City Council Work Session Transcript – 4/11/2023

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Chairman pool now call to order the city of Austin city council work session . It is Tuesday, April 11th 2023 just 10 21. A full council is

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present. Members. We. Are going to go into executive session closed session to take up four items pursuant to section 551074 the government code, the city council will discuss the following personnel matters. E one evaluate the performance of and consider compensation and benefits for the city clerk E to evaluate the performance of and consider compensation. And benefits for the city. Auditor E three. Evaluate the performance of and consider compensation and benefits for the minute, the municipal court clerk also percent to section 551071 of the government code. The city council will discuss legal issues related item E four city of Austin 2023 labor contract negotiations. Is there any objection to going into executive executive session on? Adams announced hearing none. The council will now go into executive session.

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We out of closed session in closed session. We discuss personnel matters related to items E one E two and E three and legal issues related to item E four. So we are re convening. The work session of the Austin city council. Let's move us into the first of two briefings. The first one is going to be the update on the operations of the sobering center. Honorable city council. My name is Janet Ortega . I am the

current chair of our Austin Travis county. Sobering center. I am so happy to be standing here with you today to provide you with an update. We are entering into our fifth year or we are in our fifth year of operations and, we wanted to, according to our L a. Come by and brief you all about how

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things are going and also where we're headed in the future. Over this five year period that we've been in operations we have served almost 8000 people saving valuable resources from our police and M S systems. Today. I'm here with our executive director Laura Elmore. We would like to present you again with some information on where we're at as our L a calls for and also to let you all know that very soon in the near future, we will be coming to you to again renew our inner local agreement. So with that alternate over to Laura, thank you all for your time and continued support. Thanks, Joanna. So just I wanted to educate you guys a little bit about the Austin Travis county sobering center. For those of you who are new to the council and haven't been to the center. It is our mission to enhance public health and safety by providing a safe place for people who are publicly

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intoxicated to sober up as an alternative to emergency room or jail and where appropriate to provide a bridge to recovery. Like Janis said. We've done over 8000 intakes since our inception about five years ago, and it's part of our agreement that we update the city council and the commissioner's court as to our progress and kind of our next steps. At the sobering center. There's a little picture of kind of what one of the dorms looks like, the individuals who come to us do not go to jail or the er. There are no citations or fines or medical bills. There's no cost to the clients and we are one of the only places that is open. 24 7. We have complete confidentiality where a hipaa protected facility. And we connect people with community resources and services as appropriate based on an assessment when they're discharging from our facility. We can also assist assists with coordinating transportation home . We have a van and also can just kind of help people find a

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safe ride. Our admission criteria. We don't serve anyone under 18. The person has to be suspected of alcohol or drug intoxication or in an active withdrawal period and not have any kind of obvious medical issue that would require an immediate attention from a doctor. So seizures, potentially injuries and things like that from potential assaults or other medical problems that might come with chronic intoxication. We have adapted our admission criteria a little bit around mental health. We see a lot of dual diagnosis clients. So we see a lot of people who come in that are intoxicated. But they also have some kind of mental health issue. So we will take people who have are expressing some kind of suicidal

or homicidal ideation, but they'll have to be cleared first by mental health professionals. So that might be integral care. We have telehealth capacity for that, or it might be sending them over to tell Satan to be cleared by a psychiatrist. We have a great partnership with L. C and so they're often times will be, clearing someone and then returning them back to us to sober up safely outside of

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the hospital. This is our stages of care, so the client is referred or transported to us, typically, by law enforcement, or E M S, that's been when we first opened. Those were our only referral sources was you had to come to the sobering center in a siren vehicle. We have now added in the since I've been there in about 2.5 years about 60 other referral partners, and I'm going to talk about that a little bit more later. But our intake medics when someone comes in, there's a screening to make sure it's safe for that client to be in our facility. Then our recovery support specialists will monitor the patient and continue to assess their needs. Make sure they're safe. And then our expert counselors will conduct an assessment and at that point determined, kind of is this a one time thing, or is this more of a chronic issue? Either way, that client gets some kind of intervention. Maybe it's just education about binge drinking and safety and public health, and maybe it is more long term access to treatment. So as Janice said, we were founded in 2018 are inter local agreement

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is between the city and the county. The city is funding the operations of the sobering center, and that's through a contract with Austin public health. The county is donating the facility, which is the old medical examiner's office on 12th and Sabine. So the county is taking on all the costs for the facility. Austin public health is paying our operations. This agreement is going to expire in September of 2023, which is why we're here today to kind of update you on the operations and let you know what we've been doing, how it started. How it's going where we're headed. So like I said, when we first opened, it was we opened in a kind of a careful way because we didn't want to overdo it, and we knew that there was some kind of opposition to starting the sobering center and we wanted to do it very safely, and we didn't want anybody to be concerned about it, especially the neighborhood around so it was only law enforcement and then only law enforcement and E. M S. It was only alcohol at first and then it was alcohol and other drugs. So now we're taking anybody on any substance from law enforcement, or E M S can bring to us. We also take

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referrals directly from the hospitals from emergency rooms and then we have a list. Like I said of other referral partners . When I came to the sobering center in June of 2020. That was the most common

question I was asked was how do you get to the sobering center? And at the end, the answer at the time was well, you have to basically call 911 like you have to be transported by some vehicle with a siren. And at the time it just seemed like that shouldn't be the only path in and so what we started doing was strategically adding referral partners, so there's no walk ups to the sobering center. But there are phone calls made by other entities. So say integral care is a referral partner. Capital metro is now referral partner at the university of Texas is a referral partner. Safe. Allianz life works. Other community entities can call us and say we have someone here is too intoxicated, for instance, to consent to a rape exam too intoxicated for us to really place them into a program or a shelter, and then we can sort of safely sober them up and return them to that partner in order to continue their continuum of care. We this is this is a big

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business model change that we made starting in 2020 and keeps going. We also will do hold overs for treatment centers are sober homes, places where maybe people are going to treatment for active addiction, and they have maybe relapse or falling off that treatment center. That sober house may say. Well, this person has broken the rules of our place. They can't stay here. But we don't want to kick them out to the street, which is kind of what was happening before and so we offered those partners a safe place for them to come and stay with us for 24 to 48 hours, then we return them back to treatment. So the other big change we made to our business model was that patients like I said, are able to kind of hold over for services. This was something that happened in the summer of 2020. We had a patient who was picked up by M S 75 times in 135 days, which is about every other day, the whole summer and after we saw him about a dozen times was we finally convinced him to talk to us as you can imagine some of these individuals who are chronically intoxicated, chronically ill and living on the street for as long as they

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have. There's a lot of trust. Building that has to happen first. So we ended up interacting with him enough times where he finally agreed to go to treatment. But there is no such thing as going to a medical detox for alcohol on a Sunday morning at eight A.M. If you don't have insurance, or if you're homeless, and the only option really was for him to go back on the street and drink or pretty much die on the street, you can die from alcohol withdrawal, you cannot die from, say, crack withdrawal. So we decided to hold him as long as possible until we got him into treatment that ended up being about five days. The sobering center is not designed for that . It's not a residential facility. We don't have a kitchen, but we do have frozen dinners and bottled water and showers. And so ultimately we decided that ethically morally, it was the right thing to do to just hang onto him until we could get him a bed, which we did, and that went so well that we kept doing it and we wrote it into our Austin public health contract as a pilot, and then it became a con continuous part of our service. So it is now kind of the jewel in our crown. We're calling it our holdover program.

