COVID-19 Guidance for Homeless Shelters

Contents

Key Information

- **There is widespread community transmission of coronavirus disease 2019 (COVID-19) in New York City.** If someone has COVID-19-like illness (CLI), assume they have COVID-19. To help protect health care workers and preserve medical supplies that are critically in low supply, testing should only be used for people who need to be hospitalized for severe illness such as pneumonia. For people with mild to moderate symptoms, a positive test result will not change what a doctor tells the person to do to get better.
- Individuals with CLI or confirmed COVID-19 with mild to moderate symptoms should not be sent to the hospital. They should be isolated and can self-monitor; if symptoms worsen or do not improve after three to four days, they should talk to a doctor.
- Shelter providers for the NYC Department of Homeless Services (DHS) should follow DHS guidance. DHS guidance is consistent with this document but contains some implementation details specific to DHS.
- **Note:** Effective April 15, 2020 at 8 p.m., all employees must wear face coverings when customers (including residents, clients, or program participants) are present. Employers must provide face coverings for employees at no cost to employees. For more information, please review the State order and see below for additional guidance. Read the State order by visiting coronavirus.health.ny.gov and searching for **executive order 202.16**.

Information About COVID-19

For general information about COVID-19, including how to guard against stigma, visit nyc.gov/health/coronavirus or cdc.gov/covid19. For real-time updates, text "COVID" to 692-692. Message and data rates may apply.

Most people with COVID-19 have mild to moderate symptoms and recover on their own without needing medical attention. Less commonly, COVID-19 may lead to pneumonia and other complications, including hospitalization or death.

- Commonly reported symptoms include:
  - Fever (temperature of 100.4 degrees F or 38.0 degrees C or greater)
  - Cough
  - Shortness of breath (trouble breathing)
  - Sore throat
- Some patients also report:
  - Loss of a sense of taste or smell
  - Feeling achy
  - Headache
  - Diarrhea

Most people with CLI have not been tested for COVID-19. People with CLI should be considered as if they have COVID-19 and as if they are contagious.

Most people with COVID-19 can tolerate the illness without medical intervention, as long as they receive support for all of their immediate needs. People who develop more severe disease requiring medical intervention, including hospitalization, have often been older adults, people with underlying medical conditions, or people with disabilities.

Background and Overview

Introduction

A homeless shelter can be a congregate-setting facility or have separate rooms or distinct self-contained units. Families are placed in their own units, which can be entirely self-contained, or may share bathrooms and meals, while single adults are in congregate facilities, an environment where a number of people sleep in a dormitory and share bathrooms and cafeterias. This guidance can assist homeless shelters in NYC to reduce the introduction of COVID-19 and other respiratory diseases, manage known or potential exposures to COVID-19, and reduce the risk of transmission of COVID-19 within the facility.

Homeless shelters pose many challenges due to their unique environment. Particular challenges include vulnerable populations, restrictions on client or resident movement, and alternative work schedules for staff.

Special considerations should be taken to prevent COVID-19 transmission when considering the movement of clients or residents, visitors, and staff into and within the facilities. Strategies to reduce risk should include elimination or reduction of face-to-face meetings such as case management and staff meetings. When in-person meetings must occur, practice physical distancing (keeping 6 feet or greater between people).

Responding to COVID-19 and Implementing Guidance

With widespread community transmission occurring in NYC, this document's guidance can assist homeless shelters in NYC to reduce the introduction of COVID-19 and other respiratory diseases and reduce the spread of COVID-19 within their facility.

The goal of this document is to help homeless shelter operators:

- Respond to widespread community transmission of COVID-19 in NYC:
    - Reduce the introduction and/or spread of COVID-19 and other respiratory illnesses into the facility.
    - Rapidly identify people with respiratory illness.
    - Manage and isolate people with suspected or confirmed COVID-19.
    - Be familiar with infection control guidance.

- Implement detailed guidance:
    - Appendix 1: Physical Distancing to Limit Further Spread of COVID-19
    - Appendix 2: Rooming, Isolation and Monitoring Symptoms of Residents with CLI
    - Appendix 3: Instructions for Staff or Family Members Caring for Individuals With CLI

Community Transmission of COVID-19 in NYC

During widespread community transmission, COVID-19 will be introduced into congregate settings such as schools, workplaces, homeless shelters and nursing homes. As community transmission of COVID-19 increases, more and more of these settings will have people with CLI or confirmed COVID-19 in their facilities.

