Public Health Committee (PHCC) meeting Transcript – 8/9/2023

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[10:00:48 AM]

I'm proud to convene the Austin city council public health committee . Welcome, everyone. I'm joined here by our vice chair, Velazquez of the committee. Mayor Watson and councilmember vela. Council member Kelly is not with us today. Today we have six items in our committee agenda. So we have a lot to get through. We'll start with public communications then. Then we'll take a look at approving minutes from our past committee meeting from there. We'll have a discussion and possible action regarding the reappointments of two members of the sobering center board. We also have an appointment for the community development commission. Then we will have a briefing from the Texas health action and kind kind clinic regarding sti testing and data trends. We'll also then have a presentation from Diana gray with our homelessness strategy office for an update. And then, colleagues, we do have on, on our agenda time Eid space for an executive

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session. If needed. Since we do have appointments to the sobering center board and the community development commission . Ann if we need to discuss either of those, we can go into an executive session. The material on the candidates being proposed are in your packet. If you'd like to review those. In the meantime. All right. Now we'll welcome speakers from the community. May the clerk's office please confirm whether we have any speakers. >> Madam chair, no speakers have signed up for today. >> All right. Thank you. Now we're moving to the approval of previous meeting minutes. Can I have a motion? Thank you. Councilmember vela, seconded by mayor Watson. Any objection to approving the meeting minutes from June 14th, 2023? Seeing none. No discussion. Those are approved unanimously. We now we'll have discussion and consideration of the reappointment of Dr. Chris Zabel and Chad Hooten to the sobering center board. So we have

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materials on on their resume. And I know we have Janet Ortega with the sobering center board available to answer any questions. If needed without. So can I have a motion to approve? Thank you. Mayor Watson makes a motion. Seconded by councilmember vela. Any discussion on the reappointments ? >> Just. I'm on the sobering center board, and I have very much enjoyed working with Dr. Z. He's a tremendous resource to the sobering center and has been , you know, part of it since day one. And great perspective. He's an emergency room doctor, so he deals with this kind of stuff all the time. Just very glad he's staying on the board. I'll just say that. Wonderful thank you. >> All right. Any objection to those reappointment? S okay. Seeing none, those reappointments are approved. Next, we'll have the consideration for appointment of Jenny Achilles. Did I say that right? Achilles did. The

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community development commission . I apologize for butchering your name. This is a recommended motion that has come from the community development commission and as well as my office. Millie Costa with my office, also met with this nominee. And we have her her resume and application materials for y'all's consideration. Ann. Can I have a motion to approve? Thank you. Vice chair Velasquez, seconded by councilmember ravella. Any objection to the appointment of Jenny Achilles to the community development commission? Okay. Seeing none that stands approved . Wonderful. Thank you for helping us get through our administrative items. Now we'll move to our presentation. And first up, we'll have the Texas health action and kind clinic staff. And they will provide us an update on sti testing program and data trends and you you can introduce yourselves as you start your presentation. Good

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morning. >> Good morning. My name is Christopher Hamilton. I'm the chief executive officer of Texas health action. I am joined by our chief medical officer, Dr. Sandra Guerra. Thank you for having us this morning, mayor Watson and council members, we're excited and grateful for this opportunity to talk about trends in sti testing and treatment in our community. Ken clinic focuses on sexual health in our community through sti testing and treatment, as well as HIV prevention and treatment and gender affirming care in our communities. Ken clinic was founded in 2015 and in that time we have grown to serve people across the state of Texas. Of course, Austin is our home. That sexual wellness component that we provide, we view as part of a quality of life for many people, healthy sexual activity is part of their quality of life. And I know that Austin is proud of its

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quality of life components. So when we see trends Luz and threats to that, we want to raise attention. What we want to talk about this morning is one specific component of our clinic program is our community health program. We offer a walk in testing space at our clinic on Koenig lane. This walk in space means people can access sti testing and treatment without an appointment. And if you've ever had to access health care and you know that sometimes if you're worried and you want to get in right now, appointment points aren't always available. So having a space dedicated to people, being able to walk in and access sti testing and treatment has been paramount in addressing sexual health for people. One of the components of this program allows us to also work on HIV prevention. Many times people do not understand or may not believe that they