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If we can get someone to stay, then we can get them into treatment about 95% of the time. It's not quick. It's not easy, but it does happen. So we have started to think of ourselves kind of like putty in the cracks of a broken system. There's not easily accessible substance use treatment. So we're really just kind of trying to make it work with what we have when we have patients who will stay long enough to trust us and talk to us, and we'll get them into longer term services. Here's some of our outcomes. This is a snapshot from fy 22. So in fy 22 , which is our last fiscal year that's complete with all the data we served 2032 people intake. We admitted 93% of those people, so we have a very small number that we actually don't admit the only reason we would not admit them as if they were violent and intake or if they had a medical problem that was bigger than we could handle. So we did. A total diversions from jail was about almost 1800 people. So about 88% of those that could have gone to er jail came to us. Are successful

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discharges are about 51% of those that we admitted. So it looks like a funnel. The number of intakes is big. Then the number admitted, and then the number successfully discharging. Successfully discharging we count that number very conservatively. Lots of people believe, and we won't count them as a successful discharge, but they will leave pretty much sober and not at risk to themselves or others. But we count as successful discharges like they actually sat through a conversation with a counselor and assessment and the whole process. Not everybody is willing to do that. And we're absolutely not detaining folks. So we think it's pretty good that about half of them will go through that final process with us. The holdover program I mentioned there were about 144 people that stayed in that program and 96% of them. We did a warm handoff to treatment, so that means we put them in our van and drove them directly to the door of the treatment provider, the sober house, the outpatient clinic, wherever was their level of care that was needed. So, like I said, it's a funnel the number that we're at , you know, in taking us 2000

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number that actually is seeking treatments about 144 out of those at least that's ready at that particular time, and if that's the case, and they're willing to stay, then we're able to connect them to care. We did 80 holds for referral partners, and that means what I said earlier about treatment centers or sober houses and places where people have relapsed, and they need a break. They need to be kicked out of that program. So to speak, but don't have anywhere else to go. We hold them sober them up. Return them. 80% of those went back to their original care rather than being kind of kicked out onto the street.

So what we have done and this is kind of hot off the presses. So y'all can, I will be doing my best to go through this with accuracy. Here we are, in the middle of a huge outcomes evaluation with an equity lens and a cost benefit analysis. It's not finished yet. So what I've brought you is kind of the headlines of what we know so far so that you can kind of see what your investment is producing on the other side. This is a little

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busy, but what you'll see here is some some of the direct costs and then what? What it is per diversion. So the direct costs S C at the top number. Our costs borne by the sobering center with that really is cost born by Austin public health, so that is the city's investment into the direct programming of the sobering center. It's not a total cities investment at the very bottom. It will say that cost benefit analysis includes only direct program costs. The full budget is 2.2 million for the sobering center. What we did was we, the researcher looked at our audited financials took out all all expenses for like fundraising management, managing the board any kind of like administrative costs and took that out and looked just at the program cost. So what's actually happening on the floor with with the clients? Then you have the direct costs borne by the county, and that's basically foregone rent, so they're donating the building, and this is an estimate of what they could be making on that building if we weren't using it. And then you have direct costs from ems for transport. E. M. S M S

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referring to us is something that is very, very rare. The entire country asks me about this. Every time I speak nationally on this issue, people say, how did you get sms to refer to you? They can't get sms to refer to sobering centers all over the country because of a cost reimbursement issue because CMS doesn't get paid unless they take someone to a hospital. Austin Travis county M S takes people to us and just absorbs the cost. They used to have it somehow grant funded and I'm not sure how they are doing it now, but they are doing it regularly, so there is a cost to them small cost. Their direct costs for APD for the same thing to transport clients that to jail that we may have to call them back for if somebody is violent, aggressive or something, and we call a pd back to the center, there's a small cost a P D. And then indirect costs to M S are foregone costs that they might have gotten rather than taking them to a hospital. So everybody is having a little bit of cost here. The benefits, though, are pretty substantial, so you can

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see that there's er diversions. There's jail diversions. And then there's a reduction in future er utilization. This stuff is based on like consumer price index medical, numbers that are published in the literature

about what we think that diversion saves. And, the number of er diversions we did and the number of jail diversions we did, and then the number of people that did are discharged that interacted with an expert process, which stands for screening a brief intervention and referral to treatment. The research shows that you will impact their future U E R utilization as well. And so what we're seeing here is a benefit of like 2.3 million. So what you see, really is a cost ratio benefit here of 1.4. So what that means is for every dollar you're putting into the sobering center. You're getting back a dollar 40 in the community. And then there is a cruel by parties so you can see that most of the most of the costs is going to be borne by the sobering center, which is really born by Austin public health. But most of the benefit is actually seen on the side of

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the hospital. That's they've got a 90% benefit there. So what that means is that we're saving the hospitals a lot of money by taking folks out of their er that are just waiting to sober up. So this is really important data for us. I think to look at talking to hospitals about potentially supporting the sobering center and diversifying revenue in that way so that the city isn't completely responsible for the operations, but you can see that the costs are pretty low for Travis county and for ams and the P D. But the benefits are still there. Other benefits that are difficult to quantify, and therefore not really able to be. Included in this are the individual benefits that you can imagine for the people the patients for not going to jail or the hospital in terms of avoiding a record avoiding significant costs? And kind of carnage and relationships and employment. And then long term benefits to the system and individuals related to the organization's role in connecting people to treatment. So what we know is that people can go to long term care for substance use disorder . They're going to improve their health drastically. We are