Facilities are advised to continue to adapt response plans as the outbreak evolves. They should engage with their local and State partners to learn about the evolving situation and communicate needed resources. Given the multiple potential points of access of COVID-19-infected people into congregate settings, facilities should plan to identify CLI in a client, visitor or resident. DHS facilities need to follow DHS guidance and reach out to DHS for questions and assistance.

During community transmission, the NYC Health Department recommends that facilities continually revisit the following checklist:

- ✓ **Communicate with staff and residents to keep everyone informed.**
  - Describe what actions the facility is taking to protect them, including answering their questions and explaining what they can do to protect themselves and their fellow residents.
  - Provide educational materials and information to residents and visitors in a way that can be understood by non-English speakers. When evaluating and treating people who may have COVID-19, provide an interpreter if possible. Visit nyc.gov/health/coronavirus for materials and information in multiple languages.

- ✓ **Protect your workforce, residents and clients.**
  - Provide face coverings for all staff. All staff must wear a face covering when clients, residents, or program participants are present or at any time they cannot maintain at least six feet of distance from others.
  - Inform staff about sick leave policies and encourage them to stay home if they have CLI.
  - Advise staff to check for any signs of CLI before reporting to work each day and to promptly notify their supervisor if they become ill when at work.
  - Do not require a doctor's note for staff to be able to use sick days or for staff to return to work after being sick — DHS staff should follow their agency's guidance for sick leave. Remind staff they should not see a doctor or seek a test if they do not have chronic health conditions and their symptoms are mild.
  - Incentivize protective behaviors by compensating staff for staying home if they have CLI.
  - Eliminate face-to-face meetings or activities that are not absolutely necessary. If a face-to-face or group meeting or activity is necessary, practice physical distancing. This includes:
    - Maintaining at least 6 feet of distance between all people
    - Avoiding meeting clients in small, enclosed spaces
    - Conducting case management by phone or video
  - Stagger staff work hours, where feasible.

- ✓ **Keep your facility clean and reduce the spread of COVID-19.**
  - Clean facilities routinely and thoroughly.
  - Clean frequently touched surfaces such as doorknobs, door handles, handrails and telephones, as well as nonporous surfaces in bathrooms, sleeping areas, cafeterias and offices (such as floors), using an Environmental Protection Agency (EPA) registered hospital disinfectant that is active against viruses. For more specific cleaning guidance, visit nyc.gov/health/coronavirus and look for "General Cleaning/Disinfection Guidance for Non-Health Care Settings" under the "Businesses and Other Facilities" section.

- Place waste baskets in visible locations and empty them regularly; provide residents with access to tissues and plastic bags for disposal of tissues.
- Close all common areas. If that is not, possible, enhance ventilation in common areas such as waiting areas, TV rooms and reading rooms and ensure residents maintain at least 6 feet of physical distance from each other.
- Linens, eating utensils and dishes belonging to those who are sick do not need to be cleaned separately, but should not be shared until after being washed thoroughly.
    - Instruct cleaning staff to avoid "hugging" laundry before washing it to avoid self-contamination. Instruct cleaning staff to wash their hands with soap and water for at least 20 seconds, or to use an alcohol-based hand sanitizer immediately after handling laundry.