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have a risk for HIV acquisition through sexual activity by including HIV testing in this sti testing space. We're also able to detect new HIV infection that may otherwise go undiagnosed in our community. And I'll in a moment, Dr. Guerra will share some of the statistics about what we have seen in that space as well. So by putting these things together , we're able to create a continuum of care. It is not yet a test and then figure out what to do on your own. We're able to provide treatment for that sti in that moment and we're able to schedule treatment later if that is what is clinically indicated . And if we find somebody that may be eligible for prep a once daily oral medication that is up to 99% effective at preventing HIV acquisition, somebody can start prep if they are living with HIV, that has been undiagnosed. We're then able to link them into care. The vast majority of people starting care

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within 72 hours and actually 24 hours is the standard that we look at. Meaning same day you walk into the clinic, you meet with a provider, you leave with medication, and this is a game changer in terms of HIV in our community as well. Unfortunately, we have some challenges as and I know that you were in budget season and you were hearing about a lot of challenges. One of which is our health infrastructure, a public health infra structure, state and federal resources have been limited and the CDC has sent out a letter saying, sorry, our funding over the next two years is gone for sti programs. That's a big blow to public health departments and other organizations across the country that are providing sti testing and treatment. We had a grant from the CDC, but they said, well, we're out of money, so there's no funding to go with it . There is also budget proposals at the federal level that are looking at eliminating the ending the HIV epidemic that

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would eliminate millions of dollars in resource to Austin. We also see that Texas just ranked worst for life health and inclusion. Now, some of these things I think are solvable in our community. We have this power to change this course and direction. We also know that sti and HIV disproportion impact members of our community, we, including our lgbt Q plus community, in fact, the city of Austin and its lgbtq quality of life commission commissioned a study to look at quality of life in our city. Many of those questions focused on health, health care access and service. And the one that I think find I find most shocking is maybe this last bullet point that about a quarter of the respondent said they never talked to their primary care provider about their sexual health. And there are a lot of reasons for that, a lot of reasons for that. But

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when we look at the growth in the program that we have had and the increase in demand for our services, including sti testing and treatment, we believe that we're addressing some of those reasons of providing a safe, supportive and affirming space where people can trust their medical provider to talk about their sexual health. So I'm going to ask Dr. Guerra to provide a little more specific information on what we have seen in trends in our testing program . >> Hello, everyone. Thank you for your time and attention today. My name is Dr. Sandra Guerra. I'm a preventive medicine board certified physician and I am the chief medical officer for Texas health action in-kind services that we provide. And this is the first of its kind, which is looking at a snapshot on how we are doing from a sexual health perspective with regard to the persons that we see through our walk in testing area and we call this our community health report. So

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in the next couple of slides, you're going to see a few pie charts and we're going to talk a little bit about what that means clinically. Well, first off, what we see through this walk in testing area is that we are seeing a substantial amount of need in our community to have same day just in time testing for sti exposure measures, symptoms and the need for treatment and here is a good example of this. You can see that we had over 11,000 visits that occurred. It just in our walk in testing area, which is only a segment of the persons that we serve within the Austin community and unfortunately or fortunately, whichever way you want to look at it, we were able to pick up about a quarter, about 20% of those persons actually came back positive for something. This is a phenomenal number. You would think 20% and that's not the majority. It

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shouldn't be this high. What we know from a community that once you have exceeded a certain threshold and it's usually around 7 to 8% of the people that are being tested, coming back positive, it is only showing you that there is way more disease burden out there than what we are capturing. So this is telling you that we have a very high rate of need in our community. We also are finding quite a few new HIV diagnoses as this is also concerning. We know that once you test positive for a singular sti, let's say chlamydia or gonorrhea, some that are fairly treatable with antibiotics, it still, if you are out there without treatment or have the infection for a given period of time, you are at increased risk of acquiring other infections such as HIV. Just because of the biology of

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an infection and how it makes you more susceptible to other infections is so here is a breakdown of the types of infections that we are seeing in. And I'm not going to talk to you about which one is more scary, because if you are the person who is infected with any one of these, it is impactful to your life. And of course, your future health going forward. And it's a systemic issue. Please do not look at these infections as something that is happening in and limited to one body area. These are infections that the entire body either is at risk for, such as syphilis or the area is still very susceptible to having to fight this infection and having lifelong consequences. So the illnesses that we see here, syphilis, gonorrhea, chlamydia, HIV and hepatitis C, just to name a few of the things that we see just