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hoping that there will be reduced crime rates and generally reduce mortality as a result of long term connection to care. You guys might know that we have some. We have got national recognition for this model. We were asked myself and chief Chacon were asked to go to DC and participate in a roundtable of five sobering center CEOs and five police chiefs and are part of a case study and a toolkit that's being developed by the international association of chiefs of police. And the point of that is to look at the relationship between the police department and sobering center and how the police feel that this is a break for them. For example, it takes many hours to book someone into the county jail. It takes about eight minutes to book someone into the sobering center, so they're also avoided costs there when we are putting first responders back into their roles so that they can do policing on the street rather than managing public intoxication clients. So we went to D. C this was about a year ago and since then have been

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part of their research. The international association of police chiefs research and their toolkit that they're developing for other cities in order to develop sobering center models that work with the police departments as well as we are doing here. The other pieces that we have, really, involved ourselves in the national sobering collaborative, which is a nonprofit organization that is made up the board of directors is made up of other CEOs of sobering centers across the country, and we I'm on the secretary of the board. We're working on developing a some best practices and potentially even in accreditation for sobering centers across the country so we can keep up a standard of care that matches across the board. So like I said, we are seen as being innovative here were seen as being collaborative here were seen as a model for excellence that other states often come and visit the Austin sobering center as a guide for them starting their own center, so this has been really great recognition. This is a snapshot of our strategic plan. Our board of directors just approved this in

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December. So this is a five year strategic plan for us that kind of shows what our values are shows what our vision is. None of that is really knew our mission. But our goals are there in the middle, and what we're wanting to really do is to maximize the use of the sobering center as a first line response to intoxication. What we know about that cost benefit analysis is that that those direct program costs are just kind of the meat and potatoes of what we do. The admin costs are kind of stable. So like, for example, an admin cost is like paying for that evaluation to be done right or paying me to go out and do outreach or talk to people or try to write grants and raise money. But if we could, the more people we serve, the more that cost benefit analysis is going to grow because we could do more with the sobering center is not at capacity that we could do more with the beds that we have. We could do more with the space that we have, which is probably not something you hear very often. Most people are going to say we're on a wait list, right? We can't do anymore, but we could do more. And that's because we're open. 24 7 and

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we're holding it open 24 7 as you can imagine public intoxication. Becomes much more of a problem like Saturday at two in the morning than it does on Tuesday at 11 A.M. So I think that we could be a lot more creative with what we're doing with the sobering center as a first line response to intoxication, maybe it's not always traditional public intoxication the way you think maybe it's also intervening in different ways with the public for issues of drug use and substance use that we haven't thought of yet. We would like to be developing into an essential hub for a more integrated system of care. We would like to be working with central health and the county and other entities around trying to get build up the infrastructure of treatment in this community because it is so difficult for us to get people into detoxification and two residential treatment for substance use. We just do not have the treatment beds

here. And so that has been a major challenge for our staff. And we would like to be part of the solution there. We would like to foster a sustainable model for service delivery and access responding to our community needs. What I think is important about that is that we were doing

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an annual stakeholder summit every October and gathering our folks together that our referral partners our community partners to ask for their feedback and do focus groups about how's it going? How could we do better? And we want to evolve and respond to those needs and we're able. We're already able to do that and brainstorming more ways to do that creatively. And then, like I said, we want to lead as a center of excellence and innovation, both locally and nationally, which we're already doing. Here's our immediate next steps and what we want to do. Bridge medications. This has been a huge thing for about a year and a half is that I've been trying to figure out a way that we could stock medications at the sobering center in order to stave people offer the withdrawal process from both opiates and alcohol. This is in response to the opiate overdose crisis everyone knows about but also I think that was hidden crisis is the alcohol issue in trump's county. And the city of Austin. We have a huge binge drinking community here. We also have lots of alcohol related

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injuries and deaths. And alcohol is something you can die from, right? So we bridge medications . What that means is that we would not be necessarily a detox center or a treatment center, but that we would have medications on board in order to slow down the process, stabilize people but keep them out of the hospital or the jail while doing that. In order to do that. There was a whole bunch of steps we needed to go through and which included getting licensed by the state as a first responder organization, which we did and then going to the D E a and trying to get approval to stock meds and inventory meds at the center. It turns out through all of that, that the Dea and the state were kind of confused about what we do because the sobering centers in Texas have never done this before. So again, we're trying to innovate, but it becomes a little challenging when systems have never done this before, so what we've done is kind of decided to form a more formal relationship with the community. Health paramedics through E. M S because they're already doing a lot of this. They're already initiating Beaubien, orphan and suboxone in the community there

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already bringing patients to us out of homeless camps that we can monitor for safety and they can do the medications for. So what we're working on as a pilot project with M S and the chip medics so that they will be able to bring us the medications do all the stocking and inventory of it. We already share a

medical director. And so that would be a resource kind of leveraging for us, and, so that we would be able to. We have 24 7 paramedics and E. M. T S as well as counselors and text about 70% of our staff are in recovery, so we make a great safe place to initiate withdrawal medications. So that's kind of the next step that we're working on with the chief of E. M S. In terms of mental health diversion. I think that you guys have probably heard this come up a few times. I was just talking to us public health about it as well. The county commissioners are really interested in mental health diversion. They have approached the sobering center about potentially being a partner in that or potentially piloting something at the sobering center. And or potentially being part of some more larger collaboration in the future as

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they potentially build a new diversion center for mental health. I think what's important for you all to know about that is that it is a little bit of a myth that we could separate substance abuse from mental health very clearly, oftentimes you will need many days to diagnose and assess what is a substance use issue. What is a mental health issue? We see mental health all the time. If we were going to do mental health diversion, we would need to staff it somewhat differently and probably renovate the building slightly differently. The county commissioners are aware of that. So I see us potentially being involved in that conversation, and we're happy to figure out what the county or the city how you guys would like to proceed in mental health diversion. We definitely want to be part of the continuum of care. So our strategic plan I just showed you a snapshot of, what we're basically doing is more of the same of this. We want to do the bridge meds. We want to be better at connecting people to treatment. We want to be advocates for the infrastructure being built out in the community for there to be treatment beds because a big

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part of this conversation I feel like now that we're all on the same page about diversion. We want to divert from jail for sure. We want to divert from the hospital for sure. We want to avoid that trauma. The collateral costs of that the financial cost of that. If we're going to do diversion well, we have to divert somewhere. And so where are the treatment beds? We're going to have to build that. And we want to be advocates for that in partners in that process as part of our next five years. I just wanted to call out a few pieces of gratitude to you guys and let you know what I need from you as a city council. Kathy tovo was our first inaugural city council member on our board, our bylaws and our in our local agreement requires a city council member on our board. She was a founding member. She was a huge advocate for us, and she was even reviewing this presentation last night, so I really appreciate her time. She was extremely committed, responsive and, knowledgeable board member and she's been replaced by Jose chito vela, who has been awesome