Reduce the Spread of COVID-19 in the Facility

- **Put signs in locations where they are visible to all visitors, staff and residents.**
    - Put signs at all entrances instructing visitors not to visit if they are sick. Signs in multiple languages can be found at nyc.gov/health/coronavirus. To find posters that encourage behaviors to prevent virus transmission, click on "Posters and Flyers" on the left side of the page. This includes Cover Your Cough and Wash Your Hands materials in multiple languages.
- **Make sure staff and residents are familiar with the symptoms of CLI.**
    - Screen visitors, staff, residents and all others entering the facility for symptoms of CLI at all entrances to the facility.
        - To screen people, ask them if they have any of the following symptoms:
            - Feeling feverish or have a fever (100.4 degrees Fahrenheit or 38 degrees Celsius or greater)
            - Cough
            - Shortness of breath (difficulty breathing)
            - Sore throat
        - Consider anyone who answers "yes" to any of these symptoms to have CLI. Then, have a plan to immediately isolate any resident with CLI and make arrangements for appropriate isolation (including giving them a face covering and placing them in a room with a closed door; for DHS shelters, follow DHS guidance). A face covering is any well-secured paper or cloth (like a bandana or scarf) that covers the nose and mouth.
    - Visitors and staff with CLI should not enter the shelter. Inform prospective visitors that they will not be allowed to enter the facility if they have CLI.
        - See "Reduce the Spread of COVID-19 in the Facility" for information on screening.
        - When possible, facilities should use their usual communication channels to tell prospective visitors the rules before they travel to the facility.

- Instruct residents and staff to report CLI at the first signs of illness.
- Develop plans and procedures for management of residents and clients for CLI upon admission to the facility, including admission to a dedicated location within the facility for management of CLI, or to a pre-identified facility where residents and clients with CLI will be isolated during the course of their illness.

Rapid Detection and Management of People With CLI or Confirmed COVID-19

Currently, COVID-19 is widespread in NYC and introductions to congregate settings such as homeless shelters is inevitable — transmission will occur within these facilities and there will be increasing staff absenteeism. Maintaining physical distance through cancelling or drastically reducing in-person meetings (including between clients and staff), having telephone meetings instead, and staggering activities such as check-ins, can help reduce transmission of COVID-19.

- Given current recommendations for physical distancing, suspend all day trips, visits and group activities in common areas. In addition:
  - Practice physical distancing at mealtimes through delivery of all meals to rooms or apartments, staggered mealtimes, and other strategies as possible, including sitting residents at least 6 feet apart in cafeterias, maintaining the same distance between staff serving the food and residents in line.
  - Suspend all group programs including day programs.
  - Strongly discourage residents from leaving the facility. Residents dependent on nicotine or other substances will need to leave the facility to smoke or use. Programs should counsel residents on how to do this safely as possibly (maintain physical distancing; do not share equipment).
  - Congregate homeless shelters will have unique challenges. Depending on how they are set up and the residents they serve, shelters may need shelter-specific plans that limit COVID-19 transmission in common areas, including hallways if they are used for social interactions.
  - People who are homeless and who live on NYC streets are also at risk. NYC agencies and partner organizations need to promote physical distancing, identify CLI in this population, and transport those with CLI to isolation facilities where they can be supported until they no longer require isolation.
- Implement daily screening of all clients, residents and staff for CLI by asking them if they have any symptoms associated with CLI, where feasible and in particular in sites that had a COVID case. See "Reduce the Spread of COVID-19 in the Facility" for information on screening and how to manage people with COVID symptoms.
- Implement plans for managing staff, residents and clients with CLI.
  - Staff:
    - Staff should practice physical distancing with all clients and between each other, keeping a distance of at least 6 feet between themselves and others.
    - Any staff who develops CLI at the facility must return home for the full course of their illness until they no longer need isolation. They should be instructed to wear a face covering and avoid being within 6 feet of others while in route home. They should stay home until all of the following are true:

        - It has been **at least** seven days since their symptoms started.
        - They never had fever **or** have not had a fever for the prior three days without the use of fever-reducing drugs such as Tylenol or ibuprofen.
        - Their overall illness has improved.
    - Clients of day programs: If a client develops CLI when at a congregate day program they should be transported back to their residential facility, with a face covering. For information on face coverings, visit nyc.gov/health/coronavirus. They should be isolated in a private room or other location pre-designated by the residential facility and provided with all necessary support by the residential facility. If symptoms are mild and the client does not have any chronic health conditions, efforts should be made to manage the client's illness in the residential facility rather than in a hospital for the full course of their illness.
    - Residents: Transfer clients to the pre-designated location where residents with CLI will be provided shelter. Call ahead before transferring.

Management and Isolation of People with CLI or Confirmed COVID-19

The terms "isolation" and "quarantine" are not interchangeable.