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through our walk in area. So approximately 1 in 5 patients that visit our location for walk in testing are coming back positive for something. So here are the priority populations options that we have been asked as a public health community and we do see ourselves as an extension of that public health community that we should be focusing on, because these are the persons who are at increased risk of getting one of these infections. And so we see here a list of black men who have sex with men, Latin men who have sex with men, white men who have sex with men, trans, trans women, non binary and gender nonconforming. And even though those are the priority populations, what you can see on the right hand side of this slide are all of the other individuals that we also provide care for and we continue to offer that testing for. So it is basically you can capitalize

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this slide of saying we test humans as does so. What we do see in our results though, is a disparity in who is getting their HIV, getting diagnosed with an sti and so probably won't come as a as a huge surprise to folks. But but unfortunately the younger cohort is having more positive reactions. It is not because of anything of their own doing, but it is actually because of the persons that they are interacting

with. There is more Shaw infections in that community and so therefore you're going to see chlamydia, gonorrhea. What we are seeing is a younger age cohort is more likely to have it, but you can see we still run the gamut. We have people who are testing positive across all age spectrums. We also see a disparity in the population that are getting infected, which is very consistent with the priority populations that we

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were asked to look at from a public health perspective. So black and Latino men having sex with men make up about 27% of those who were diagnosed with chlamydia and 37% of gonorrhea diagnoses. This is something that should be of concern to all of us and a need to intervene. We also see some more serious and lifelong infections that we can see happening in these populations as well. Syphilis is an infection that can be sexually transmitted and is most likely sexually transmitted, but if not treated, it can actually cause problems in every single part of the body. Everything from having issues with your nervous system that makes you seem like you're having strokes at a young age to heart and other areas. And of course, if

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someone is pregnant and is exposed to syphilis, you can have a congenital syphilis outcome, which we you have seen in the news is that across Texas , in several of our communities, we're seeing a very scary number of congenital syphilis pregnancies and deliveries. Syphilis is very important. Of course, hepatite C is as well. We have heard of this and how it can have lifelong consequences to your own liver health and the ability to manage that over time . And again, we're seeing the disparities in the priority populations that we discussed before. Black residents of Travis county are approximately 9% of the population. But black men who have sex with men make up 16% of kind clinics. Syphilis diagnoses. Further, highlighting the disparity stis that persist . So we need to make sure that we are addressing these in a timely fashion and a full

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fashion. Not just testing, not just giving you the result, but actually treating you for it and continuing to support you, going forward to prevent a re infection. A new infection, and to get you on preventive medications such as prep to prevent you from acquiring HIV. In summary, our walk in testing area is a vital and component part of our community. We are proud to be partnered with Austin public health and other organizations that are doing similar work. But the volume that we are seeing just through our walk in testing area is definitely demonstrated. It being impactful to our community and helping our community stay healthy in order for them to live productive lives in our Austin community, it is

important for us to eliminate health disparities and we need to focus in health care that on those areas that we really can

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be impactful. And this includes the lgbt plus individuals in our community. We are a critical partner in this public health infrastructure. We are working hand in hand with Austin public health and other public health organizations, dshs and CDC, to address these vital components. And we will need sustained financial support in order to continue to provide these critical services that we have provided to date. >> Thank you. Thank you so much . Do you have any say? >> Thank you. We're happy to answer any questions you have. >> Thank you. Thank you. Dr. Guerra and Mr. Christopher Hamilton for joining us today to provide this really important information. I think it was really helpful for us to learn more about the data trends and also welcome to council member Ryan alter for joining us today. You know, I'm with you on acknowledging Singh and wanting to do more on reducing health disparities in our city. And I want to thank our vice chair

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Velasquez, for he has an amendment up for council consideration Ann regarding our, you know, the city supporting and doing more on sti testing. So I appreciate your leadership on this issue. Colleagues any questions or comments? Yes. Vice chair. >> Thank you all for being here with us. And thank you, Mr. Hamilton, for the tour. I came and toured the kind clinic recently and they're doing amazing work over there. I had a few questions. You were talking about the rise in sti. Do you have the year to year numbers on that from last year to this year ? >> Go ahead. Go ahead. >> I was going to say, the most comprehensive data that we have is from the department of state health services, which just published its 2020 data and gives the most full picture of what is happening in Travis county. We see that sti rates in Travis county are still above those of other cities like San Antonio and Houston. The number total number of infections has more than doubled. If we look at 2018, I believe it almost