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and enthusiastic and supportive from the beginning, and I really , really appreciate that. It makes a huge difference to me as an executive director to have city council representation on our board. Shoutout to Adrian stirrup and the Austin public health staff who manage our contract. This has been a hard contract for them to manage. It's totally different than all the other contracts. So there's often times little snafus and hiccups and confusion and in that process, and they've been really supportive advocates for us as well. The two things I need from the city council's this this inner local agreements going to come across your desk for renewal. It expires in September. And so for the sobering center to continue to exist, we have to renew that in our local agreement. So that will be coming your way. And so I wanted you guys to all know, have the opportunity to come tour the sobering center if you'd like, but to hear from me, kind of how we've been doing and where we're headed. The other small piece to that is, is just that we make sure that and when we go forward in the budget, I think when we first started out,

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we were asked to give Austin public health like a 10 year forecast of our budget, which is very hard to do in 2018, and then even became kind of ridiculous in 2020, right. Everything kind of changed what we'd like to do now, and I think what Kathy was advocating for was for us to be in a collaborative kind of conversation with Austin public health about what are the needs of the sobering center. What is Austin public health willing to do able to do and how we work together to craft a budget every year going forward. We did put together kind of a draft of a five year budget, assuming no major changes, but we'd like to be in kind of constant communication with Austin public health through that process. That's what I have for you today. What questions do you have for me? One. I see a hand up council member harper-madison or council member of L a. Did you have your hand up? The city manager. City manager. Why don't you go ahead? Just one quick. I mean, I think it certainly would want to. Boston public couple want to sit down with you and work through the appropriate budget. For the new fiscal year

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for the new head of local rather one of the things that you mentioned, and I would urge just to really focus on his that this is really a health issue. The city of Boston in 2004 divested his assets. Its primary care offsets to central health hope we lowered our tax rate so they could increase their tax rate to provide care for the poor and the vulnerable in this community. And so I simply would urge you to sit down and begin to work with central health to see what their proper role is in this certainly the city is not going to abandon its role, but I think it's appropriate for us to say to them. What role do you play in? As you talked about mental health? That's a huge issue, not just for the people in the sobering center. But in the homeless camps that exist throughout the city. Behavioral health is a huge issue, and there's a lot of people working on a lot of different venues. But I want to come in the work that you're doing, and

we're certainly certainly willing to enter into those negotiations in good faith. And ask you to really begin to visit with my

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Kiessling and others at central health about what their proper role is in this yes, I agree. And I have met with central health of several times and I think that's something that's an ongoing conversation. They've asked me before to give them data to give them financial data . You know about 30% of our patients are more than one time visitors, you know that are chronic users. But about 70% of our patients are one time visitors, which is kind of surprising to most people. I think so. I think we get all of it right. We have the people who are definitely living on the streets and using in a really chronic way and need that low income healthcare and then we also have people who are tourists who are in town for south by southwest. So we have all of it. But I 100% agree that that is part of the role of central health and will be continuing to investigate that relationship. Thank you. Council member harper-madison. Thank you very much. I actually have been getting very interested in from a behavioral health perspective. And getting out in front of, substance use disorder, and I was listening to this podcast

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one time where they talked about the concept of arrested development so the person could be 65. But they started using when they were 11. So they're still 11 and a lot of those folks are who were dealing with that are coming to the sobering center that are experiencing homelessness, chronic extended homelessness. I keep thinking about excuse me. So like in philly, for example, they have this really great recovery high school. So what they're doing is they're catching it before a person has had 40 years to accumulate 40 years worth of substance use disorder, and so all of the staff all of the faculty, everybody in the building is a person in recovery and their peers are all in recovery. And so when they leave, you know recovery centers. They go straight into this recovery high school. Their chances of recurrence are next to zero. It's so incredible I just wonder if I'm wanting to bring that a similar thing to that to Austin, especially because we are such a drug city , you know, I mean, I think about it a lot. You know, my kid

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was on U T campus. I would hear stories that just terrified me. And so that said I wonder have been thinking about who are the potential education partners. But I wonder how much of that also needs to be combined with an initiative like a sobering center. I wonder if that's something that you know, as your business model continues to grow and expand. I wonder if that's something we can visit along the way. There is a sober high school in Austin. Okay yeah, it's very small. It's called university high school and it kind of got, I don't know. If you guys remember this. There was a merger of Austin recovery and

university high school in a youth serving substance use group called keystone. A couple of years ago. And so it may be under the name now of Austin recovery or Austin recovery network, but it does exist, but it's very small. And they're located on the U T campus, actually in the basement of a church there, so it does exist, and there's definitely opportunities to probably partner or expand on that. I think that is one thing that's

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really critical about our services is that you have to be 18. And that's not true. Everywhere in the country, but most places it is so it's definitely true that if you're 16 or 17 and your publicly intoxicated you're probably going to go to jail, you know, or some kind of facility like that our gardener bats or or the hospital, depending on what's going on, but I hear the same thing and as a mom, it's like terrifying to hear some of the stuff that was going on on campuses. Would be happy to talk more about that. Yeah. What is the reasoning behind 18 is it that they can self admit versus a minor? Yeah I think a lot of it was also about just setting setting up really narrow operations at the beginning because we had never done this before, and it was new, and everybody wanted it to be kind of very predictable and easy to manage. And yeah, so technically , they volunteer to go. And so I think with a kid, you'd probably have to have consent of the parents, and it becomes a whole another kind of service model. But we can definitely look at at doing that. But that is that was probably the original reasoning. Makes sense to me. Council

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member villa and then council member Fuentes. Well thank you very much for the presentation. Excellent and I have a big shoes to fill with Cathy. I know how engaged in how hard working she was, but I've really enjoyed working with you and being on the board. You know, you talked about limiting when? When the sobering center was first established you you wanted to limit its scope because, as you had mentioned in previous conversations, there's a natural mission creep to it where everybody wanted you to do everything for anybody affected by substance abuse, but you needed to keep it, limited to get off the ground. How are you seeing? I mean, looking forward . What areas? Do you think that this will bring center could jump into over the you know the next year and the next budget cycle. What do you looking at? So yeah, it was definitely the board's interest to limited

