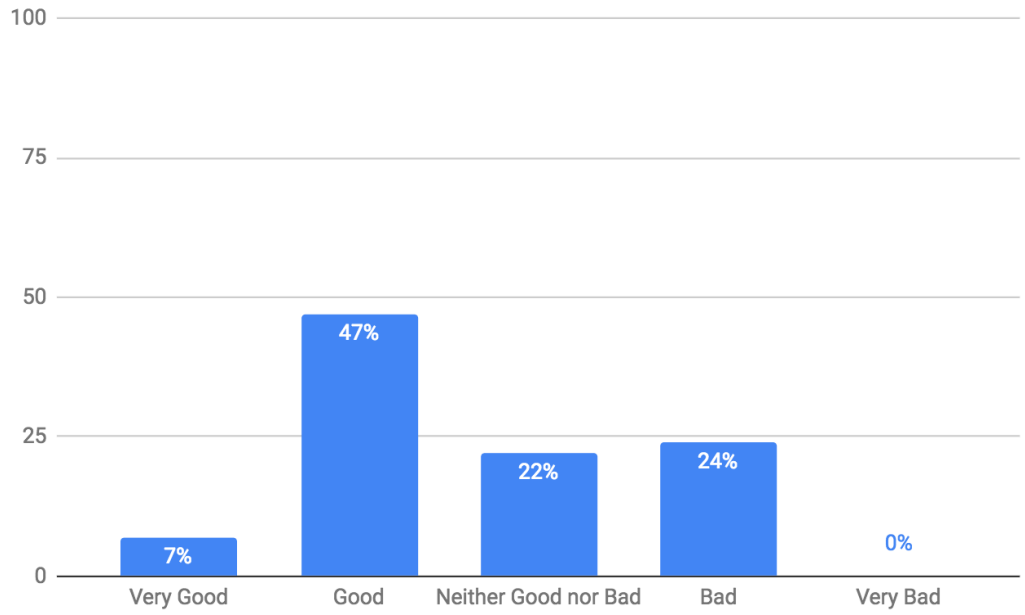
For the first two questions, we provided audience members with a scale of five possible responses, ranging from "very bad" to "very good." For the last question, audience members could respond with answers corresponding to more, less, or about the same. Questions 1 and 3 drew 43 votes, while 45 votes were cast for the second question.

1. How would you rate the quality of life of seniors in Austin?



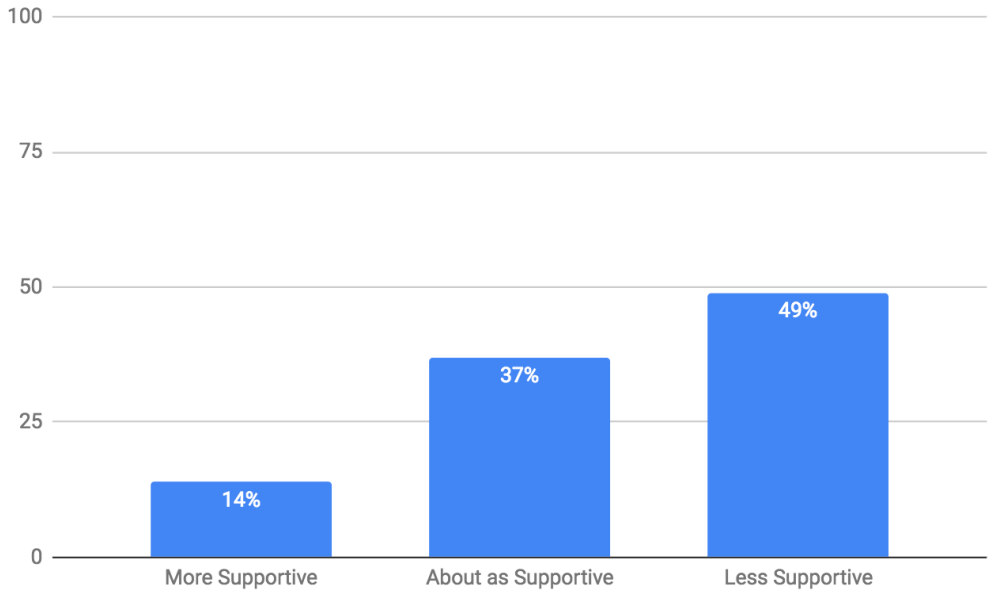
With the first question, 49 percent of respondents felt that the quality of life for Austin's seniors was “Neither good nor bad.” The next most-common responses to the first question were “Good” (35 percent) and “Bad” (14 percent).