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quadrupled from 2018 to 2020, I don't see that trend reversing again. It's a little too early to know the full picture of Travis county until we have that from department of state health services. >> Thank you. You mentioned that y'all had a grant from the CDC. How much was that funding until it was cut? >> $0. I mean, now they ran out of money. They said we wrote a great application and they would love to fund it if they had the money. So the grant is awarded but not funded. >> And you y'all mentioned that while there are other providers that offer these same type of testing and services, y'all put a focus on on the lgbtqia community, how many other folks have that same focus? >> I don't want to speak for others. I

know that our foundation and core and part of our mission has really been to provide an expertise in serving this community, meaning we understand and provide an environment that is not shaming , that is not judgmental or not stigmatize, talking about sexual

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activity or sexual behaviors that anybody entering our clinics engages in. >> And as a city, how much of an investment are we making right now in the clinic? >> We only have federal dollars that are passed through from city of Austin for HIV treatment. Thank you, sir. Yes, mayor, I want to follow up on that. >> Was that answer just about the city aspect of it? When you say you only have federal dollars, help me. Is that all all the financing you have is federal pass through dollars? >> No, the primary mechanism of funding our organization is through the 340 be medication savings program. So it is prescription medication that results in savings back to our organization. We suffered about a $9 million loss last year, about a 53% reduction because of a change from a manufacturer in that program. So that has left us at a hard spot and figuring out how we can continue to serve

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our community. >> So have you talked to the two central health board of managers ? >> We are discussing with central health a way that they could provide care for people, that we are taking care of and what I would call more longitudinal services like people that are going to come back to us over and over. So people that are accessing HIV, medical care, prep care or any other of those services where there's a longer term relationship versus sti testing and treatment, which may be 1 to 2 encounter years. >> So what if the population that you serve would otherwise qualify under the central health parameters? Why would you draw that distinction? Ann if testing would be a way to prevent future harm, why would that why would there be a distinction in there where it's more longitudinal, as you say? >> Yeah. So there we do have a distinction in in the types of

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services that people need and meeting them when they need them. So so people coming into our walk in area is usually an acute they're starting their health care journey for some reason symptomatology exposures other things. Sometimes what we find is that they have an acute infection. We speak to them about the opportunity to be able to either treat the current infection as well as being able to prevent future infection if they are interested, let's say in prep, then we are able to quickly move them into a more long term relationship as our patient. That will then access prep. Prep is something that requires us people to have laboratory testing done every three months. It needs a clinical visit to make sure

you're not having any side effects or issues, and hopefully that becomes a long term healthy relation, meaning we're able to keep people healthy from not acquiring infection. Other

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infections, such as HIV or hepatitis, require a more long term because because of their the nature of the infection, it is not something that can be cured, but it can be managed to a healthy state. And that also requires longitudinal evalu action. So that's that's the main difference. >> And I get I get the difference between the categories of care. Yeah. What I'm not understanding is why there would be a distinction between the financing of the different categories of care, particularly if, if you could provide testing and, and acute care that maybe takes you out of the need for longitudinal care. Right. Go ahead. >> I think the that Y Y city of Austin. Why not central health question comes down to where the authority is for our communicable disease control

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that the state of Texas delegates to a public health department in its community communicable disease control and that is part of sti testing and treatment. And so this split out of funding for Austin public health and its functions to provide sti testing versus central health that has focused on longer relationship based care. Does that help clarify a little bit? >> It does. And what it tells me is something else we probably ought to be universally and globally addressing in this community, and that is that we don't need those silos because there may be there may be funding Lang that ought to be going to this sort of thing. But we're not doing it because we've we've grown into a tradition of and that's not a that's not a criticism of your presentation or what the answer to the question. It is how as we go forward and try to achieve multiple goals, how we break

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down those silos or those traditions, because there may be funding that ought to be available. So thank you. I didn't mean to take so much time, but I appreciate that. >> Thank you, mayor. Yes. Councilmember alter, I just want to pick up on that. >> Just a little bit. What Paul , of your population that you serve is uninsured, about 50. Okay and so are most of your services for the insured portion or most of your services covered by either medicaid or whatever private insurance they have our clinical services are provided to patients regardless of their ability to pay patients will use their insurance when filling a prescription, for example, if they don't have insurance to fill that prescription, then we work to find other means to cover that, including our own funding to either pay for no cost or low cost medication to access. Do you all are you all able to or eligible for any of the U.S. Pool money from the