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partly because there was fear, I think of it looking like what the arts used to look like right that people would just line up outside or that people would be drinking excessive amounts in order to find a shelter bed and things like that. So we wanted to keep it really narrow in scope to kind of see. What is this? Like? Now that we've learned so much, and it hasn't been that way, we've really kept the operations

really clear. The protocols are really clear upon admission. We don't currently take walk ups. I'm not sure that we would want to take walk ups necessarily. But I do think that there is a huge issue and difference between the issue of public intoxication and private intoxication. So if you look at our demographics and are substances we serve it's going to be 75% men and 75% alcohol, but we know that that's not all that's going on in this community. We know that there's a lot of opiate use. We know that there's a lot of meth use methods number two for us, but still it's way behind alcohol. So when you think about public intoxication, you think about mostly men, drawing attention to themselves, mostly using alcohol

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but opiates and women and tend to use privately and if you're going to do opiate overdose, that's going to be a private thing as well. You're not usually at a party doing that. So I think there's other places for us to get into here, and it may be things that I've thought of our sort of integrating more with 911. Intermittent integrating more with the M S, like, how could we go out potentially on calls that maybe maybe we go with the police department? Maybe we go with integral care, and we try to help assess at the scene, so and we have a van and we can transport people. We're doing outreach on sixth street, so we're doing a lot of public health and awareness of just like safety and giving out water , making sure people have safe rides home. I think we're probably preventing DW is doing that. But can't can't count it don't know how to manage the data of it right? And then the other big thing is that bridge medications piece. I think, integrating with pms to where we have we can give people meds to stabilize them and keep them from crime in the walls. While we're trying to talk to them. You can't really rationalize

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with a drunk person or a person who's been on meth for seven days and hasn't slept. So if we can keep them long enough, build the trust long enough to have the treatment conversation with them. Sometimes that requires medication, so we're going to need we're going to need to become more and more medical and, like the city manager is saying, this is a public health issue. This is a this is a disorder of the brain that needs to be addressed. Like with the needs of the brain. And so I see us doing that I see as potentially getting into we could get into the area of detox or treatment. If we really wanted to if the board wanted to, that would require a pretty significant change in the building. You have to be licensed, and there's rules about how that works by the state. It would also change our staffing. And so rather than having paramedics and emts we'd have to have nurses would be a different model. I also have the same question of that is that a function of the sobering center? Is that a function of central health or is it both? Is it a partnership somehow, but I think that there is a little bit of a vacuum of leadership in terms of the substance use disorder,

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taking that mantle up and saying, we're going to be the lead on making sure that people without resources get this access to care, because historically, we've just incarcerated those people. We haven't really effectively treated these issues. And so now is a really good time for a paradigm shift to say who is going to take up that that role. I think the sobering center has a key role to play in that it doesn't have to be all things to all people, but we could develop out the infrastructure we've already built. The governance model of that works really, really well, like having the board be jointly appointed by the city council in the commissioner's court has been great. It's great for me because I have access to the folks that are influential. That can make decisions quickly, and that's not a typical nonprofit model. You know, we're a nonprofit organization so we can take donations, but we're also a local government corporation. So I think there's something there with the infrastructure that's already built that we don't have to reinvent the wheel if leadership in local government or. The community in general wants to invest in creating more

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treatment beds than jail beds. That's going to be a long term process, and we're going to have to reallocate some resources, and I think the sobering center could play a huge role in that. But again, it doesn't have to be the treatment provider for everything we have somehow have to bring treatment. More more treatment beds to Austin, assuming that you could. Get licensed and build out the facility to add a substance abuse component. What? What kind of capacity do you think the again just working within the existing footprint of the building that that you have? What kind of capacity do you think there would be for beds for substance abuse, treatment or or detox for that matter? Well there's currently 16 beds on the first floor. What I would love to do my next step in terms of the bridge meds piece in the holdover program. Is I would like to renovate that second floor to where it basically matches the first floor to where we have at least double the capacity. I think that building is really poorly utilized. It's poorly laid out. We're currently it has the homeless outreach

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street team on the third floor has sobering center admin on the second floor, and then we're only using the first floor for direct care. So this is something I'm talking to the county about is could we renovate the building to where we use holdovers? We put holders on the second floor because they're sober. There's waiting to go to treatment. We use it almost like a respite and then use the first floor for all the public intoxication piece. But if we did more outreach like if we drove the van around, we could find people that need help. You know, it was just waiting for us to for them to bring to us. Is also kind of a passive model. We could be more active in the community. We have bed capacity, so I think we could double the capacity easily. We could probably do more if there was someplace else for hosts to be. I don't know. But the host has been there since the beginning, so I don't know if that's the right place for

them and related to that. I understand that in your prior, professional role you managed substance abuse center. That's right. Yes so I guess from my perspective, we seem to be very well positioned to move into that role. Given that we have

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the space the need is there. The director has experience in managing that type of facility. So I would like to move relatively aggressively to add that also is there any substance abuse treatment available for uninsured folks right now and in Travis county? There is very, very limited number. So you've got a new entry and you have Symbicort, and that's about it. Hmm everything else costs about $30,000 and what would be the wait list, for example, if I wanted to get into a substance abuse treatment program, and I'm indigent. What what? What timeline? Am I looking at? It depends. I think if you're going through a traditional like the ocr process where you have to get on a wait list, and you don't have anybody kind of helping you through the process, it could be weeks could be months. We're able to do it in a number of days. But that's because we've developed relationships and we also know the system really well, so we

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can kind of knock down those barriers really quickly. Get somebody get their medications. Help somebody get there. I'd get get all into place. Again those were things that sobering center was not designed to do. We started doing those things mostly because I'm a social worker. And when I came in in 2020, I was like, what are we doing here? Like we can sober people up and send them out. But, like, send them out to wear, and so we started kind of doing this. Hold over in this bridge and all that, so we've been slowly building it with the resources that we have, but it's kind of a it's kind of fragmented and I appreciate and in the discussions that we've had your comment and other folks comments about how that moment when someone decides like they've had enough and they want treatment. Like you got to get them in treatment. Like you can't be like okay. Come back in two weeks. You know, like you, you lose them, and they may not be ready, so I just I think that really spoke to me of the need, especially for so many folks are already passing through your doors. And you have essentially the expertise and the ability to