- Isolation refers to the separation of people who are sick with a contagious disease from people who are not sick.
- Quarantine refers to the separation of people who are asymptomatic (not experiencing symptoms) who were exposed to a contagious disease to see if they become sick. Quarantine per se is no longer practiced or generally recommended in NYC given the widespread nature of the disease at this time. However, everyone should practice physical distancing, wear a face covering and stay inside except for critical needs.

Testing:

- At this time, COVID-19 testing is not recommended for people with mild or moderate symptoms and should be reserved for hospitalized patients when testing is needed to make clinical decisions. This will let New Yorkers who are more sick access the care that they need, protect our health care workers and others from infection, and protect people from getting COVID-19 if they don't already have it.
- This recommendation may be subject to change based on testing availability and the course of the COVID-19 outbreak.
- There is no need to transfer a patient to an emergency department for evaluation for mild or moderate illness for testing or supportive care.

Isolating or Placing Together People With CLI or Confirmed COVID-19 in Congregate Facilities:

Facilities where a client with mild illness is already in an individual unit with a private bathroom can remain isolated on-site and have meals and medications delivered by a family member or staff; facilities without capacity to isolate people with mild illness should transfer them to another facility, if available, such as a hotel arranged by the DHS for isolation, by following guidance and algorithm provided by DHS.

- People who have CLI or confirmed COVID-19 should be isolated in a semi-private room (with a bathroom) until **all** the following are true:
    - It has been **at least** seven days since their symptoms started.
    - They never had fever **or** have not had a fever for the prior three days without the use of fever-reducing drugs such as Tylenol or ibuprofen.
    - Their overall illness has improved.
- People with confirmed COVID-19 (that is with a positive test) can be placed together in a small group (two to three people) in an enclosed room with private bathroom.
- People with CLI can be placed together two in a room with a private bathroom. At this stage of the outbreak, with limited COVID-19 testing, patients with CLI are considered to have COVID-19 and can be placed together.
- In situations where a private bathroom is not available, a shared bathroom can be used if proper cleaning occurs after the individual that is ill uses it.
- Do not place anyone with COVID-19 or CLI with a client who is not ill.
- Strongly encourage people with CLI to stay in their room except for necessary medical appointments or for those who must smoke. Provide a face covering to any person with CLI to place on themselves if they must go out to smoke or during transport to a medical appointment.

People at High Risk for Severe illness

People who are at most risk of severe illness are people 50 years of age or older, with highest risk after 65 years of age, and people who have other health conditions including lung disease, moderate to severe asthma, heart disease, a weakened immune system, obesity, diabetes, kidney disease, liver disease, or cancer. People that fit these criteria should be prioritized for accommodations with fewer people, such as private or semi-private spaces with reduced density that allow for maintaining at least 6 feet of distance between clients.

Mental Health Response

Some facilities provide mental health services ranging from full-service, on-site services to evaluation of community clients and referral to off-site providers. A disease outbreak can be stressful for clients, residents, and staff members. It is natural to feel overwhelmed, sad, anxious, and afraid, or to experience other symptoms. Have plans in place for people who regularly receive mental health services, including:

- If a client or resident must be isolated because of CLI or confirmed COVID-19, consider alternative arrangements such as video conferencing for continuity of mental health services.
- Implement procedures to identify and update at least weekly the mental health resources (such as providers, pharmacies) that are available.
- Review and update the following things, as needed:
    - Provider contracts
    - Emergency medical protocols and procedures, including transporting people to inpatient mental health facilities, if necessary

    - Evaluation of clients and residents for other medical needs (see section titled "Rapid Detection and Management of People With CLI or Confirmed COVID-19")
- When transporting a client or resident is necessary, implement procedures to make sure receiving facilities are notified before the transport takes place.

For all clients and staff for whom stress, or other symptoms become overwhelming, NYC Well, a free and confidential mental health support service, can help New Yorkers cope or connect to mental health services.

- NYC Well staff are available 24/7 and can provide brief counseling and referrals to care in over 200 languages.
- For support, call 888-NYC-WELL (888-692-9355), text "WELL" to 65173 or chat online. You can also visit nyc.gov/nycwell and click on their App Library to find apps and online tools to help you manage your health and emotional well-being from home.

Continuity of Operations

During the COVID-19 outbreak, anticipate and plan for staffing challenges.