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state? Since you're providing uncompensated care? >> We have not looked into that part yet, but we're on a journey and exploration of many different sources of funding. If somebody wants to offer universal coverage for everybody, that would be wonderful. Sure so we're stuck applying for different pots of money in the meantime, I think you may have just gone to meddling on that part of it. >> So. >> Okay, that helps. Thank you very much. >> Any further questions? Good deal. Thank you so much for joining us. >> Thank you very much. Great presentation. Thank you. >> All right. Now we'll move on to item three. I want to welcome Diana gray, our homelessness strategy officer for a briefing on issues related to homelessness. >> Good morning, chair, vice chair and members. We'll have a brief briefing this morning as as you recall, we spent some time together on the July 20th

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council meeting, at which time the council approved or authorized the negotiation and execution of our our contract with our vendor for the marshaling yard so we can go on to the agenda here for the next slide. So I'll give a brief update on the status of the marshaling yard on the eighth street shelter, which is the former Salvation Army facility on the expansion of capacity at our bridge shelters and on the heel initiative. We are currently negotiating the control act with endeavors for the marshaling yard operation. Ann expect to have our documents ready to route for signature, probably next week so that is moving apace. A few details to be worked out, but progressing as anticipated. We in the rfp asked them to be ready to stand up with at least partial

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occupancy by the end of August, and we anticipate achieving that aim in terms of amenities and services. I think we wanted to talk a little bit about some of the additional detail that we're garnering at this time regarding some of the questions that council had raised last week. So for example, the shuttle service endeavors has multiple 15 passenger vans and what they are contemplating at present is using several of those at a time , having a route to two bus stops, probably every 15 to 20 minutes to really diminish the need for people to go on foot through the neighborhood to get to bus stops and also utilizing those vans to some degree on an ad hoc basis. If someone has an appointment that they need to make. Et cetera. Or they need to bring someone into shelter, we are working through the referral pathways and we'll be meeting regularly with endeavors to

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understanding what they anticipate their bed capacity to be at any given time, and then working with our various outreach teams to bring people into shelter. And so that will include host who will be working closely with APD as well as our other street outreach teams that the city funds in partnership with our nonprofits, both the chair and the vice chair, were able to join in a walk through of the facility on Monday, along with staff from the mayor's office and other elected officials from the neighborhood. So we did that Monday morning, and as soon as we have our contract in place with endeavors, we will also plan another community meeting so that we can answer some of them more specific questions that we know neighbors may have the downtown shelter, the facility at 501 east eighth street, the

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former Salvation Army downtown shelter, real estate and law are in the process of negotiating the lease. For that, it is pending execution. You may recall that there were some anticipated repairs of the building to get it ready for occupancy. That is expected to take at least six weeks. And so we are probably looking at a September, October for launch. But the amendment to the urban alchemy contract is ready has been executed by urban alchemy. We have a few details to nail down before the city executes as a reminder that will be 150 beds with supportive services on site achieved. Some economies of scale because of course, urban alchemy is already operating next door. And we do anticipate that the lease with the Salvation Army will be a year from the time we execute. And so would be looking to demobilize that facility a year from the

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time we inked the contract. We have completed our expansion Ann of the two bridge shelters to double occupancy in each room. You may recall that in June we had a heal site in at Gaines creek, where we filled all of the rooms at northbridge shelter. We are actually carrying out a heal initiative, relocate mission this week as we speak. And south bridge shelter is now ready and is being occupied. I'll talk a little bit more about that in a moment. So the heal initiative now with the current effort, we will be on the 14th encampment that we have served the images that are shared with you here are of the Gaines creek greenbelt relocation from last month or excuse me, from June. And so cleanup crews did a great job of restoring that space. We understand that pard will be

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erecting some fencing around the area to allow for further regeneration of the natural space. And the 14th site which is underway now now is also on west Walden creek, but north of the site that was done

for heal site seven that has been that area has been the site of multiple encampments over time. And so we're now addressing an encampment that was further north than the original site that we addressed. And just a reminder that we're sort of tracking as we move along. We are still seeing very high rates of acceptance into bridge shelter. We are currently running at about 85% of people who are offered transfer into bridge shelter are accepting. So we don't have all of the numbers for site 14 yet. I will tell you that yesterday we relocated 28 people from the Bouldin creek site, Ann, and our continuing

