



**MINUTES FOR THE MEETING OF THE BOARD OF THE
BOSTON PUBLIC HEALTH COMMISSION
Thursday, June 16 2016**

A meeting of the Board of the Boston Public Health Commission ("Commission") was held on Thursday, June 16 2016 in the Hayes Conference Room, 2nd floor, 1010 Massachusetts Avenue, Boston, MA 02118.

Board Members Present:

Francis J. Doyle, Esq., Chair
Monica Valdes Lupi, JD, MPH, Executive Director
Manny Lopes
Myechia Minter-Jordan, MD, MPH

Also Present Were:

Grace Connolly, Rita Nieves, Dr. Huy Nguyen, Tim Harrington, Chuck Gagnon, Kathy Hussey, PJ McCann, Mimi Brown, Catherine Cairns, Dr. Anita Barry, Dave Henley, Leslie Karnes, Alfred DeMaria, Elizabeth Doyle, Beth Grand, Stacey Kokoram, Steve Stephanou, Elizabeth Church, Devin Larkin, Jen Tracey, Lisa Conley, Ché Knight, Marje Nesin, Snehal Shah, Debbie Allen, John Wilcox, Julien Farland, Lindsay Kalter, Jack Tracy, Chief Jimmy Hooley, Gerry Thomas, Brad Cohen, David Susich, Mía BrodyField, Margaret Reid, Vivien Morris, and Debra Paul. John Auerbach participated via conference call.

Proceedings:

Chairman's Comments

Francis J. Doyle, Esq.

- Good afternoon. I want to welcome you all and thank you for being here today. I was recently appointed as the Chair of the Board of the Boston Public Health Commission by Mayor Marty Walsh. I have been working with Monica a little bit already, in some ways I think it is the full transition now, from prior administration, prior leadership within the Commission and at the Board level, to really be the Walsh Administration's Public Health Commission now. I think that's important to sync up with all the other City agencies, the other priorities, the Mayor's priorities, etc. Monica has been a wonderful partner in that. I know she's already moving forward on many, many fronts.
- As you know, our Mayor has a lot of priorities that he's already issued. He's been very involved his whole life in the area of substance abuse and opioid abuse is something he's very concerned about now. All of the things you've had to deal with regarding homelessness and the closing of Long Island, in the first couple of years. I want to compliment Dr. Nguyen and his leadership in the interim to be able to carry forward. He got hit with an awful lot during that period of time and handled it very graciously. The outcome still is that we are going to have to coordinate even better around homelessness.
- You'll see tonight on the agenda that Infectious Disease, under Dr. Barry and her leadership, had a lot of hits over the last few years. Who would have guessed that we'd have Ebola scares in the U.S.? Who would guess that even in the early days of the Zika outbreak in South America that it would be now well, maybe now the mosquitoes will get all the way up to New England? Who knows?
- I think this is an awful big agenda ahead of us and new complexities within public health for us to face. I welcome the opportunity to be able to serve in this capacity. By way of background for those who don't know me, I've been running the Boston HealthNet for the past 19 years which is the affiliation of the Boston Medical Center, Boston University School of Medicine and 14 of our health centers forming an integrated health care delivery system along with our sister agency, the Boston Medical Center HealthNet Plan, just to make the difference plain. Prior to that, I actually was part of Mayor Menino's team in merging the hospital and, in fact, forming the Commission 20 years ago. I have familiarity and have been deeply involved for many, many years. I hope, in some way, to help Monica and the team here at the Public Health Commission to bring some of that old school, new school and am delighted to be working with Dr. Minter-Jordan and Manny Lopes who are friends and colleagues as well. So, again welcome to all of you and the dawn of a new day here at the Commission under new leadership. Now, I'll turn things over to Monica.

Report from the Executive Office

Monica Valdes Lupi, JD, MPH

Executive Director, Boston Public Health Commission

- Thank you, Frank. We are very pleased to have you Chairing the Board and look forward to working with you and the rest of the Board members moving forward. It's going to be an exciting next couple of months.
- Just some really quick updates in terms of the Executive Report. I wanted to share with the Board that I believe is the first meeting for my new Chief of Staff, Catherine Cairns. Several of you have already met her in our different visits to the centers. I know she has been in touch with Frank prior to today's Board meeting and just wanted to acknowledge Catherine, our new Chief of Staff. I think this is her one (1) month anniversary with us. Just like you, Frank, Catherine also worked here in a prior life at the Commission from 2005 to 2010 under the leadership of Dr. Barry. This is great for us that we've been able to complete our Senior Leadership Team here in the first four (4) months of my work here at the Commission. Welcome to Catherine who's hit the ground running already.
- I also want to share an update with the Board on the Trauma Listening Sessions we've held across the City. This is work that we've been able to do over the last two (2) fiscal years with support from Mayor Walsh and our budget, which funds eight (8) Community Health Centers to stand up trauma recovery teams. As we look into redesigning the work, we knew that it was going to be really important to make sure that we gathered and engaged with our community residents and community partners as we went through this process. We held four (4) sessions that we were able to do in Roxbury, Dorchester, Mattapan, and East Boston. We're going back to do another in East Boston and will be working with Manny to figure out some different ways of engaging community residents. Based on feedback we've gotten in those Listening Sessions, we've been planning to hold probably between 4-6 more smaller discussions. We will keep you posted on those.
- I will say that in all of the Listening Sessions there were themes that I would report back to the Board. Definitely an interest in the immediate aftermath of a traumatic event, such as a homicide in the community, to ensure that we're providing a culturally competent, consistent trauma response approach and continuous services. There definitely has been feedback about the need to pay attention to immediate response, but also equally important, looking at that we're ensuring that we're providing long term recovery services and working with our Community Health Centers to ensure that we have the services that so often these families need beyond that first month, then for six (6) months and for the years to follow. We've heard that loud and clear in these Listening Sessions and discussions. We will continue to keep you up-to-date on that.
- Related to trauma, there's this one thing that I just added was that we had a Senior Staff meeting today where we talked about the recent homicides in the City followed by first, the Burke School shooting, followed by the Orlando mass shooting, and also recently there was a shooting in Mattapan. We're working with our colleague at the Mattapan Community Health Center, Dr. Azzie Young and then just before this meeting, talking with Manny about the homicide they're investigating on the body of a woman that was found in East Boston. It was just a reminder about how important our work is on the issue of trauma response and being able to address the needs of our communities. I began to talk with the Senior Team this afternoon about how we can be more proactive in terms of reaching out to colleagues in Orlando and allowing staff an opportunity to really share what we've learned from the work that the Commission's done on the Boston Marathon aftermath and the response activities and the recovery activities related to that, and how we can be proactive about sharing some of those reminders and materials that are available to our community residents. Debbie Allen, our Bureau Director for Child, Adolescent and Family Health, reminded me that we have materials that we've developed following Boston about exposure to our young children in the news and putting out a reminder and tips for parents and families about that. We'll be doing that work in the upcoming days and weeks.
- Just a plug that we have pushed the button for our Public Health Accreditation process with the Public Health Accreditation Board (or "PHAB"). I know you've been briefed on the Public Health Accreditation process. We were able to package all the prerequisite materials with the Assessment, the Health Improvement Plan, and the Strategic Plan. So the clock is ticking. We have, I think, until the next year to work diligently with the staff and with the Board on ensuring that we're ready for the PHAB site visit which will happen within the next year. More to come in a future Board presentation on the PHAB, but know that we're going to be doing a lot of work with our Accreditation Team to ensure that all the staff are aware of the accreditation activities and to really get support Commission-wide on our efforts.
- Finally, on a staffing note, Vivien Morris, who some of the Board members might know, is our Director of our Office of Racial Equity and Health Improvement, recently shared with us her plans on stepping down from that post. I wanted to let the Board members know that Vivien has been really generous about her time and helping us transition the work of the office and teams. Her last day will be August 26, 2016. Between now and then, we'll work with her in terms of filling that position and ensuring that we've got a good transition plan with the staffs. Vivien is enjoying a much well-deserved two-week vacation in Italy, otherwise, I'm sure she would be here with us this afternoon. So that is my Executive Office Report, Frank.