- Expect that many staff will become sick and will need to stay home until they are no longer a risk to others.
- Expect additional staffing shortages due to changes in child care needs since day care programs and schools are closed.
- Anticipate and plan for shortages as supply chains are affected; pre-order essentials to maintain adequate reserves.
- Partners during routine operations will be affected similarly. Facility operations may need to adjust to challenges as they happen across associated programs, organizations and agencies.

Appendix 1: Physical Distancing to Limit further Spread of COVID-19

Limiting the number of people who congregate and interact with one another within a facility and allowing more physical space between people can help to reduce the spread of COVID-19. Depending on specific facility needs and severity of exposure to people with COVID-19, physical distancing can range from decreasing the number of people who can congregate at a time for different activities to suspending all nonessential activities. To avoid stigmatizing those who are affected, explain to clients and staff why people are separated from others.

The following are examples of physical distancing that can be considered in congregate settings to limit the spread of an infectious respiratory illness:

Sleeping Arrangements	• Increase spacing so beds are at least 6 feet apart, or 3 feet apart and placed head to toe. • If space allows, put fewer residents within a dorm/unit. • Arrange beds so that individuals lay head-to-toe (or toe-to-toe), or use neutral barriers (foot lockers, curtains) to create barriers between beds. • Move residents with symptoms into separate semi-private rooms with closed doors and provide a separate bathroom if possible. • Where only shared rooms are available, it is appropriate to place people with CLI or confirmed COVID-19 together. • Patients without COVID or CLI but at high risk for severe illness (such as older age, people with underlying health conditions) should be prioritized for semi-private rooms either on-site or off-site. • Otherwise, house the ill person in a room with the fewest possible number of other residents. o Avoid housing older adults, people with underlying health conditions, or people with disabilities in the same room as people with COVID-19 or CLI. • In some circumstances, it is better to keep families or other close groups together. If there are accompanying family members (or other personal contacts) of the ill person, it is acceptable to keep them housed together, even if they are not ill, if there previously was an extended opportunity for exposure because they may already be infected. If there is an older family member or a family member with underlying health conditions, consider separating them from the rest of the family members.
Mealtimes	• Stagger mealtimes to reduce crowding in shared eating facilities. • Stagger the schedule for use of common and shared kitchens. • Residents with CLI should have meals delivered to them.
Bathrooms and Bathing	• Create a staggered bathroom schedule to reduce the amount of people using the facilities at the same time.

Recreation and Common Areas	• Avoid using common spaces or create a schedule for using common spaces. This schedule should limit the number of people allowed in the space so that each person can keep at least 6 feet of distance between themselves and others. • Reduce activities that congregate many residents at once such as “house meetings” and only allow activities where physical distancing of at least 6 feet can be maintained.
Transport	• Opt for transporting fewer people per trip and ensure that passengers have more space between one another. Passengers and the driver should wear a face covering. Keep windows open now that it is warmer.
Communication	• Reduce the number of face-to-face meetings and other interactions. • Consider using the following methods of communication: bulletin boards, signs, posters, brochures, emails, phone, or sliding information under someone’s door or mailbox.
Staff Activities	• Eliminate unnecessary assembly of staff, such as large meetings where information can be communicated using other platforms. • Opt for video, web, or audio conference meetings instead of in-person meetings when possible.

Appendix 2: Rooming, Isolation and Monitoring Symptoms of Residents with CLI

Create more space in sleeping arrangements for all residents

- Increase spacing so beds are at least 6 feet apart, or 3 feet apart head to toe.
- Put fewer residents within a dorm or unit. Convert common spaces to sleeping areas to spread people out.
- Arrange beds so that individuals lay head-to-toe (or toe-to-toe) or create barriers between beds using items such as foot lockers, dresser or curtains.
- Avoid housing older adults, people with underlying health conditions or people with disabilities in the same room as people with symptoms.
- Where possible, keep elderly residents and people with behavioral health conditions in familiar surroundings to minimize confusion and behavioral challenges.

Isolate ill residents. Keep those with CLI apart from those who are not ill.
It is critical to develop and implement plans to isolate (separate) residents with CLI from residents without symptoms.