2. How would you rate the job Austin is doing in improving deficiencies in seniors' quality of life?



For the second question, 47 percent felt that Austin was doing a "Good" job improving the quality of life for seniors. The next most common responses were "Bad" (24 percent) and "Neither good nor bad" (22 percent).

3. Do you think younger generations show support and concern for older adults more or less than when your generation was their age?



For the third question, 49 percent of respondents said that younger generations are less supportive of older adults, while 37 percent said they are about a supportive.

Appendix I.
PRP Op-ed in the *Austin American-Statesman*

Professor Jacqueline Angel and PRP member Andrew Scoggin wrote an op-ed that ran in the print edition of the *Austin American-Statesman* on Sunday, April 15, 2018. The following pages contain images of the op-ed as it appeared in print.

OTHERS SAY JACQUELINE ANGEL AND ANDREW SCOGGIN
Special Contributors

Demographics show Texas must plan for aging communities

Every day, the population of the United States, including Texas, is getting older. This poses important challenges to Social Security, Medicare and a host of state and local programs. In fact, the Census Bureau recently announced that it projects there will be more older people than children in the United States by 2035. We can't afford to wait 17 years to start thinking about changes that we need to make.

This new demographic and social reality gives us an opportunity to rethink how we adapt to an aging population in ways that benefit all age groups. Texans, as they have in the past, can set an example for others to follow.

Changes cannot depend on a few advocates. Everyone must become aware of the issues. It takes people from different fields, backgrounds and age groups to offer solutions that truly change the way society treats the aging process.

Seniors aren't the only ones who benefit from effective policies on aging. Younger generations will age and eventually benefit. But younger generations can also reap the benefits today.

In 2013, approximately 40 million family caregivers in our country provided uncompensated care that, according to the AARP, had an estimated worth of about $470 billion. Improvements in effective care for seniors clearly benefit family members who are at risk of caregiver burnout if they must provide care to an aging relative without outside help. By taking some of the burden of care off families, we can put much of this time back into the economy to help keep Texas thriving.

We need to do a better job incorporating older residents into all aspects of city life.

We also have a chance to create a more inclusive society by breaking down traditional divides between older and younger age groups. For example, certain parts of cities in Texas and across the nation are becoming more age-segregated partly as the result of gentrification and displacement.

In smart cities of the future, social resilience will be a key ingredient for building stronger communities and for addressing aging-in-place issues. In 2013, a research report published by the Federal Reserve Bank of Atlanta concluded that cities with a high degree of social resilience tend to enjoy numerous health and economic benefits. Put simply, it is not only the right thing to do; it is also not feasible to continue isolating adults based on their age as seniors become a greater share of the populace.

Our cities in Texas can serve as incubators of innovation that make aging a healthier, less socially isolated experience.

In coming up with solutions, more city mayors are establishing task forces on aging, city councils are forming commissions to inform age-related policy, and civic leaders are working with community members from all segments of the population. Cities could also create short-term plans that contain concrete steps to foster social inclusion and improve the health and well-being of seniors. Dallas, for example, has a Senior Affairs Commission consisting of 15 people selected by City Council members and the mayor to guide city staffers. And vulnerable seniors in Dallas can get help from caseworkers in the city's Office of Senior Affairs.

Dallas is part of AARP's Network of Age-Friendly Communities, a World Health Organization initiative that also includes Austin, Brownsville, Fort Worth, Houston and San Antonio. Leaders of communities in this network recognize they must consider all factors, such as skyrocketing property values that make it hard for the elderly to stay in their homes, to maximize civic engagement and be more age-inclusive.