- Thank you, Monica. Monica and I have talked about trying to make the Board meetings more effective, more oriented to today's issues as much as we can. She's put together with staff a terrific combination of presentations to illustrate where we are at on Zika both locally, nationally, and at the State level as well and where we see that progressing and the activities we are currently undergoing. Dr. Barry will be presenting to give us an understanding of the prevention and control issues that we're taking very seriously now as well as the latest science and the local activities with regard to the Zika virus. Thank you, Dr. Barry.

Presentation: Zika Virus in the United States

Anita Barry, MD, MPH, Director of Infectious Disease Bureau

Dave Henley, Suffolk County Mosquito Control Project

Leslie Salas Karnes, MPH, Project Manager of Education & Outreach

Alfred DeMaria, Jr., MD, Massachusetts Department of Public Health

John Auerbach, MBA, Centers for Disease Control & Prevention

- Dr. Barry thanked Mr. Doyle and commented that here we are talking about yet another virus and that today we would be talking a little bit about the Zika virus. First, Dr. Barry wanted to acknowledge several experts in the room joining her. Dr. Al DeMaria will be speaking about the State perspectives and plans. Dave Henley, Superintendent of Suffolk County and Eastern Middlesex Mosquito Control, and Leslie Salas Karnes, Infectious Disease Bureau's Project Manager for Education and Outreach.
- Dr. Barry stated the primary topics to be discussed were the epidemiologic and clinical features of Zika, then Dave Henley would speak about the mosquitoes in Boston and how we monitor them, control them, etc. Leslie is going to chat a little bit about the educational materials and the outreach we've performed to-date, then perhaps a national overview and certainly discussion.
- The Zika virus is closely related to the dengue, yellow fever, Japanese encephalitis and West Nile viruses. Prior to 2007, only rare human disease cases were reported from Africa and Southeast Asia. In 2007, the first outbreak was reported on Yap Island, Federated States of Micronesia. In 2013-2014, more than 28,000 suspected cases were reported from French Polynesia. In May 2015, the first locally-acquired cases in the Americas were reported in Brazil. Current outbreaks are occurring in many countries or territories in the Americas, including the Commonwealth of Puerto Rico, the U.S. Virgin Islands, and American Samoa. The spread to other countries is likely. Cases among U.S. travelers to areas of ongoing outbreaks have been reported; those numbers are also likely to increase. Local vector-borne transmission of Zika virus has not been reported in the US.
- The Zika virus is transmitted in a number of ways: vector borne bite by an infected *Aedes* species mosquito; maternal-fetal either intra-uterine or perinatal; sexual: by an infected man to sexual partners; and by blood transfusion or organ transplantation (currently no reported cases). The *Aedes* species mosquitoes can transmit Zika. The *A. aegypti* is a more efficient vector for humans than the *A. albopictus*. *Aedes* mosquitoes also transmit dengue and chikungunya viruses. They live indoors and outdoors. They are aggressive daytime biters, but also bite at night. The *A. aegypti* prefers to bite people.
- Map charts were shown indicating the estimated range of both the *Aedes aegypti* and *albopictus* in the US. The maps included areas where mosquitoes are or have been previously found. The areas on the maps do not necessarily mean that there are infected mosquitoes in those areas.
- As of June 1, 2016, a total of 1,732 cases had been reported to the U.S. national surveillance program (ArboNet): 618 were in the continental U.S. and 1,114 in U.S. territories. As of May 26, 2016, there were 341 pregnant women with any laboratory evidence of possible Zika infection reported to ArboNet: 195 in the continental U.S. and 146 in U.S. territories. To date, 11 sexually transmitted cases have been identified.
- The Zika virus symptoms include a rash, fever, joint pain, Conjunctivitis (or "pink eye"), muscle pain, and headache. Most people with Zika virus infection have NO symptoms. The clinical course of the illness itself is mild, lasts several days to a week, and most people fully recover. Hospitalizations and death are rare. Guillain Barre Syndrome has been reported following Zika virus infection, but a causal link has not been established.
- Other infections can cause similar symptoms. Dengue and chikungunya viruses are transmitted by the same *Aedes* mosquitoes. Dengue and chikungunya can circulate in the same area and rarely cause co-infections. The clinical features of all three are similar. It's important to rule out dengue because the clinical management is different.
- Laboratory confirmation is important. Current tests look for either antibodies to Zika or Zika genetic material. Positive antibody tests must be confirmed by a second type of test. Confirmatory tests not yet available at the Massachusetts State Laboratory and must be sent to the Centers for Disease Control and Prevention (CDC). Results are not available for weeks. The type of test used depends on the particular situation, including the timing of exposure.
- Why is a second test needed? Zika virus antibodies (IgM) can be positive due to antibodies against closely related viruses like dengue and chikungunya. The second test (plaque reduction neutralization titer - PRNT) may help to distinguish between the different antibodies. It can be difficult to interpret the test results in people previously infected with or vaccinated against a related flavivirus (like dengue).

