UNIVERSITY OF CALIFORNIA, BERKELEY

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To the San Francisco Board of Supervisors,

Thank you for this opportunity to serve our community at a time of national emergency. As faculty members and graduate students with the University of California, we offer the following evidence-based recommendations for the sheltering and care of people experiencing homelessness in San Francisco.

The bottom line: Based on current evidence and accumulated knowledge, one can only conclude that ensuring that all people experiencing homelessness can properly shelter in place will further flatten the curve in San Francisco, decrease the demand for services from San Francisco hospitals, protect healthcare workers and first responders, allow us to lift shelter in place orders sooner than if PEH are not sheltered in place and make it safer for all of us to resume normal activities when those orders are lifted.

I. Public health principles and evidence to date about the novel coronavirus that are relevant to policies regarding people experiencing homelessness

PRINCIPLE A: In order to limit coronavirus infections overall, we have two primary tools.

- ONE, we can decrease the contact rate, i.e., the likelihood that people are exposed to people who are infected. Our primary tool for decreasing the contact rate, i.e., the likelihood that susceptible people in the population are exposed to people who are infected is *social (or physical) distancing* when we are in public settings, *sheltering in place* to avoid non-essential contact with others, *quarantining* for people who may have been exposed to prevent transmission should they be infected, and *isolation* of people who are infected from people who are not sick.
- TWO, we can decrease the probability of transmission of infection from someone with the virus to someone who is susceptible if and when such contact takes place. Our primary tools for decreasing the transmission probability, i.e., the likelihood that susceptible people are infected if they are exposed are: a) frequent access to handwashing and hygiene in sanitary sites, b) cloth masks for everyone, surgical masks for the sick.
- We also know that partial social distancing or social distancing of just vulnerable individuals is much, much less effective for our community than complete or near complete social distancing by all individuals. As an example, a recent report found that social distancing of elders will reduce the number of cases by 21% while social distancing by all age groups can reduce the number of cases by 94%.
- Social distancing early in a pandemic is far, far better than doing so later, as we are seeing in the difference in the experiences of NY and CA. However, this must apply to all populations in order to be most effective in the long run.
- It is well documented that individuals are at their most infectious right before they get sick or as they get sick (when they may not yet recognize that they have COVID-19). It also appears that some individuals may be infected and transmit disease unknowingly. Thus, all healthy individuals need to be treated as both potentially infectious as well as susceptible.

PRINCIPLE B: Another tool to decrease the effect of the pandemic on mortality is to do all we can to maximize the effect of our tools on the most vulnerable, primarily by encouraging them to shelter in place and not be in public settings at all.

II. What does this mean for people experiencing homelessness?

Under current guidelines and conditions, we need to apply both our primary tools to the population of people experiencing homelessness as well as the general population.

People experiencing homelessness cannot reduce their contact rate in encampments, on the street, in most shelters, or if they are unstably housed in situations where they cannot socially distance (such as trading sex for a place to stay or for basic

needs). In addition, people experiencing homelessness cannot reduce their transmission probability because they do not have access to the resources to do so (masks and the ability to wash their hands properly and often).

In addition, people experiencing homelessness because of their underlying poor health are much more likely as a group to become severely ill or die from COVID19 whether or not they fall into the currently accepted vulnerable groups. People experiencing homelessness have poorer health and weaker immune systems than they would if housed. Multiple factors to which people experiencing homelessness are exposed are well known to depress immune responses, including experiences of stigma, chronic exposure to violence, substance use or abuse, poor sleep and nutrition, childhood trauma, and exposure to the elements. At all ages, they are more likely to suffer from chronic diseases, including asthma, cardiovascular disease and diabetes, and to physically age more rapidly. In the Bay Area, they are also more likely to be over 55 years of age than people with a place to call home. One illustration of this is evidence from NYC finding that among COVID-19 positive PEH, 30% were hospitalized.