This does not mean that cities should prioritize the needs of seniors over those of other groups, but rather that every effort will be made to ensure that they contribute and enjoy what has been labeled "active aging."

Leaders should particularly focus on expanding public transportation and affordable housing to help seniors remain in their communities and live independently. We need to do a better job incorporating older residents into all aspects of city life.

Inventiveness is part of the social fabric in Texas. We have an opportunity to make similar innovations for the aging process. The conversation must start now.

Angel is a professor in the LBJ School of Public Affairs at the University of Texas. Scoggin is a Master of Public Affairs candidate at the school.

BALANCED VIEWS

FROM THE LEFT

Activist Shaun King is many things, but he's no terrorist

Leonard Pitts Jr.
He writes for the Miami Herald.

Shaun King is a controversial guy.

As an activist and journalist, he's been prominent in the Black Lives Matter movement, defended the Palestinians and attacked the Republican Party. On Monday, apparently as a result of his politics, King was briefly detained at JFK Airport by an agent of U.S. Customs and Border Protection while returning home from Egypt.

In a series of tweets and a telephone interview, King described a "frustrating" and "weird" episode like something out of "The Twilight Zone." He said he was approached by a customs official who pulled him out of line and took him to a nondescript office. His wife, unwilling to be separated, came along, as did their kids.

King said the agent first attempted to ply the children with small talk but that he, King, told his wife and kids "to not say a damn word." According to King, the agent asked why they had visited Egypt – "traditional family vacation" was the reply – then inquired about King's work with Black Lives Matter. He spoke in such a way, said King, that it became obvious he had "been reading my tweets and knew all about me."

And King said the agent made reference to his "case," indicating that whatever this was it was ongoing and longstanding.

Again, King might be controversial, but he's no terrorist. Granted, some conservatives, citing uprisings in Baltimore and Ferguson and random cop shootings in Baton Rouge, New York City and Dallas, are ever eager to conflate Black Lives Matter with violence. But that's specious reasoning – like conflating the mainstream pro-life movement with violence because of deadly shootings and bombings by anti-abortion fanatics in Birmingham, Wichita, Brookline and Pensacola.

And anyway, CBP never accused King of terrorism. So one is hard-pressed to explain what happened as anything other than a clumsy attempt at political intimidation, the government's unsubtle way of letting a critic know that Big Brother is watching. I asked a CBP spokesperson if the government is monitoring Black Lives Matter as a terrorist organization and how that squares with the First Amendment.

In response, I received a written statement: "Each traveler must present themselves to CBP for inspection in order to be admitted to the United States of America. This was a routine inspection typical of daily operations at our ports of entry across the nation. CBP treats all international travelers with integrity, respect and professionalism while keeping the highest standards of security."

Bad enough the statement did not address the questions I posed. But … "routine"?! Is this kind of thing really routine?

All I can say is that I've traveled to 13 countries and it's never happened to me. A friend who's journeyed to 25 countries said she's never experienced anything like it. And King himself told me that he understands random and routine screenings, but, "This was not that."

It certainly doesn't sound like it. Indeed, one feels the ragged breath of authoritarianism moving the hairs at the nape of the neck.

Some people will think King's politics justify what happened. Sure, he's a controversial guy, but guess what? In America, you have that right.

What happened Monday should induce us to remember just how important our rights are.

And how fragile they can be.

FROM THE RIGHT

What can be done in Syria? By the U.S., precious little

George F. Will
He writes for the Washington Post.

On April 22, 1915, chlorine gas, wafted by favorable breezes, drifted from German lines toward enemy positions held by French troops near Ypres, Belgium. This was the first significant use of chemical weapons in a war in which 100,000 tons of chemical agents would be used by both sides to kill almost 30,000 soldiers and injure 500,000. The injured would include a German corporal whose voice, bearing traces of a gas attack, carried him 15 years later to Germany's pinnacle. The man who was U.S. president when Adolf Hitler committed suicide 30 Aprils after Germany's 1915 gas attack had been Capt. Harry Truman in 1918 when his artillery unit fired shells containing some of the chemical agents that the Allies had developed in response to what Germany did in 1915.