- The Zika virus in pregnancy, particularly in the first or early second trimester, can cause microcephaly and other fetal brain abnormalities. Infants born to women with Zika infection have also had hearing loss, eye defects, and intra-uterine growth retardation (causality not yet established).
- Microcephaly is the clinical finding of a small head when compared to infants of the same sex and age. Reliable assessment of intracranial brain volume. Often leads to cognitive and/or neurologic issues. Mechanisms: primary due to abnormal development (often with a genetic etiology); secondary due to destruction of normally-forming brain tissue (by infection, vascular disruption).
- Women who have travelled to an area of risk or whose male sexual partner has travelled to any area of risk should have laboratory tests to assess for infection. Women who have evidence of Zika infection need additional testing (such as ultrasound testing) to evaluate the fetus. The CDC recommends that pregnant women should avoid travel to areas with ongoing Zika transmission; if travel cannot be avoided, then women should avoid mosquito bites. Pregnant women should avoid unprotected sex with male partners who live in or travel to areas with ongoing Zika transmission for the duration of the pregnancy; this includes men who do not have symptoms of illness.
- Pregnant women in Boston, particularly those who have family or friends in areas with ongoing Zika transmission, may travel back and forth and spend significant amounts of time in areas of risk. Pre-natal care can be inconsistent; screens and bed nets may not be available or routinely used when indicated; recommended (safe in pregnancy) insect repellents can get expensive and may not be used when needed.
- Laboratory confirmed Zika cases in Boston residents are reported to BPHC. The BPHC Infectious Disease Bureau ("IDB") investigates reported cases, performing outreach as needed; cases to date have all been in people who travelled to areas of risk. Pregnant women with Zika and their infants are entered into a national Zika pregnancy registry.

Dave Henley, East Middlesex & Suffolk County Mosquito Control Projects

- Dr. Barry turned the meeting over to Dave Henley so he could talk some about surveillance and control of mosquitoes in Boston and what this Board of Health needs to really know what we might get this season.
- Mr. Henley began stating that as Dr. Barry mentioned, there are two (3) mosquitoes that transmit the Zika virus. One of them is the *A. aegypti*. We're not really worried so much about the *A. aegypti*; it's a Southern mosquito. There are significant populations in the U.S., but they're in Florida, Texas, Arizona, and California. It's possible that some could come up here. They've been found in areas around Chesapeake Bay, Charleston, and Louisiana. If they were to come up here, they certainly wouldn't survive the winter.
- The second species *A. albopictus* is actually a secondary vector and is not believed to be responsible for most of the cases of Zika, but is a possible vector, so we're watching out for it. That mosquito was introduced into the U.S. in the mid-1980's. It's gradually moved up to what they believe is its Northern limits. It has actually settled at what they call an isotherm, where average temperatures during the cold part of the winter are 32 degrees. That line is actually in the south coast of New England. Currently, there is only one established population of *A. albopictus* in Massachusetts and that's in the City of New Bedford. It's been found there annually since 2009. It's occasionally found in other areas; once in Boston, also in Worcester and Ayer. It's not a big factor.
- The surveillance program for the Suffolk County Mosquito Control Program has been around for 40 years. In that time, they've never seen an *A. aegypti* and have only seen one *A. albopictus* and that's fairly significant. The CDC says that Boston is in an area where essentially we're going to have mosquitoes getting rides or hitch-hiking into our area. We need to be on the lookout for *A. albopictus* that might be coming into the area and establishing a population during the summer and may or may not survive the winter. A person named Matt Osborn from the Department of Public Health did a study this past winter where he looked at *A. albopictus* eggs in tires in New Bedford. What he found was that the eggs in tires that were submerged in water survived the winter and the eggs that weren't submerged in water did not survive the winter. That's interesting information.
- The Mosquito Control Project and the Department of Public Health are running a surveillance program using a specialized trap called an "over trap". It looks like a 16oz plastic cup with cardboard inside. We're putting those in areas where there is considerable interstate commerce or international commerce. In Boston, that would be East Boston, the Seaport District, and Castle Island. We've actually been doing this since 2014. The goal is to capture mosquito eggs, bring them to the state lab in Jamaica Plain where they raise them through their larval and pupal stages and then adult stages and then identify them. The state lab has an insectary there. They have an 80% success rate in raising mosquitoes to their adult stage. Some day they'll probably doing PCR tests on those eggs, so you could put several hundred eggs into a batch and look to see if any of them were *A. aegypti* or *A. albopictus*.
- The Suffolk County Project also operates other types of traps. We use something called a "grab-it trap" to look for *Culex* mosquitoes for West Nile virus purposes and we use something called a "CDC light trap" we bait with CO2 to look for aggressive male mosquitoes. Although those types of traps are inefficient in collecting *A. albopictus* and *A. aegypti*, they'll still occasionally collect them if they are in the area. In fact, the one mosquito that was collected in Charlestown in 2014 flew into a grab-it trap. Those traps are all around the City of Boston, particularly for West Nile purposes, we put those traps geographically to look for *Culex* mosquitoes. The light traps we tend to put near large wetland areas since we're looking for mosquitoes that come from wetlands.