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take folks immediately and put him into treatment. I just really feel compelled to take advantage of that again very much, noting the concerns are the financial we need to split the costs among other folks that are also responsible for this type of treatment. You on central health. And others as well. But but we have a great opportunity and I would really like this council to move forward in that direction. I think from the perspective from my perspective as a as a nonprofit leader, it helps a lot when the board and

or the governing entities of our board , which is the city council and the commissioner's court are able to give me that type of information right like this is what we've invested already in central health. This is the role of central health. This is what we know how that we know the hospital systems benefit from this and so being able to as leaders go to those systems with me and say, hey, we how do we split the cost of this versus me? Trying to like bang on the door of central health and go hey! Can we do a contract? Can

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we do a little small thing? It takes longer and it's not as effective. I think I think in one last question any idea what expansion into substance abuse would cost in terms of again? I know this is very preliminary, but just the general scope of the amount of funds you would need to operate, you know, a small substance abuse Trejo to go into, like, treat the treatment business well in my former role, I was the CEO of Austin recovery for of time period. The budget of Austin recovery was about $8 million, and we had about 52 residential beds, but we also had outpatient services. And after care and things like that, so that's kind of a ballpark. There were times where we were running a detox and times where we weren't medical detox is super expensive. That's why people don't want to do it because it's very expensive. Like, for example. Detox probably blue cross blue shield would pay a treatment center $1000 a day for detox. Medicaid will pay $96 a day and were expected to do the

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same service. So that's why there's no detox for indigent because the business model doesn't work the reimbursements from the state or terrible and so nobody can find a payer for it. That's the that's the trouble with it. It's very expensive, but it's very accessible. If you have money. If you have great insurance, you can go to detox. Anytime you want. There's tons of for profit treatment centers in this city. Thank you very much and look forward to continue to work with you for your questions, and I just want to shout. Give a shout out to Jenna Ortega, also the director of the board who I've known and worked with and who I really enjoy speaking with and looking forward to work with you on this sobering centerboard Janet. She is wonderful. Manager did you need to say something before we go to council member Fuentes? It's just really. I mean, I think she's she's outlined the issue. Treatment center would be expensive, and I do think there's a lot of people that have some role to evaluate. For instance, when we ran Brackenridge then and then del seat UT though I was there last time for that. We would hold

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patients in an inpatient capacity. Even though they their medical treatment was done. They were there for other reasons you couldn't discharge him. You couldn't discharge him because there was no

treatment facility long term care. Rehab care all those things. The interject just have a real tough time. Getting those extended services beyond the acute care and that's why I say I mean part of it is the need to plan and what the role is of the various agencies in terms of how you bring that plan to life and it is expensive and it's going to take a lot of a lot of partners to kind of figure out the puzzle agree. Any other questions. Alright. I think council member, Fuentes said hers were answered. Thank you so much for the presentation . We really appreciate the work you're doing in our community. Thank you so much for your time. Alright that will take us to our last item of the day, which is a briefing update on the city's

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emergency management plans and responses. Yes mayor pro tem. I'm I'm gonna ask him to come on up and let me just do a couple of introductory remarks. We combined the emergency management and energy. Emergency management plans together for purposes of this work session. And we try to move as fast as we can, with with that bias for action. You know what we've seen in Austin is a series of storms that we think are going to happen more frequently. And one that we, perhaps in the past, have not quite been prepared to manage in an appropriate way. We think this is going to happen. I said it was going to happen more frequently. We've noticed that our preparation just hasn't been with. It's needed to be. And so one of the things that we want to focus on today we're going to get into some detail is first how we opened up the emergency center. And who needs to be available at that emergency center so we can bring the city's resources to bear on that specific emergency. The second is how we communicate and make

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sure that the communication is coordinated in a way that delivers to the community exactly what's happening, what needs to be done and what they can do to prepare themselves for that emergency? And finally, how each department can assess its own assets. About what? How what they can bring to the table to be able to respond to that emergency. And so all of those things are ongoing right now, so that we can have a more focused approach. And I think the briefing today is going to give you an insight into that, and we look forward to the after action reports that we get into detail. This is just a preliminary snapshot, and we're gonna get into a lot more detail here in the future. And with that, let me turn it over again. Thank you. And I'm sure the management Garza good afternoon mayor, pro Tim council. Thank you for your time. Got it, buddy. Three principles outlined by interim city manager Garza across the enterprise. We have started the process. Of improving the city's response to emergencies. And fundamental tool to that would be the after action report process and after action report , process or natural action

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report is a tool that allows us to quickly assess our performance and understand where we can get better in our overall efforts. That process is going to play out over a five phase structure. That structure will begin with a departmental preliminary analysis that will allow us to take a look at what we're doing in each individual department. It would also include when I'll talk about in an upcoming slide or share briefly hot wash. We'll talk about through that process went well. Well what were some of our challenges and what are areas that we can improve on? Phase two will include a preliminary after action report as you all know, the full actor actor after action report takes quite a bit of time to complete, but I want to be clear. We're already working on these issues. We're not waiting until the completion of the actor after action report. Phase three is a joint after action review with Travis county as one of our primary partners is really important that we understand how we work

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together, whether we're working well together or not. Are there additional opportunities to improve upon that? Base four is the improvement process that will allow us to really dive deeply into the solutions portions for some of the more complex issues and then phase five is the completion of the, the after action report. Next slide, please. This is this is an example of a hot wash from one of our city departments. You might notice, for example in challenges on the item one. They've identified silos and overlapping objectives as one of the things that's causing problems or contributes to issues as they move forward, and just as a example here, we want to make note that this is happening. Across the city and pretty much every department as we work to get better. Next slide. Part of my charge, while on assignment is to conduct an assessment of the homeland and

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security emergency emergency management office and over the last two weeks as part of that process, I've had a chance to meet meet with the mayor's office as well as each council office, and I want to take a moment to thank all of you who took time to meet with me to share your thoughts on that process or how we could get better. And I hope I wasn't too pushy and demanding your time. But I just want to make clear that this issue has been really , front center for interim city manager, Garza and all the all of the other city leaders as we want to make sure that we're supporting the people of Boston in the most beneficial way possible. The by far the most common topic that I heard from each of you when we met revolved around communications, we talked specifically about the strategy for digital communications. What happens when we don't have the ability to communicate throughout normal channels? I E . When there are extended power outages, we may not be able to

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use our traditional methods of communications. Think cell phones, etcetera. We also talked about the frequency for communications. What is the best practice in this space communications and protocols for elected officials? Many of you wanted to know what exactly is it that I'm supposed to do during an emergency? How can I help? Where can I be of most benefit shelters was also a huge topic. The strategy for messaging and protocols was something that came up for many of you as, point of clarification that needed to be made there. We were not clear. In many cases, wind shelters were opening, which shelters were opening when and then also backup power. Many of you shared concerns about the fact that we have or don't have backup power , and many of the locations that have been identified for backup shelters or emergency shelters. Training. Was another area that was mentioned quite often.