III. What are our recommendations?

1. Hotel rooms for most individuals
    a. For people who are not infected or sick: make it possible for all people experiencing homelessness to shelter in place (as we are instructing the general population to do) in **hotel rooms** or similar single-occupancy vacant units with private bathrooms. This will minimize their exposure to people who are infected (tool 1) and decrease their likelihood of being infected if exposed through individual access to hygiene and cloth masks (tool 2).
    b. For people who have been exposed to people who are sick: quarantine, preferably in a separate hotel from those who do not appear to be infected or sick. These individuals should have access to cloth masks.
    c. For people who are sick but do not require hospitalization: isolation, preferably in a separate hotel from those who are sick. These people should have access to surgical masks.
    d. In all hotels: provide for basic needs, including 3 meals a day delivered to each room, monitor temperatures daily, provide supportive services (possibly by moving shelter staff when appropriate with clients).
    e. Allow individuals to bring their belongings and pets into hotels with them.
2. Shelters for the minority of individuals who cannot function safely in hotel rooms and who are not sick, with partitions and increased numbers of bathrooms and sinks/hand sanitizer stations per person. Provide cloth masks. Provide basic needs and screening as for #1.
3. For people in encampments: halt confiscation of tents and belongings, provide or clear additional space so tents can be spaced far apart. Provide written official notices of halting tent confiscation and communicate in outreach so PEH understand new regulations; provide food and sanitation (regularly serviced latrines; handwashing stations; individual packs of sanitizer; sharps disposal and harm reduction supplies; and trash/garbage collection) so people can minimize their movements and shelter in place in their tents. Provide tents to people who do not have tents and who are sleeping outside. Provide cloth face masks with backups and replacements through outreach. Conduct outreach-based screening so new infections can be detected ASAP and sick individuals can be moved to hotel rooms.
4. For people in cars: halt ticketing and towing of cars, provide safe parking areas so cars can be parked far apart, provide food and sanitation (regularly serviced portable toilets with handwashing stations; individual packs of sanitizer; sharps disposal; and trash/garbage collection) so people can minimize their movements and shelter in place in their cars. Provide tents to people who do not have tents and who are sleeping outside. Provide cloth face masks with backups and replacements through outreach. Conduct outreach-based screening so new infections can be detected ASAP and sick individuals can be moved to a hotel room.
5. For people in unsafe living situations/at risk of homelessness (domestic violence, couch surfing, trading sex for a place to stay, existing jail/prison without housing): provide a hotel room to shelter in place. Given decreased access to basic needs, to decrease negative effects on these vulnerable individuals (unsafe behaviors and food insecurity) continue to provide basic needs (including food) and supportive services. Provide cloth face masks with backups and replacements through outreach. Provide screening so new infections can be detected ASAP and sick individuals can be moved to a hotel room.
6. For people who have recovered from COVID-19 who have a documented negative test: Individuals can live in a safe congregate setting with shared facilities. Given decreased access to basic needs, to decrease negative effects on these vulnerable individuals (unsafe behaviors and food insecurity) continue to provide basic needs (including food) and supportive services and/or lengthen their hotel stays for the duration of SiP.
7. Provide a single point of entry or contact for people who are homeless or unstably housed to access COVID-19 related services, care, or housing.

IV. How can we maximize the feasibility and acceptability of these recommendations?

- Bring recommendations in dialogue with unhoused communities to establish partnership and identify how we can best meet their needs.
- Service providers including Compass, GLIDE and others have partnered to provide these services in ways that acknowledge the needs of clients. We support the planning efforts they have made.
- Current laws criminalizing individuals for their homelessness need to be suspended (panhandling, sit/lie) and replaced with increased provision of basic needs without threat of punishment (confiscation of belongings, refusal of partners or pets).
- Ensure people experiencing homelessness have rapid access to care, and if necessary, hospitalization to decrease the need for intensive care.
- Have storage options available and accommodate pets for those entering hospitals, hotels, or shelters to prevent PEH avoiding medical care or screening out of fear of losing property.

We are preparing a report to the Board in a few days to further document the evidence for our recommendations. In the meantime, if you have questions, please feel free to contact Coco Auerswald, MD, MS, Associate Professor (coco.auerswald@berkeley.edu) or Sarah Ferrell, MPH cand. (sferrell@berkeley.edu).

Respectfully submitted (in alphabetical order by last name)

Kamran Abri Lavasani. Student, UC-Berkeley-UCSF Joint Medical Program
Colette (Coco) Auerswald, MD, MS. Faculty, UC Berkeley School of Public Health.
Joey Chiang, MS. Student, UC-Berkeley-UCSF Joint Medical Program
Sarah Ferrell. Student, UC Berkeley School of Public Health
Jay Graham, MPH, PhD. Faculty, UC Berkeley School of Public Health
Chris Herring, PhD candidate in Sociology, UC Berkeley
Jessica Lutz. Student, UC Berkeley School of Public Health
Sandra McCoy. Faculty, UC Berkeley School of Public Health