- *A. albopictus* and *A. aegypti* usually develop in small water holding containers. The best strategy to combat them is source reduction. The problem in tropical areas, particularly in urban tropical areas, is sanitation and unreliable water sources. There's a lot of water holding containers for these mosquitoes to develop. In the U.S., we have a much cleaner environment, but there's still a need to do a better job. At the Suffolk County Project, *A. albopictus* developed really well in discarded tires. Over the winter, the staff collected over 700 tires from open space areas and vacant lots around the City. There are still a lot of tires sitting in people's back yards that we're not getting to, but that's a process we're going to have to do in the near future. We've also asked our staff to identify and catalog any areas where they see trash in open space areas with water holding containers. To emphasize, *A. albopictus* and *A. aegypti* do not breed in wetlands, but rather in water holding containers. It's a matter of finding them. It's important that people know that if they have water holding containers, whether it's swimming pools, rain barrels, or even extendable pipes for their gutters, those are all really good habitats for *A. aegypti*. People need to know that.
- Control for *A. albopictus* is really difficult. The main problem is that they are daytime biting mosquitoes. It's difficult to control mosquitoes today because of the concern of impacting bees. In Brazil, they're blasting the air with thermal foggers, but we're not going to do that here because we're really concerned about the bees. All of our spraying is done at night. We do have the option of spraying during dusk and dawn because apparently the *A. aegypti* stay active during pupuscular periods. One thing about *A. albopictus* is that they have a very short flight range. So, maybe spraying in a small area, if you identify where, would work. By spraying at dusk, we're really limited in the total area we can cover with a truck-mounted sprayer; maybe at dawn we'd have a little bit better opportunity. We also have a backpack mist blower we can spray we call a residual pyrethroid we can spray onto vegetation which also works in small areas. It's extremely difficult to control *A. albopictus* on an area-wide basis.
- With larval control, it's frequently directed at wetlands, but we do some large scale larval control for West Nile purposes. Already, we're treating all the catch basins in Boston for *Culex* mosquitoes. Although catch basins aren't the favorite places for *A. albopictus*, they will develop in them. Outside of that, you can do larval control if there's a neglected swimming pool or something that you can't easily take the water out of or turn over that is developing. If there's a tire pile or a pile of trash that can't move or would take a while to move, then we could use the backpack mist blower to control the larvae in the pile of trash. Again, this is a limited type of barrier.
- Since *A. albopictus* isn't here, we have the opportunity to see what's being done in other areas of the country. In Suffolk County New York, which is close to the Northern limit, they had a large population of *A. albopictus*. A few years ago, they had locally transmitted cases of dengue. They are trying to see if they can use a helicopter with BTI over a neighborhood area to see whether the BTI would settle into small water holding containers. They'll judge their results by what the actual adult population is that survives.
- Dr. Barry and the Board thanked Mr. Henley for his report. Dr. Barry moved along stating that Ms. Karnes would be giving us a sample of some of the educational materials we've developed and the efforts we've done so far.

Leslie Salas Karnes, MPH, Project Manager of Education & Outreach

- Ms. Karnes spoke about the educational materials currently being distributed. We've created a number of educational materials to share with the communities to inform them what Zika is, how it's spread and to give them tips on how to reduce their risks. We've prepared facts sheets for the general public and some specifically for women. There are fact sheets in 7-8 languages which include English, Spanish, Haitian Creole, Portuguese, Cape Verde Creole, French, Chinese, and Vietnamese, as well as brochures, flyers and posters in English, Spanish, Haitian Creole and Portuguese languages. The brochures are constantly updated with changes the CDC promotes.
- In addition, we also plan on distributing the insect repellent. We just got a batch of Deet Insect repellent that is Natrapel (20% Picaridin formula with up to 8 hours of protection). We also hope to give out mosquito bed nets. We're getting them free from Heading Home Healthy on a program supported by Global TravEpiNet, MGH and the CDC. The goal is to help travelers stay healthy when they are returning home to visit friends and relatives.
- We have also been doing outreach to local travel agencies, local businesses, check cashing and money wiring stores, and bakeries; faith-based organizations; community events: BCYF Block Parties, Summer in the Park movie nights/concerts; and other community-based organizations. Key partners we have been working with include the Boston Public Schools have sent factsheets in packets to families. Zika materials have been sent to providers at early childcare programs. Massport has put up posters at Logan Airport. A local Haitian radios station has been doing regular announcements.
- On May 20, 2016, IDB hosted a conference call for local women's health care providers. The goals were to: provide an overview of Zika cases in Boston residents, particularly pregnant women; identify challenges in providing direct care; identify available community and clinical resources; and talk about gaps: what would be helpful? Hospitals, health centers, MDPH, and community agencies participated in the call.
- Some of the highlights from the Zika conference call were: cultural and socioeconomic issues present serious barriers. Some resources are available: Healthy Baby/Healthy Child home visits for pregnant and postpartum women; YOFES to reach the Haitian community in Boston through radio and television show. The current process to obtain approval for Zika virus testing at the State Laboratory is difficult for healthcare providers. BPHC worked with MDPH to simplify the approval process for the two largest birthing hospitals in Boston. If this pilot is successful, the new system will be expanded.

- It's important to note that other mosquito borne illnesses occur in Boston: West Nile virus and Eastern Equine Encephalitis virus. Mosquito control efforts are important for a number of infections, not just Zika: human surveillance, vector control (larviciding), mosquito surveillance, prevention (screens, use of insect repellent, removing standing water), and education and outreach.

John Auerbach, MBA, Centers for Disease Control & Prevention

- Monica thanked Mr. John Auerbach for joining us via conference call. Mr. Auerbach commented that when he heard we were having this meeting, he was happy to participate given that the Boston Public Health Commission, objectively speaking, is known as the best local health department in the country. He commented that we are all doing such terrific work and Monica is doing a terrific job. We are already interacting with her at many different sections of CDC. We very much appreciate the work you are doing in Boston.
- In the interest of time and to avoid duplication, Mr. Auerbach asked to move ahead to the fifth slide of the presentation titled *What Is CDC Doing?* He would focus on that since a good deal of his early slides were saying very similar things to what had already been presented by Dr. Barry and others.
- As background, CDC activated its Emergency Operation Center for Zika in January of this year and moved to Level 1 activation, the highest level, in February. The Emergency Operations Center is the Command Center at CDC for monitoring and coordinating the emergency response to Zika and to bring it together with CDC scientists that have expertise in a wide range of different issues like Zika, reproductive health, birth defects, developmental disabilities, and travel health. In fact, Dr. Friedan has said that this is the most complex mobilization that we've been involved in at CDC because of the range of the different areas of expertise that are necessary to be involved in the planning and response.
- This slide lists a number of different activities the CDC is involved in. We clearly are doing careful monitoring and reporting of cases throughout the country. We also have strong linkages internationally and are making sure we're learning from the experience of other countries, South America in particular. We're very actively involved in the response in Puerto Rico where we suspect that we will see the largest number of cases in the U.S. We're involved now in both publishing and disseminating guidelines and assisting local, state and U.S. territories in developing appropriate Zika response materials.
- A few days ago, we released an interim Zika response plan which is about 60 pages long. The purpose of this response document is to describe the CDC response activities, in particular, for the first locally acquired cases of Zika virus infection in the continental U.S. and Hawaii. The response outlines in the plan are based on the currently available knowledge about Zika and its transmission. These activities may change as more is learned about Zika. I dare say we are learning almost every week more information that is useful in terms of having a well designed response.
- Within this report, the CDC guidance to state and local jurisdiction recommends a Zika action plan be developed to guide activities through what we are calling a "phased approach" that's based upon the possibility of four different stages of preparation for local transmission, initial detection of local transmission, by this we mean a single locally acquired case or cases in a single household. The third stage should be ongoing transmission, but in a limited area. The fourth stage would be ongoing transmission in a more wide-spread area.
- There are clearly parts of the U.S. that should be involved in that first stage: preparation for local transmission, but will never see a local transmission case. We hope that the number of areas in the U.S. where there is ongoing transmission is very limited, but we are not taking any chances on that, so both the monitoring and the mobilization is with the intent to be prepared. As we look at those different phases, in each phase the CDC and other federal partners will be available to coordinate closely with state or local on a defined set of activities that are aimed to reduce risks of local transmission.
- You heard Dr. Barry refer to the U.S. Zika pregnancy registry. The purpose of that registry is because we want to learn more about pregnant women in the U.S. with confirmed Zika virus infection and the impact that has on their fetuses or their infants. To learn that, we have to gather as much information as we can, so we're collaborating with all the different health departments across the country to collect this information and monitor it. Initially, for example, there was thinking that if babies were born without microcephaly, or immediately apparent birth defects, that may mean those babies were healthy. We're now seeing some evidence that babies may appear to be healthy at birth and need to be followed for some period of time in order for us to be certain that there aren't birth defects that weren't apparent immediately. In addition to the U.S. Zika Pregnancy Registry, there's a parallel Zika Active Pregnancy Surveillance System in Puerto Rico that we established and are monitoring. These registries will end up being used to inform pregnant women on the risks of Zika and update our recommendations on clinical care and plan for services and support for pregnant women and families that are affected by Zika.
- There was a change in the reporting that took place in May for this registry. We are now collecting information about pregnant women whether or not they have symptoms of Zika virus in order to get the full picture now that we're aware women that don't have symptoms can still have babies that have birth defects. We want to make sure we're capturing as much information as possible so that we can accurately provide people throughout the country with the information that's necessary.

