From: Mary Magee
To: Carroll, John (BOS)
Subject: Dear Supervisors,
Date: Thursday, April 30, 2020 4:13:58 PM

Dear Supervisors,

I am a registered nurse who worked for four years at a supportive housing hotel in Tenderloin through the DPH's Direct Access to Housing. After 23 years as a nurse, and 21 years at SFGH, my chosen transition to working in a supportive housing was the biggest professional challenge that I underwent in my career. I was the initially the only nurse in a building of 80 people, then advocated for a half time nurse. During my four years there, there was a room set on fire via a cigarette, a resident jumped out a window (her life saved only by an awning and my holding her body up from below while waiting for 911) , multiple people were found dead (either from disease or OD), one resident hung himself, one person was stabbed, another resident bled to death in her room, and residents were threatened, sexually exploited, and robbed by one another regularly. Falls were frequent and often required 911 assistance. It was also a vibrant community, in which the staff (case managers, property managers and nurse) joined the residents in trying to build some relationships of trust, which took time.

As a nurse, I managed medication for about 30 residents. I could not possibly check in on 80 patients daily . However, I did many room checks and nursing assessments, and called 911 multiple times a week if not per day for medical emergenciestbat arose regularly. There were a preponderance of folks who could not self manage themselves and would have been endangered if they did not have IHSS workers to assist them with laundry, shopping and keeping room clean enough to avoid eviction.

Unlike what I am hearing about the current deployment of nurses to the newly set up hotels, I was not responsible for finding linen or assuring that 100 meals were developed. I had an office and was well supplied unlike nurses who report having to stand for 12 hours in a lobby. We would admit no more than 2 people a day while these hotels have admitted one person every 30 minutes. I understand the urgency of getting people off the street, but the hotels need to be well staffed to handle this degree of admissions. I also did not have to deal with a large number of citizens walking in asking for shelter and services that they are hearing about. And I was not asked to distribute cigarettes and alcohol, which then ran out while people still asking for them.

I actively pursued work in the supportive housing setting and this meaningful work changed my life. But in the end, the work was exhausting and the staffing insufficient. If this is true in the long established supportive housing hotels, how much harder is it in these quickly thrown together hotels in the midst of a pandemic.
Please consider the following:

Do deployed workers have a clear chain of command to use as resources and to clarify issues?

How available are the staff supervisors and do they check in at the sites? Do these supervisors have experience working with this population?

Have the deployed nurses had recent experiencing working with with medically complex adults (we have heard that some nurses are being deployed from foster care and maternity.

Are the nurses' duties clearly spelled out? Is it "do the best you can" or are there clear duties spelled out? It is the natural inclination for a nurse to feel responsible for a patient medically, but this is not feasible with the current staffing, so clear duties helpful, albeit with some flexibility in a setting so much less controlled than what they are used to .

Will nurses have responsibility for helping people with medications? Must have access to a computer with EPIC database loaded if nurse is going to be able to check records, contact primary care, etc.

Will the nurses/deployed workers have a designated area that will have chairs, phones workspace, and supplies, available from the beginning of deployment?

Training on Narcan usage or encourage comfort level with calling 911.

Training on full PPE in case it is needed (only inpatient nurses would have recent experience with full PPE).

Coordination with other job classes also working there? Coordination with security?

Feedback loop so issues can be resolved and changes made?

I appreciate your patience with this long testimony and ask that you consider seriously these concerns.

Mary Magee

Sent from my iPhone

From:	Leigh Escobedo
To:	Carroll, John (BOS)
Subject:	For today's committee meeting: Hotel placement of homeless and others
Date:	Thursday, April 30, 2020 12:51:49 PM

I am recently retired from Tom Waddell Clinic and Supportive Housing. I worked at The Empress and at The Plaza. In my 15 years at these homeless venues I never once saw the Mayor or Supervisors visit. When I spoke with them at events I always invited them.
My comments on placing homeless in regular hotels:
#1: Assigning staff without experience with the homeless population is unsafe for the workers.
The level of staffing needed is probably not possible.
#2: Working in supportive housing was difficult and traumatic. Clients are in and out of the hospital, alcohol and drug recovery, unable to care for themselves even with some help in these 'independent living' sites. Having them scattered throughout the city in hotels is, I will just say, ridiculous!
#3: Many clients in supportive housing need 'higher levels of care'. A true assisted living or Laguna Honda. The city can build these on the current Laguna Honda site. My guess is that the money saved on frequent medical would pay for this over the long term. If those clients are moved into the care they need, rooms and apartments would be freed up in supportive housing.
#4: There are brilliant nurses, doctors, other providers, case managers, paramedics, fire people, and clients themselves that could inform the 'powers that be' on what is really needed. Have a round table with the staff that work in supportive housing, SROs, respite and sobering, and with the first responders. These frontline staff can tell you what is working and what is not.
#5: The Mayor and Supervisors should visit every site that houses the homeless. Sit with the staff and clients. Listen, watch.
Thank you! I have lots of informative experience and am happy to share.
Leigh Escobedo PHN

Sent from my iPhone

From: Sue Hestor
To: gordon.Mar@sfov.org; Ronen, Hillary; Haney, Matt (BOS)
Cc: Carroll, John (BOS)
Subject: Hotel Operations Update -200140
Date: Thursday, April 30, 2020 6:37:53 PM

When 200140 Hotel Operations Update is scheduled again at GAO, I ask to be notified. Particularly if time is not the regular GAO committee time. (Watching Plan Comm items interfered a bit.)

You all have my sympathy ***and encouragement*** for digging in there in the face of not diffident response from some city officials. DON'T GIVE UP.

THANK YOU.

Sue Hestor

From:	Mary Magee
To:	Carroll, John (BOS)
Subject:	Testimony re: HSA (separate from testimony on hotels)
Date:	Thursday, April 30, 2020 5:39:42 PM

Dear Supervisors,

I have just finished listening to the Government Audit and Oversight Committee meeting's Hotel Operations Update. I would like to comment on the issue of HSA's deployment of furloughed workers

The following was reported to me by a deployed HSA employee who experienced the following. A few weeks ago HSA was deploying clerks (clerical workers) to work in a motel setting where patients from Laguna Honda were placed. These workers were given less than 24 hours notice and for some, their shifts had been changed significantly. At a training the next day, they were given very general information and training re: their DSW status and a binder. Duties were NOT described in detail. Workers, who had received an email that they were being deployed to a city COVID/quarantine site were not told that the residents in the hotel were not COVID +. They lived in fear, not knowing either way, and understandably assuming the residents were COVID+. No protective supplies such as masks, gloves, or sanitizer were provided on site. The workers brought them from home. It was very worrying for them-their usual positions are clerical. Though they were told that as on site monitors, they would only be doing non medical triage, a medical issue did come up.

This method of deployment leaves a lot to be desired in terms of adequate notice, communications, coordination, training. A binder is not training, and a sense of safety.

Thank you for your consideration of these issues, and for the hearing.

Sincerely, Mary Magee