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Community preparedness and resiliency was a topic as Austin starts to experience storms more often and whether issues more often, council members and elected officials wanted to know what are we doing to prepare our communities? Clarification on roles of elected officials. Doing emergency was also, topic as it relates to, what kind of training would we have available for elected officials so that they understand where they might be of most benefit? Practice we talked about training. There's also desire to have frequent practice. There's one thing to train, but if we don't practice we don't get a chance to really hone our skills and see where we can be better to become more proficient with the training. And so that's gonna be important going forward and diversity of exercises while the hot topic right now. Ah senators around winter storms. There was also a desire to have discussions and training and practice around. What do we do when there are floods? What do we do if there

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are fires, and we're asking people to leave their homes at one A.M. In the morning? What is that process looks like so we want to have a portfolio of training exercises that allows us to practice. Many of the issues that we might run into in our communities and lastly, the role of the homeland security and emergency management office . Each of you wanted to know a little bit more about what is under the purview of that office . And if there are things that are there that may not be within that scope. Where should they be ? And who's in charge of those? Those actions? And that concludes this portion of the briefing, and I will turn it over to Stuart rally from Austin energy. Thank you. Good afternoon mayor pro Tim council members. I'm Stuart Riley, interim general manager of us and energy, and, some of this we've covered at a Austin energy utility oversight committee meeting, but I just wanted to follow up on what Ken snipes mentioned are after action

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review at Austin energy is focused on our response to the winter storm in order to better understand our actions. As they pertain to our response to the winter storm identify factors that contributed to any process breakdowns and identify effective strategies for responding responding to future emergencies going forward and our after action approach consists of five steps plan, discover, analyze, improve and report we've come through the discovery phase. We have over 150 preliminary findings from that discovery phase. We're currently in the analyzed phase. And so as we're looking at this phase, we will address those critical questions and look at root causes for any of those preliminary findings and ensure that we haven't missed anything. Next slide, please. Just to let you know some of what that discover phase consisted of on the left side. We have a graphic that just points out that we have over 200 incident command participants at Austin energy

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that have been interviewed. Our corporate quality services group is leading that effort to do our after action review process we've had over 20 cross functional meetings. And I also want to point out that our corporate quality services group that's looking at our process has also gone to look at every council work session and Austin energy utility oversight committee meeting as well as any of the questions and comments that we receive from council members because you know the input that you provide us as that conduit to your constituents is an important part of our of our process as well. Overall the preliminary findings that we have from this discovery phase are listed in the middle here, things that rose to the top restoration operations technology planning incident command, logistics and public information. A lot of areas roll up under that restoration operations section. So once our report is really once we've come through all those findings, and our report starts to be synthesized. We will have that broken down into

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different areas from what you see here. Next slide. Oh and I'll also mentioned that as we're entering into this analyzed phase. We're we're receiving that information. We're synthesizing that data and we're looking for anything that we could have missed. Perhaps any duplicates or any high level findings, but we're looking first at the at the really important items that have bubbled up to the top. And here we have on the slides just some of the major issues that have risen to the top. No, nothing is going to surprise you here in terms of the outage map. We know that the outage text alerts confused customers and sent them into an outage reporting loop and we've already made some improvements to those text alerts, increasing the time out threshold, but there's more work to do there for sure. Also customers could not always identify their outage on the outage map, so we know already we need to work with our vendor to improve the user experience when that kubra outage map platform in terms of restoration

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coordination. A lot of our findings as I mentioned are in this area, particularly around doing the assessments. A lot of our findings in different areas, whether it's the restoration, coordination or communications. Has really pointed to a process improvement that we have. That's necessary for doing a system wide assessment of what the situation is out on the out in the field to be able to communicate both internally with our mutual aid crews and with the public as to kind of what the situation is out there, so we know we have a lot to do there. Communications we already know that there were insufficient communications with us and the and other departments and with us in the public, and so we are part of that city wide process and looking at citywide emergency communications, and we'll continue our work there. Also a big one that's risen to the top is the incorrect system wide as estimated time of restoration. I mentioned that in, in relation to the system might assessment process that we need, and we know that that caused a big challenge for our

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customers. And of course, vegetation infrastructure, the extreme weight of ice on trees. Broken poles, broken cross arms down wires. We will be examining opportunities to upgrade and repair our existing distribution infrastructure and invest more in resiliency overall on these items that were not yet into the improved phase. We already know we need to take action on grid resiliency and we are. We're not waiting to take action on some of the things that we've identified here. Already we are looking at or preparedness, our communication and our restoration practices. Index side so going forward our next step as we get into the improved phase, we will identify effective strategies will have tangible timelines specific targets. For all of those items. We will execute a third party review to look at our after action process to ensure that there's a thoroughness and completeness. And we will integrate this into the overall city of Austin after action

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report. We'll finalize our report and we will issue it. Also as a standalone report in order to be reviewed by our industry partners and any regulators. And that is our presentation, and we are happy to answer any questions. Questions. It was popular public works gonna make some statements of this is it? Can I see that? That's it. Okay? Yeah. So any questions for our departments. Have a question for city manager . I believe you also had sent some memo out recently outlining communications regarding our emergency. Response, so it might be good to highlight. That information. Okay, let me pull the memo. Well, I think in essence, remember, in essence,

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what we were trying to say, is that when we communicate about an emergency. That it needed to be accurate. Thorough. And also be able to explain to people what was happening so there would be no surprises in terms of the type of event we were experiencing. And, and also to not. Indicate in the communication things that we couldn't that we couldn't actually know for sure. I think one of the things that happened during a storm Mara is that we try to answer a question and in good faith. When we maybe didn't have that that information, but but it's not just the initial communication. It's the ongoing communication so that were accessible to the various social media that are various media platforms that are out there so that those individuals can get the information they need. And, as Ken mentioned in his presentation was that when you have a power outage, you're gonna have to think about other kinds of assets that you use to get the word out to the

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community. Thank you for that. And the other question I had, is for either of you, but if you wanted to touch on the dual language communications, the Spanish communications as part of our response, anything that bubbled up any strategies or commitments that you would like to share out at this time. Customer thank you for that question. I'm no commitments at this point, but that issue did bubble up as one of the items on the list. So I'm definitely tracking that, and we will work on making sure that the language access piece is covered completely for any issues going forward. In fact, we've actually had a conversation specifically about that. So we're on that one. Thank you. I appreciate the presentation. I know we've had the opportunity to sit down with you. And so we're appreciative of that, I and my team had been through both storms as an elected official. And so they were quite different. I think that's what even though they involve Austin energy, you know one was about power not coming