Such weapons seemed so sinister that the 1925 Geneva Protocol banned their use in war, but not their development. This resulted in mutual deterrence during the next world war, during which poison gas was used only for genocide. Might this fact have motivated Israel's alleged attack on a Syrian air base a day and a half after the Syrian regime was again suspected of using a nerve agent against a rebel position in a Damascus suburb?

Since 1997, a chemical weapons convention joined by 192 nations, including Syria, has banned the production and use of such weapons, which illustrates the limits of arms-control agreements – they control those who least need to be controlled. Denmark is impeccably compliant; Syria is not. Did anyone other than U.S. Secretary of State John Kerry believe his 2014 claim that "we got 100 percent" of Syria's chemical weapons removed from that country after the 2013 attack – including the same Damascus suburb – in which a nerve agent killed, according to the U.S. government, 426 children and 1,003 others?

U.S. ability to influence events in Syria has been vanishingly small since Barack Obama ignored the "red line" he drew in 2012 regarding Syrian chemical weapons. The "enormous consequences" Obama threatened turned out to be … Kerry's chimerical accomplishment.

One year ago this month, Syria's regime used sarin, which prompted U.S. cruise missile attacks that did not deter last week's use of chemical weapons. If at this late date the only, or primary, U.S. objective in Syria is to economize violence and minimize atrocities, the ghastly but optimal outcome is a swift final victory by Bashar Assad's regime. A negotiated end to this civil war has long been a fantasy.

Almost seven years have passed since Obama, a practitioner of ineffectual rightmindedness, announced in August 2011 that "the time has come for President Assad to step aside." Assad remains unconvinced. This question, however, remains: What, if anything, should the United States do in response to the gratuitous use – it will not alter, or perhaps even hasten, the civil war's outcome – of these odious weapons in an urban setting? Firing cruise missiles into Syria might be cathartic, but catharsis is not a serious foreign policy objective.

America has embarked on an audacious, not-thought-through experiment. The nation is shrugging off its post-1945 leadership on behalf of democratic pluralism that makes nations lawful and tranquil, and is upending the world trading system it created. Saying goodbye to all that is saying hello to we know not what.

WE WANT TO HEAR FROM YOU

Do you have a submission for Viewpoints? Have something to say about politics, history, arts, technology, business, development, popular culture, science or other issues affecting Central Texas? Please send it to views@statesman.com along with a photo of yourself and a short bio. Submissions should not exceed 650 words.

OTHERS SAY JACQUELINE ANGEL AND ANDREW SCOGGIN
Special Contributors

Demographics show Texas must plan for aging communities

Every day, the population of the United States, including Texas, is getting older. This poses important challenges to Social Security, Medicare and a host of state and local programs. In fact, the Census Bureau recently announced that it projects there will be more older people than children in the United States by 2035. We can't afford to wait 17 years to start thinking about changes that we need to make.

This new demographic and social reality gives us an opportunity to rethink how we adapt to an aging population in ways that benefit all age groups. Texans, as they have in the past, can set an example for others to follow.

Changes cannot depend on a few advocates. Everyone must become aware of the issues. It takes people from different fields, backgrounds and age groups to offer solutions that truly change the way society treats the aging process.

Seniors aren't the only ones who benefit from effective policies on aging. Younger generations will age and eventually benefit. But younger generations can also reap the benefits today.

In 2013, approximately 40 million family caregivers in our country provided uncompensated care that, according to the AARP, had an estimated worth of about $470 billion. Improvements in effective care for seniors clearly benefit family members who are at risk of caregiver burnout if they must provide care to an aging relative without outside help. By taking some of the burden of care off families, we can put much of this time back into the economy to help keep Texas thriving.

We need to do a better job incorporating older residents into all aspects of city life.

We also have a chance to create a more inclusive society by breaking down traditional divides between older and younger age groups. For example, certain parts of cities in Texas and across the nation are becoming more age-segregated partly as the result of gentrification and displacement.