- The CDC does not have the resources that we need to respond to the risks associated with Zika. I'm sure you all know that the President made a request to congress months ago for \$1.8 billion dollars to respond to Zika. Congress is still deliberating what amount to approve for the work. That has created certain difficulties in terms of ensuring that we have at CDC, and at state and local, the resources we need in order to prepare appropriately. We are hoping that those resources do become available quickly in the absence of those resources. At CDC for example, we've had to do a variety of things including reassigning people from their normal jobs to work in Zika; sending people on details in Puerto Rico and other parts of the country, and we've had to redirect money from other sources. We have released some specialized funding for Zika; approximately \$95 million has been released in three (3) separate RFPs. One that focused on surveillance, prevention, and intervention activities for infants with microcephaly and other adverse outcomes in the amount of \$10 million. There was a \$25 million RFP for public health preparedness and response and was focused on a variety of different planning and response activities. The third RFP was for epidemiology and laboratory capacity funding that included funding that was available for the pregnancy registry work as well as for laboratory and epidemiology activities. With that, I will turn things over to Al and am happy to stay on the phone for the questions.

Alfred DeMaria, Jr., MD, Massachusetts Department of Public Health

- Dr. Alfred DeMaria stated he would outline briefly what we're doing at the state level. The message here is that, first of all, we don't really expect ongoing transmission of Zika in Massachusetts. We really don't have the conditions for that. We are taking the opportunity to learn about what we do have in Massachusetts that in the future might give us problems: if *A albopictus* spreads or *A aegypti* gets here eventually. Looking at what the rest of the country is doing, expectations are that ongoing transmissions will occur in the South.
- The other important point about Zika is that the real concern is pregnant women. If this did not have the effect on the fetus that it does, we probably wouldn't be here talking about Zika. It would be like dengue, occurring with travelers. We get several hundred travelers a year with those infections coming back to Massachusetts and don't really worry about transmissions. The focus is on people who travel. You can see from the educational materials it's really that focus and we're still getting people, pregnant women, returning to Massachusetts from travel. You'd expect with recommendations to don't travel, and a lot of people have cancelled, but what we're seeing is that a lot of women who are pregnant already in places outside the U.S. where Zika is transmitted, now coming home to Massachusetts and needing evaluations.
- Starting in February, we started implementing nine (9) different high complexity tests in a strategic fashion. So the first test was the PCR test that looks for viral nucleic acid, that's a test looking directly for the virus that has to be done within one to two weeks of onset of symptoms because the virus doesn't hang around in the blood for much longer, although it does hang around in the urine for twice as long. So we are testing both.
- The second test was the IgM, which is the antibody test to indicate whether you have early antibodies to the Zika virus infection. That has a problem that Dr. Barry spoke about. It is very difficult to interpret and has to be followed up by the more specific test, the plaque reduction neutralization test, which actually requires growing virus culture and looking at the effect of the antibody on the growth of that virus. Fortunately, we are one of 14 states that have a public health laboratory capable of doing the PRMT tests. Most public health laboratories don't do PRMT. Because of the mosquito surveillance we've had in place for the last 60 years, we are able to do the PRMT.
- Each of these tests needs to be implemented, the staff needs to be trained, and it needs to be validated. The same people have to do all of that formative work is doing the daily testing work too. The testing volume is high so we have to screen for testing, otherwise we'd be inundated with tests. We receive many, many more test requests than we approve. Basically, over 90% of the tests we approve are for pregnant women who have had exposure and in an appropriate time interval for testing. Sometimes, for example, today two women came back who were planning to get pregnant, but we didn't hear about them until 2-3 weeks after their return. Testing during the appropriate time gives you information that may or may not be significant, so we really have to do the screening tests. It's great that we've been working with the Commission to get some of hospitals on the fast-track for that testing, because it really was a problem for them. We recognized that problem and have gotten great assistance from the Commission in implementing this fast-track testing. We will test other individuals who are not pregnant, symptomatic individuals, Guillian-Barré syndrome any unusual cases, but that's less than 10% of the screening that we're doing. We hope to expand screening and testing more as we get more experience with the tests. It's always going to be limited because we have limited resources in the laboratory to do this testing. The same people who have the expertise to do this testing will be doing the West Nile and triple E testing during the regular mosquito virus season. That's been the issue with testing.
- We're working with partners and the CDC on raising awareness and doing a lot of counseling with people about travel and about return. I am working with the Mosquito Control Project on surveillance. We probably will not be testing mosquitoes for the virus because of collecting a sufficient number of *A albopictus*. As Mr. Henley said, we will be looking at other ways to assess whether there's a potential for the virus in the state.
- On the national level, we are working very closely with the blood collection agencies. This is another initiative to work with them to identify the areas in the country where there is ongoing transmission, because they will have to put that into their question package in terms of travel as well as probably for donors. That's another issue that affects Massachusetts because of the numbers of people who travel. We have a very high rate of travel to areas where Zika is transmitted.