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through the lines because you weren't able to distribute it the others because the lines were broken. And those are very different situations that the city had to respond to. But I'm also looking forward to the information just about what are the expectations for the elected officials. I think a lot of us would just love to be able to share the exact information that we're all getting in all the platforms and newsletters that we have access to, but if there's anything we can do to be more helpful that is actually trying to track down resources that can be of assistance. I think a lot of us know that community members really well. And can help try to fill in any gaps. But oftentimes during these winter storms, everyone's just trying to do exactly what their constituents are asking of them all the time and anywhere we can eliminate duplication and streamlining these situations, I think will be helpful. Did you say when you expect the report to be finished? Did I miss that? The report is scheduled to be finished in late June. Thank you. Council member Alison alter. Thank you appreciate us having this opportunity, to

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speak about this and I believe we also have a after I action, report coming to that and finance committee, for our April meeting. Related to the audit that we did. After Yuri. So I appreciate this conversation being here as well. I had a question about H, R, and particularly the emergency management departments, level of staffing relative to what we had authorized and where that is at now. And what's being done to make sure that those positions are filled. Counselor thank you for that question. We're prioritizing those positions. I think in the last budget cycle, I believe it was 17 positions that council committed and we're working to expedite right now hiring a for those positions and their top priority right now. I just met with hr yesterday to talk about the status of those positions and when the late phases of moving forward with the hiring process for those for

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so between June and August of last year, we authorized 17 positions. How many of those are now filled now that we're in April of 23? I believe is there . I don't think we filled any of those 17. Okay? So. I bring this up city manager because we had a similar set of issues in our Austin water. Audit that the inability to fill the positions and I and I suspect if we drilled further down, we would find that there were hurdles from our hr process that we're making what is a complicated task within a difficult hiring environment much harder than it needs to be, I think six of those 17 were reclassification positions that took more than six months to get reclassified alone. So this this issues are related across you know the various after action reports or audits that we're getting back and we really need to make sure

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that we have the staff in place. To address the emergencies what we learned from the Austin water after action report was that if you're going to be prepared for that 1% case when you have the extreme events not having enough staff is an extremely problematic situation to be in, and it. It also leads to problems with management and operations that make you less likely to be able to pivot. In the time of emergency, so I really want that piece of it. To be rectified as we move forward and to be leaning in. Can't expect our emergency department to be prepared in between the events when, first of all, we have very little time when we're not in an event, but then when they don't they're not getting the staffing. To be able to do what we're being what they're being asked of them. Well, certainly evaluate that and figure out a way to expedite.

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Thank you, and then with respect to the emergency communications, to what extent? Are we going to going back to the very basics? Of emergency communications. I've heard Jesus articulate some of the kinds of things that you need to be able to communicate during an emergency. But I think because we've been in emergency operations and mode for so long. I think we've we've lost that muscle to step back and say if you were in an emergency, and these this is how it's extremely important. That we communicate in that situation. So are you going to be going back to those basics? Yeah yes, I think that that's a that is the case. And I think, but it also adds that week that we're looking at the structure. We have a very decentralized communication. Structure. Many departments have their own communication offices. We have a central office. Huh.

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There there's not a robust connection between all those pieces. We had one example just this week. It's not an emergency. But there was something that was key that was happening within the department and the central office wasn't even aware of it. I mean, part of it is we? We've got to build a muscle of 11 family one connection so that we all understand what? Who's who's playing what role and then finally, it's really not just the initial communication so that it's clear. It's understandable. It's in the various media's that need to be there. The various languages it's what happens after that initial communication so that we don't allowed, allow there to just be a blank where people kind of having to figure out stuff on their own. And I think, that's why we're going to need to do the I guess the tabletop exercise to kind of exercise that muscle, but I think it's something that we know we need to pay a lot of attention to so one of things that we're going to be looking at, when they come back in audit and finance is

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kind of what they've completed from the earlier after action reports and we don't always complete things from. After action reports, so I hope that there will be a clear implementation plan for this after action report and that as part of it, you're also looking at some of the recommendations that get kind of repeated. Over incident over incident but we haven't managed to address but yet they rear their head again. And again in the language access is one of those that you know has come up again and again and again. There there are a series of findings that have been have come out in the after action report. In the for both storms. Either one prime example that we're I'm not saying we're struggling with it. We know it needs to get done, but we knew in 21. We needed to figure out how to get generators to the warming centers. So in 23, we don't have. We don't have that quite figured out and so that in that two year period we weren't

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able to deliver. And there's a lot of reasons for that. But we shouldn't be making excuses. We need to figure that out what we've said too. All the individuals that are involved in this effort is that it isn't an issue of resources. It's an issue of somebody stepping up and taking responsibility and then driving at home, and I think that's why kids in the role he's in now. Is to be identifying clear roles and responsibilities for folks and then have the authority to drive it and when that drive when he's not able to drive it. He's going to bring it to the proper attention to the right level so that it can be taken care of. Thank you. I do hope that during the budget process, though, if there are resource needs that those are made apparent, and if we're deciding not to fund them that that is made of a parent to council. I already have a budget question. Ready to ask you. What? What did they ask for? That? They didn't get. So be great. If you can. You know if there were taking very seriously the requests. I understand that not every request might get prioritized. But in the past one

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of the challenges we've had is that they have been needs for emergency preparedness. That through the process of the budget where we're where we're being asked not to ask for new money, they're not bubbling up. That and then we don't even know that these needs have been identified for us to make choices about those one of the things that I'll be interested to see what what can and Bruce pulled together in terms of these after action reports is that under a unified command structure for an emergency. All of the city's assets are at the disposal. Of the homeland security emergency department. All of the assets not not just some of them all of them. And then they've got to make the decision of what assets are going to be needed in that immediate emergency, and those that might be needed. 24 hours out of 48 hours out. And we have a lot of assets in the city, and so not not, you know, not that that I want to be known as somebody. Who, is frugal, too frugal with money. I want to make sure that that we're

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spending money in a wise way. Who needs it? And you know, not have kind of duplication throughout the organization that may not be necessary to really be effective, so that's an evaluation that will immediately thank you. Any further questions. And I'm gonna need some health services here in a few minutes. Thank you for the presentation. We look forward to the next steps. Central help, please. With no other business ahead of us. It is 2 38 pm and I'm adjourning the work session of the Austin city council.