In smart cities of the future, social resilience will be a key ingredient for building stronger communities and for addressing aging-in-place issues. In 2013, a research report published by the Federal Reserve Bank of Atlanta concluded that cities with a high degree of social resilience tend to enjoy numerous health and economic benefits. Put simply, it is not only the right thing to do; it is also not feasible to continue isolating adults based on their age as seniors become a greater share of the populace.

Our cities in Texas can serve as incubators of innovation that make aging a healthier, less socially isolated experience.

In coming up with solutions, more city mayors are establishing task forces on aging, city councils are forming commissions to inform age-related policy, and civic leaders are working with community members from all segments of the population. Cities could also create short-term plans that contain concrete steps to foster social inclusion and improve the health and well-being of seniors. Dallas, for example, has a Senior Affairs Commission consisting of 15 people selected by City Council members and the mayor to guide city staffers. And vulnerable seniors in Dallas can get help from caseworkers in the city's Office of Senior Affairs.

Dallas is part of AARP's Network of Age-Friendly Communities, a World Health Organization initiative that also includes Austin, Brownsville, Fort Worth, Houston and San Antonio. Leaders of communities in this network recognize they must consider all factors, such as skyrocketing property values that make it hard for the elderly to stay in their homes, to maximize civic engagement and be more age-inclusive.

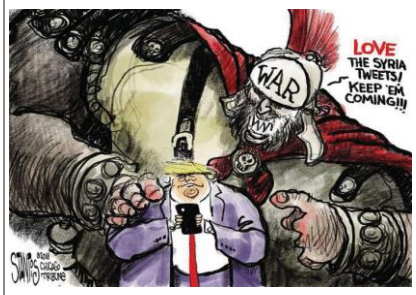
This does not mean that cities should prioritize the needs of seniors over those of other groups, but rather that every effort will be made to ensure that they contribute and enjoy what has been labeled "active aging."

Leaders should particularly focus on expanding public transportation and affordable housing to help seniors remain in their communities and live independently. We need to do a better job incorporating older residents into all aspects of city life.

Inventiveness is part of the social fabric in Texas. We have an opportunity to make similar innovations for the aging process. The conversation must start now.

Angel is a professor in the LBJ School of Public Affairs at the University of Texas. Scoggin is a Master of Public Affairs candidate at the school.

SCOTT STANTIS CHICAGO TRIBUNE



THE WATER COOLER FROM FACEBOOK.COM/STATESMAN

Trump nominated Morales for U.S. district court. ABACA PRESS / TNS

As reported by the American-Statesman's Johnathan Silver, President Donald Trump has nominated Austin attorney David Morales to be a U.S. district court judge and fill a vacancy in Corpus Christi. Morales closed the Texas investigation into Trump University when he worked in the state attorney general's office. Morales is a partner at law firm Kelly Hart & Hallman and focuses on litigation, administrative law and public law. The attorney general's office investigated Trump University in 2010, looking into whether the university violated the Texas Deceptive Trade Practices and Consumer Protection Act. Morales, then deputy attorney general for civil litigation, said in 2016 that he closed the investigation without first talking to Greg Abbott, who was attorney general at the time, after the university agreed to leave the state and not return.

Karl Jennings: Trump draining the swamp into the court system. Nice.

Danny De La O: Scratch my back, I scratch yours.

Michael Steensma: Good. He can leave Texas and join the circus that replaced the swamp.

Matthew Saylor: Shockingly shocked.

Paula Doublin: Interesting. Drop one, win one.

Johnnie Vaughn: Just a coincidence. Nothing to see here, folks. Move along now.

Dave Glina: Quid pro quo.

Amanda Phillips: How convenient!

John Nettle: He was wrong to stop the action against Trump University, as the recent verdict shows. He failed the people of Texas.

Marianna Romero: Worse to worst. The country is falling apart. Trump, go away!

William Nick Stoffel: Just a coincidence, no doubt.

Michael Hathoot: Nope. Nothing fishy here.

Simon Medrano: *¡Aye madre mía!*

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