- Dr. DeMaria stopped there as we were running out of time. Mr. Doyle thanked Dr. DeMaria and though we are running late, said he had a few questions of his own. While we have you on the phone, John, and with Dr. DeMaria, both of you have expressed a lack of funds as an issue and Mr. Doyle wondered if there is an advocacy role we should be playing at this point. He knows it's very early on, but with all of the outreach activities we're attempting to do, the limitations even within the Commission financially, you might be able to advise us how to advocate for more funding for both the state and CDC. Or even locally, best and most judiciously streamline our funding at this point in New England and Massachusetts.
- Mr. Auerbach thanked Mr. Doyle for the question; it's certainly an important one. Certainly, if you all are interested in taking action with regard to the funding issue, then this is the time when members of Congress are actively debating what the decision will be. So if you so chose, make sure your elected officials were aware of your opinion about that that would be the thing to do.
- Dr. Minter Jordan had a couple of questions. Dr. Barry regarding women who are pregnant or expecting to get pregnant, you didn't mention anything. What advice is going out? Dr. Barry responded that if a women thinks she might be getting pregnant we would advise that she shouldn't do that if she's travelling to an area of high risk. If she has a partner who is travelling, she would want to refrain from getting pregnant for at least eight (8) weeks if the male partner had no symptoms and at least six (6) months if the male partner had symptoms before she became pregnant. I will tell you, like with Ebola, it was discovered that the virus can persist in the semen. There are studies going on at the CDC that is enrolling men who have had Zika doing sequential longitudinal testing on semen just to see how long this Zika virus stays in the semen. If a man has had symptoms and has been in a high risk area, you want to defer getting pregnant for at least six (6) months.
- Dr. Minter Jordan's other question was for Mr. Henley regarding the sprays. Is there any toxicity associated with that and how do we advise the public when you see spray trucks, etc? Mr. Henley replied there is toxicity with it, but it's difficult to control something that's the body weight of a mosquito. What we're actually impacting are small night-flying insects. If we were to spray during the daytime, it could impact bees. We don't do any adult mosquito control at nighttime. A person should be able to absorb the spray and shouldn't have an impact. When the EPA approves the pesticides for use, they have a minimum level they determine what level causes an impact on people. They won't approve of a use that's at least 100 times greater than that reference dose if it causes an impact on people. Dr. Minter Jordan asked if there were any environmental concerns. Mr. Henley said the environmental concerns were for night-flying insects. There are warnings to stay away from rivers and lakes, but we tend to avoid large bodies of water. There haven't been any impacts in recent years anywhere in Massachusetts.
- Mr. Lopes had a question for Ms. Salas Karnes around the outreach efforts and our collaboration with other cities and towns around Boston. In the past, in some areas we have coordinated outreach efforts knowing that the population is very, particularly right now, very migrant. Ms. Karnes said that is a good question and definitely thinks we should; we haven't done any so far. We could definitely work with them.
- Dr. Barry commented that we try to use city resources for city residents, but that being said, East Boston, of course you're going to see people from outside of Boston, but we'd love to have you doing posters, and all kinds of things in the Health Center. Of course, if people could see those materials and take them with them. We'd also like to partner with Most Holy Redeemer Church and you guys. Mr. Lopes said he already sent the email.
- Mr. Doyle commented there's one other side to this then we'll turn to the Homeless presentations because we are getting a little bit tight on time, unless there are other questions from the audience. The whole issue of this being like an STD as well is new to me, and I think, to many. I'm concerned that while we are focused on pregnant women, as far as education and outreach, that that is not really in the public sphere, at least as I see the public sphere. I'm sure that to clinicians it may be more evident right now. I was wondering how we approach that, Dr. Barry, Dr. Nguyen, my colleagues, Dr. Jordan, how do you deal with that? And do we treat it like it's a potential STD, I guess it is technically? How do we outreach for that purpose?
- Dr. Barry said she would just echo what Dr. DeMaria said which is our major group of concern is pregnant women. So making sure that women who are pregnant, or may become pregnant, are aware that this could be sexually transmitted is really a key priority for us. She referenced briefly that the guidelines are that you should avoid certain sexual contact and that's just a very hard sell, but we're working on it. Dr. Nguyen said it's focused on the travelling community.
- Mr. Doyle asked Dr. Nguyen if he felt that in our provider network in Boston, if you will, our primary care provider network that it is evident to them now, that this is an issue not just for pregnant women to be aware of, but to advise travelling males as well? Dr. Nguyen stated he thinks a lot of the providers who work in our Community Health Centers, for instance, have a lot of experience with patients who travel a lot. They have a lot of travel consultation and guidance with their patients. He thinks there's definitely a lot more work that we can do to get the word out, but thinks those are conversations that a lot of providers are used to having with patients that travel and coming back from these countries.
- Ms. Valdes Lupi added that we've been having visits with the Community Health Centers. We were at Southern Jamaica Plain Health Center. They actually talked about the education and outreach around Zika because the serve a predominantly Latino population. We were talking with one of the Women's Health staff there. She talked about some of the challenges in doing that outreach to women who have saved up money throughout the year to make their trip back home with their children to Puerto Rico, Dominican Republic, and the challenges in convincing them to just stay here in

Boston. She raised that point because if there are ways that we can help educational materials or tailoring the message, she thinks it would be beneficial. She looks forward to dropping off more of the posters and materials to a lot of our health centers that are working some of the women in the populations that are impacted.

- To Mr. Doyle's question around advocacy, Ms. Valdes Lupi wanted to point out that we are working through our national association, NAACHO (National Association of County & City Health Officials), we did provide some preliminary feedback on the draft Interim Response document and also on the funding front with the National Association.
- Mr. Doyle thanked Ms. Valdes Lupi. He asked the audience if they had any questions for our panelists; there were none. Mr. Doyle thanked Mr. Auerbach, Dr. DeMaria, Ms. Salas Karnes, and Mr. Henley for coming. Mr. Doyle moved on to our next item on the agenda, a discussion on homelessness and where we are at with our Homelessness Programs at this point and time. He gave the floor over to Ms. Valdes Lupi.