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work today and probably tomorrow. But of the 13 encampments that were previously decommissioned and we moved about 560 people into shelter and then had housed. 200 of those, many of them still in shelter and case management and of those 200 who received permanent housing, 42 have graduated the program. Rapid rehousing is time limited. And so these are individuals that would have received their year or so of rental assistance and case management. And then transitioned off of that that housing subsidy and active case management. We are tracking the time it takes from the time someone enters shelter into the to get into permanent housing. And that has been steadily increasing over time. Just as a point of reference, during the pandemic when we were running

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the protective lodges, which were a very similar model, we were having luck getting folks into housing in 90 to 120 days. So 3 to 4 months and we are now at about six and a half months on average. And so continuing that work and continuing work with our partners at echo to open up available Katy of units in the community, but that does continue to be a challenge for us and for our partner service providers. With that, I will take any questions you might have. Thank you, colleagues. >> Yes, councilmember alter, want to step in front of the vice chair here. >> I wanted to ask you about that last slide that you just had about the timeline Ann as it relates to the case managers, who's who's case managers are those? >> So we have dedicated rapid, rapid rehousing programs for the heal initiative and those contracts are with endeavors same vendor that's running the

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marshaling yard family eldercare, and also with Austin area urban league. And so it is sometimes people will come into the shelter and they actually are already working with a long term case management already in a rapid rehousing program and have a case manager there. But those are the three primary dedicated programs that we're utilizing to get people into programs. >> So someone already has a case manager. Would they not be included in the 340 assigned Ed or. I'm trying to figure out what I believe those those would be likely be assigned included in that number. >> So the thing that we're tracking is

one of the things we're tracking is how long it takes us to get folks a case manager in the early days, we had as we ramped up these contracts because we sort of were just starting, we had a significant lag from entry into shelter until they got their case manager and access to that rental subsidy before we went to double occupancy. I will tell

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you, we had finally gotten to the point where as soon as someone came in, we had their case manager had capacity for them by very rapidly increasing the size of the program. We now are having a bit of a wait again, but we're working on the back end to look at those contracts and see how we need to adjust the size to create the capacity. >> When do they do the coordinated assessment? Is that before or during Lang? >> So again, when folks come in at intake, we assess whether they have had are already in the coordinated entry system and our goal is to get them that coordinated assessment within a week or so of entering if they're not already in the system. >> So that's not so much a bottleneck. It's then getting them the case manager. That's correct. And in in looking at the continuum, I think about, well, if we plug in a bunch of resources to one piece, that could potentially just move the bottleneck to another spot, right? So if we invested in more

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case managers in order to get people that coordination quicker or is it likely that they would receive a housing outcome faster or is it that then we would just have a more people waiting for our units to become available? Right. >> So I would offer a slightly different frame for that conversation. Council member, which is that we don't typically fund just case managers. We have to fund the whole program because you could add case managers if you don't add the corresponding adding capacity to provide rental assistance, then you can't get that person into housing. So we really have to look at the whole program and that in that program design, our nonprofit partners will have varying strategies for making sure that they can actually get the units right and so they may have staff that are only doing landlord outreach, for example. So we really need to think about

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the program capacity. I think the again, the wait time isn't so much wait for a case manager, but it's, you know, it's for that overall program capacity Katy and yes, understanding where we are in terms of caseloads et cetera is a good barometer for it, but it's not the only one. And typically our housing vouchers. >> Is that what individuals have to get into housing? >> So for rapid rehousing, it is akin to what we think of as a housing voucher, but it's not coming through the housing authority. It's sort of not that particular. It is a fund. It is a basic a line item in the nonprofit's budget that they have that is

available to support the rent of that individual as they move into housing. The expectation for the case manager is that they are assessing where that individual is. We do have quite a few folks come in who do have earned income. They just may not have

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enough to pay market rent. And so they're adjusting that appropriately and then likely kind of decreasing it over time so that people have time to stabilize, to increase their income and then as this program ends, become remain stable. All right. Thank you very much, vice chair of Alaska's thank you for the tour the other day. >> Of course, we will. The shuttle be running or co occurring at the same time as city bus hours only the only reason I'm asking is how are we ensuring and this can I mean, if you don't have it right now, you can always get it back to me. How are we ensuring that we're making we're providing service to our folks that may work in the service industry, that may be working overnight or working till 2 or 3 in the morning? >> Yeah. So I don't know for certain. There will be likely a general curfew for the property at time at which in the evening people need to be in. But it is