Homeless Services: Housing, Employment and Front Door Triage

Elizabeth Doyle, Department of Neighborhood Development

Beth Grand, Director of Homeless Services

- Ms. Valdes Lupi commented this was to follow up on a request from the Board to tell you a little bit more about what we're doing as a city on the Mayor's action plan to end veterans and chronic homelessness and to tell you a little bit more about the work we're doing in FY17 with the funding we've received through the budget cycle this year. We've got Elizabeth Doyle, who is a colleague from our Department of Neighborhood Development, who'll walk us through the city-wide action plan.
- Ms. Doyle thanked everyone for inviting her to make a presentation. As much as there has been a lot of work on this plan, and we are making progress, it's also a very exciting time. We're doing things very different from what we've done before and like to tell everyone about it. So thank you again for the invite.
- The Mayor's three-year action plan to end Veteran and chronic homelessness in Boston was rolled out in 2015. The services and support system needed to be redesigned. We went from talented and committed providers using different methods and providing different services (program-centered model) to an integrated network of providers that coordinate efforts to achieve collective impact (client-centered model).
- The Action Plan has two goals: end Veteran homelessness by the end of 2015 by housing all chronically homeless Veterans; no Veteran is forced to sleep on our streets; when a Veteran becomes homeless, it is rare and brief; and all homeless Veterans housed or on a pathway to stable housing. The other is to end chronic homelessness by 2018. There were 613 chronically homeless individuals in January 2016; 69 chronically homeless individuals have been housed since then. There are 544 currently chronically homeless individuals in Boston.
- Chronic homelessness among Veterans in Boston has ended. We reduced the overall number of homeless Veterans by 44% in just over two (2) years. We've reduced the length of time Veterans remain homeless and have built a community response system. We continue to house approximately one homeless Veteran per day; 636 Veterans have been housed since July, 2014. No Veteran is forced to sleep on the street. On a single night, 5 or fewer homeless Veterans sleep on the street in Boston and they are offered shelter every night.
- We work from "by-name" lists of every homeless Veteran and chronically homeless individual in Boston. We conduct housing "surge" events and foster a "surge" mentality. We set clear targets and used data to track progress. Bureaucracies bring in new resources and become more flexible with time.
- We hosted five (5) "housing surge" events since November 2015. At these events, over 35 housing vouchers were issued on the spot; health insurance was upgraded; criminal records were mitigated; provided same-day proof of income and identification; connected to housing search assistance; and provided hot meals, gift cards and transportation. The next "housing surge" will focus on chronically homeless elders (50+). We plan to connect elders with nursing home diversion services, home care, and other home-based stabilization and to connect elders with BHA housing units.
- A chart was presented showing the various stages of interventions: street strategy, addiction services, coordinated access, new units, permanent supportive housing, front door triage and income expansion and benefits. We are partnering with many public and nonprofit agencies. From the City of Boston: Department of Neighborhood and Development, Office of Veteran's Services, Elderly Commission, Boston Housing Authority, and the Boston Public Health Commission. From the Commonwealth: Department of Veteran's Services, Department of Housing and Community Development, Department of Mental Health, Department of Public Health, Executive Office of Elder Affairs, Department of Criminal Justice Information Services, Department of Transportation, MassHealth, Interagency Council on Housing and Homelessness. On the Federal level: Department of Housing and Urban Development; Department of Veterans Affairs, and Interagency Council on Homelessness. The Nonprofit partners are: Pine Street Inn, New England Center and Homes for Veterans, Massachusetts Housing and Shelter Alliance, HomeStart, Inc., St. Francis House, Hearth, Inc., Metropolitan Boston Housing Partnership, Bay Cove Human Services, Vinfen, Volunteers of America Massachusetts, Veterans, Inc., Boston Health Care for the Homeless, Project Place, Casa Esperanza, Commonwealth Land Trust, Children's Services of Roxbury, and Brighton Marine Health Center.

- Ms. Grand explained the mission of Homeless Services Bureau ("HSB"): provide safe emergency shelter services for ALL who need; address issues at the Front Door to aid in diversion and discharge planning; decrease the length of stay by housing chronic homeless and homeless veterans; increase client income by employment and access to mainstream benefits; decrease costs of high utilizers by providing effective interventions; address issues of viral suppression for HIV clients; reduce recidivism for people leaving criminal justice system; address substance abuse and mental health issues; and provide stabilization services for newly housed clients.
- Many of the guests served by HSB face barriers to transition and often face numerous barriers simultaneously. Within our population: 65% have chronic substance abuse; 50% have less than a high school diploma; 45% have mental illness; 30% have co-occurring disorders; 25% have legal issues; and 15% have HIV/AIDS. This unique situation requires a multi-faceted approach to treat and prevent homelessness.
- There was a chart that showed the Organizational Overview of HSB. Emergency Shelter: Southampton Street, Woods Mullen, Shelter, and Front Door Triage. Clinical services includes: Operations, Case Management, Mental Health Services, Healthcare for the Homeless, and substance abuse. Workforce Development includes: Serving Ourselves, Work Experience Program, Career Center, Operations - Kitchen/Janitorial; Maintenance - Facilities; and Maintenance - Culinary Arts. Permanent Housing includes: Rapid Re-Housing; HUES to Home; Long Term Stayers; SSVF; SAMSHA Mission Housed; and Community Housing. Rehabilitation Services include: Wyman Reentry Center; Project SOAR; and Safe Harbor.
- The City of Boston accounts for 32% (\$5,134,000) of HSB's FY17 revenue sources. 51% (\$8,252,000) comes from the State. Federal funding accounts for 12% (\$1,970,000). Another 5% (\$823,000) comes from other sources including \$180,000 in billing for CSPEC like services.
- There was also a chart showing our grant sources. State Grants: Department of Housing and Community Development, DPH Bureau of Substance Abuse Services, and Department of Mental Health. Federal Grants: Department of Housing and Urban Development, Substance Abuse Mental Health Services Administration, Housing Opportunities for People with AIDS (HOPWA), Ryan White Care Act, and Emergency Solutions Grant. Other grants: Friends of Boston's Homeless (FOBH); Mass. Behavior Health Partnership (MBHP) - CSPEC; Mass. Health Others - Pay for Success; Office of Workforce Development Neighborhood Jobs Trust; and Mass Health Billing for Mental Health Services starting in FY17.
- Next was a chart with a breakdown by shelter and the number of individual emergency shelter beds in the City of Boston and their funded nightly capacity and funded nightly capacity and winter overflow. The total number of men's shelters funded nightly is 1,092 which increases to 1,464 during the winter. Women's shelters fund 365 nightly with an increase to 442 during the winter. Please note: NESHV not included in calculations.
- BPHC's Emergency Shelters. At Southampton Street Shelter, there are 437 male beds available with an overflow of 50-90 for men. At Woods Mullen Shelter, we have 200 female beds with an overflow of 40 women. Our shelters provide a warm bed, three meals, clothing, medical care, mental health care, case management, housing referrals, and day program services. Some of the on-site providers include: Boston Health Care for the Homeless; DMH Outreach Team; BEST; HomeSmart; HEARTH; Rosie's Place; Impact Employment Services; Bridge Over Troubled Waters; Parole; and Social Security.
- Long Island vs. Southampton Street Shelter. There are both positives and challenges with Southampton. On the positive side we have: location, increase access for vulnerable populations, single sex facilities open 24 hours, and stronger linkages and partnerships. The challenges include: profile of guests - many are medically compromised (130 were restricted from Long Island); increase in prevalence of guests with substance abuse disorders (56 incidents over 4 months including 4 fatal overdoses); increase in violent behavior (over same 5 month period, 76 men were barred for "threat of extreme violence or engaging in extreme violence" compared to 21 from 2014); increase in mental health crisis (175 active with 27 ambulance calls over 5 months); one of the few facilities that allows Sex Offenders; constant flow of guests throughout the day; increase in demand for emergency shelter beds; and a larger, more complex physical space.
- We have a new initiative Front Door Triage: adopted from the triage models at hospitals. This allows for diversion (family reunification, friends, point of origin) that sticks, provides Connections to Rapid Rehousing, clinical services, Work Force Development, Alternative Housing, and Permanent Supportive Housing (CAHP); and connections to downstream resources such as substance abuse, young adult, elderly, and mental health.
- The Front Door Triage at Southampton started in February, 2016. In the first 4 months, we connected with 265 new guests (63%); 50% have engaged with staff and close to 400 referrals have been made; 42 guests have moved out of shelter within the first 60 days: 14 have gone to substance abuse inpatient services, 10 have gone back to live with family, 8 have been accepted to Transitional/Supportive Housing, 4 have been sent to DMH services, 3 were permanently housed through Rapid Rehousing, 2 youths have gone to Bridge Over Troubled Waters Shelter, and 1 was sent to Barbara McInnis for Medical intervention.
- Current Housing First programs include: Long Term Stayers; Mission Housed; SSVF; Pay for Success; HUES to Home; Rapid Rehousing. These programs provide stabilization services to approximately 150 guests at any time. Housing placements as of March 2016: we have placed 721 emergency shelter clients in housing since 2009 (113 in the last 8 months); 459 have gone to Permanent Supportive Housing (56 in the last 8 months); 262 have gone through Rapid Rehousing (57 in the last 8 months). We have an over 90% tenancy retention rate.

- Housing First targets those homeless individuals who use Boston hospital emergency rooms more than 10 times in a 6 month period. The goal is to improve health and housing outcomes and reduce utilization of expensive acute medical services and promote coordinated primary care, behavioral health and addiction services. We are in partnerships with Boston Health Care for the Homeless Program, Massachusetts Housing and Shelter Alliance and Mass Health/Mass Behavioral Health Partnership.
- Workforce Development has 2 new locations: one at the SOS Career Center at 1022 Mass. Ave. and the other SOS Kitchen at 196 Quincy Street. The Serving Ourselves Career Center provides 2 hours a week of classroom instruction utilizing Adkins Life Skills, a renowned career model developed by researchers at Columbia University. Career Center staff offer clients a different way to approach job readiness by discovering their strengths and taking responsibility for their own employment future. SOS also provides on-the-job training: SOS Kitchen has 24 client workers; Maintenance has 2 client workers; Deep Cleaning has 5 client workers; Janitorial has 8 client workers; and Clothing Inventory & Distribution has 2 client workers.
- The Wyman Reentry Center opened in 2007 on Long Island. It provides a 30-bed stabilization and transitional program for men involved in the court system. All referrals come from state or county correctional facilities, drug courts, shelters, parole offices or agencies serving homeless ex-offenders. The program provides Case Management, Health, Mental Health and Substance Abuse Services referrals to job training, long term employment and housing. 171 men participate yearly in Wyman Reentry. 60% of the clients who completed the program moved onto supportive or permanent housing. 3,400 prisoners are released from state prison each year; 6,500 from county correctional facilities.
- Transitional Housing consists of two programs: Project SOAR (Stability, Opportunity, Achievement and Recovery) and Safe Harbor. Project SOAR has 20 units of safe transitional housing to clients enrolled in the Serving Ourselves Job Training Program. The goal is to provide supportive assistance to men and women facing substance abuse as they transition from shelter to permanent housing. 55 men and women are served annually. Since 1995, nearly 900 people have moved from shelter to permanent housing through Project SOAR. 67% of participants engage in vocational training. 70% of participants move on to permanent housing at program exit.
- Since 1994, Safe Harbor has been a national model for innovative and compassionate treatment of homeless men and women with symptomatic HIV who are struggling with addiction. The program provides short term housing, healthcare, mental health and substance abuse counseling so clients can engage more fully in HIV treatment programs. There are three phases of treatment that gradually transitions their recovery supports to the community. 55 men and women are served annually. 45% of program participants obtain permanent housing, transitional or other supportive housing at program exit. Of these, 70% have maintained 1-year later.
- We have working relationships with community permanent housing. One Wise Street is located in Jamaica Plain, has a nine (9) unit substance-free recovery home for working, formerly homeless men. Units are funded through HUD/Mckinney Permanent Housing dollars. It was opened in 1990. Nine Valentine Street is located in Roxbury and provides supportive housing to seven (7) formerly homeless women whose children are temporarily in the state foster care system or residing with friends and family. Units are funded by BHA Project Based Section 8 Subsidies. It opened in 2001. Porter Apartments is located in Jamaica Plain, provides six (6) BHA Project Based Section 8 Subsidized on-bedroom units to individuals who are capable of living independently, but are in need of affordable housing. It opened in 2003. Friends of Boston's Homeless (FOBH) was founded in 1987 as a 501(C)(3) non-profit corporation working in unique public/private partnership with the BPHC Homeless Services Bureau. FOBH develops and supports innovative, solution oriented programs to help the homeless move beyond shelter and back into the community as independent citizens and seeks to increase the public's awareness and understanding of the realities of homelessness.

Adjournment

Mr. Doyle thanked everyone for attending and adjourned the meeting at 6:10pm

Respectfully submitted by:



 Kathy Hussey, Board Secretary