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typical in our shelter facilities that have those types of hours that if someone has a job that is in the evening hours, that, you know, as long as they can establish that, then they work with the individual. So I don't know whether those shuttles are not so much sort of to take people back and forth to their jobs, but more to the public transportation. So there are a couple of questions here. I think one is about the hours of the transports, Ann and then, B, what is the accommodation that that endeavors would be prepared to make for people who might have other working hours? And we can certainly follow up with you on that. Thank you, ma'am. >> Colleagues, any further questions? Thank you. Thank you . Thank you. Miss gray. The questions I have are around acknowledging that we have of the marshaling yard that we're opening up as an emergency shelter that will open up later this month. We also have the downtown shelter for the arch

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operated by urban alchemy that will also open up. And you mentioned that that will open either next month, September or October. So we will the city will have to emergency shelters that we are operating and running for a year. Can you speak to the referral process and how that will work? So that came you shared with us a recommendation on how that piece needs to be worked out. Any updates on the referral process and knowing that we're going to have to do shelters stood up within the next 6 to 8 weeks, how does that work? How does that look like moving forward? >> Sure. And these conversations are ongoing as we move toward contract execution. But I think in in concept, what has been agreed is

that we will be meeting regularly with the endeavors staff who will be projecting their number of available beds over the course of, say, a week. If we need to do it daily, we will. But we're going to start looking at, say, a week as an operational period and then essentially saying to

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our different referral partners , as we believe we have this many referrals for you this week , we have this many beds available for you to and then maintaining contact with them so that if there's additional capacity we can extend that to those folks. But they then are working directly with endeavors to bring those folks into shelter and how about the you touched on the public transportation piece, family endeavors has some vans available where they can an assist the referral agencies and picking up individuals who are voluntary voluntarily deciding to join to enter into one of our shelters. >> If someone surrounding the marshaling yard decides to walk up, it is. 8:01 P.M. On a Tuesday night. Will they be admitted into the emergency shelter? If there is space, we are not framing the marshaling yard as a walk up shelter, and that is in part because we don't want to generate a ton of foot

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traffic in the neighborhood. >> But what we will be doing, I think, is, of course, endeavors will speak to that person and talk about what the outlook is and connect them, whether it's directly to an endeavor staff person or or one of the other referral points. So we'll make sure that that isn't a significant sort of churn for those individuals. But we don't anticipate that an individual would typically be able to just walk up and gain access that night unless it's a case of, you know, serious health and safety in that moment. >> Yeah, I just wouldn't want anyone turned away, you know, especially if there is space available. Sure >> I think it is my expectation that we will be utilizing these beds given where we are as a community. I think that probably even our referral sources will have to be doing some sort of triaging Wright determining who most needs access to shelter. But we'll certainly do our best to utilize as all of the beds

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that we have available at any given time and is the arch arches also referral only? >> No, no walk ups. >> So currently the arch and this is something that we talked about a little bit during our briefing last month on our shelter system overall, the arch is maintaining its own waitlist. So it is walk up and then they maintain their own waitlist. They also have about 20 beds set aside at the arch for referral through the community care health care for the homeless clinic that is on site at the arch. But historically in our community we waitlists have kind of been maintained on a shelter by shelter basis, which is as you can imagine, not necessarily the most efficient way to do things. >> Okay. And lastly, and thank you for the tour that councilmember Velasquez and I were able to have of the marshaling yard a few days ago. I just

want to share my concern that whenever the marshaling yard is opened, that there is any type of roundup happening

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through enforcement. I don't what I would hate to hear or to see is on August 21st, whatever day is the opening day that we have law enforcement going out into parks and underpasses and Ed and forcing individuals into the shelter. I know this is a voluntary shelter, but I just want to make sure that we are putting some some safeguards in place to avoid that. Thank you, councilmember. >> All right. >> Any further discussion? Okay thank you. Thank you. All right, colleagues, that can concludes our business for our committee meeting. Our next committee meeting was originally scheduled for September 6th, although it sounds like there might be some scheduling conflicts that would prohibit us from or that would keep us from meeting quorum. So we are looking at meeting on September 20th instead, depending on everyone's availability. That will be an important meeting for us. We'll

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have an update from central health and they will be providing a briefing on their health equity plan as well as their role in providing a continuum of care with our homelessness response system. So unless there is any further business, it is 1048 and without objection, I will adjourn this meeting.