- Clients with mild illness that are in facilities with an individual unit and a private bathroom, can remain isolated on-site and have meals and medications delivered by a family member or staff; facilities without capacity to isolate people with mild illness should transfer them to another facility, if available, such as a hotel arranged by the DHS for isolation.
- People who are at most risk of severe illness are people 50 years of age or older, with highest risk after 65 years of age, and people who have other health conditions including lung disease, moderate to severe asthma, heart disease, a weakened immune system, obesity, diabetes, kidney disease, liver disease, or cancer. People that fit these criteria should be prioritized for accommodations with fewer people, such as private or semi-private spaces with reduced density that allow for maintaining at least 6 feet of distance between clients.
- People with confirmed COVID-19 (that is with a positive test) can be placed together in small group (two to three people) in an enclosed room with a private bathroom.
- People with CLI can be placed together two to a room with a private bathroom. At this stage of the outbreak, with limited COVID-19 testing, patients with CLI are considered to have COVID-19 and can be placed together. Designate a bathroom for people with CLI and a bathroom for those without symptoms. In situations where a private bathroom is not available, a shared bathroom can be used if proper cleaning occurs after the individual that is ill uses it.
- Monitor resident health and move residents immediately into the areas designated for CLI at first sign of illness.
- Residents with CLI should not be leaving their rooms unless necessary for health reasons such as chemotherapy or dialysis.
- Residents with CLI can be removed from isolation (separation) from other residents when **all** of the following are true:
    - It has been **at least** seven days since the resident's symptoms started.
    - The resident never had fever, **or** the resident has not had a fever for the prior three days without use of fever-reducing drugs such as Tylenol or ibuprofen.
    - The resident's overall illness has improved.

Monitor symptoms of residents and when to refer for medical care

- Routine outpatient COVID-19 testing is not needed. If a resident has CLI, the resident should be assumed to have COVID-19.
- Do not transfer a resident to the hospital for evaluation for mild illness for testing or treatment. However, if severe symptoms occur, medical care should be sought as they can signal life-threatening illness. Contact a doctor or nurse at the DHS isolation site if symptoms worsen.
- Residents who are able to self-monitor should monitor their own symptoms. In cases where staff must help residents monitor symptoms, they should do so from 6 feet away.

- Visit nyc.gov/health/coronavirus for the list of risk factors that increase risk for severe illness; residents with CLI or risk factors may require closer monitoring.
- Staff should assess whether residents develop more severe illness and consult a doctor or nurse at the DHS isolation site. Staff should refer residents to the hospital or call **911** if they have any of the following:
    - Trouble breathing
    - Persistent pain or pressure in the chest
    - New confusion or inability to stay awake
    - Bluish lips or face
- This list is not all inclusive. If there are any concerns about a medical emergency, clients should be instructed to contact site staff and consult a medical provider immediately (their doctor or the site nurse) or call **911**. The caller should tell the 911 dispatcher of the client's symptoms.

Appendix 3: Instructions for Staff or Family Members Caring for Individuals With CLI

Interacting with a resident with CLI

- All residents with CLI should be isolated.
- Identify and limit the number of staff or family members interacting with isolated residents.
- Maintain physical distancing as much as possible. Complete caregiver tasks from 6 feet away or more. Leave food or medication outside a door or 6 feet away from the ill person.
- All staff must wear a face covering when clients, residents, or program participants are present or at any time they cannot maintain at least six feet of distance from others. (A face covering is any well-secured paper or cloth that covers your nose and mouth.) You should also use disposable gloves as available when you enter the room where the ill individual is isolated. When you have physical contact with the ill individual (for example, helping to bathroom, bathing, changing clothes) cover your clothing with a gown (washable or disposable), if available. Whenever leaving the bedroom, carefully remove the gloves, face covering and gown. Put the disposable items in a trash can and the washable or reusable items in a plastic bag until ready to be washed, and reusable masks in paper bag or other breathable container. Wash your hands with soap and water for at least 20 seconds. You may also use an alcohol-based hand sanitizer.
- If no gloves or face covering are available, limit close contact with the person and if possible, have the individual cover their mouth with a tissue or cloth. Provide a plastic bag for the direct disposal of the tissue after use.
- Bundle tasks that require close contact together to limit encounters with the ill person.

Help with basic needs

- Make sure you can help the person adhere to instructions for medication and care, and provide support for getting groceries, prescriptions and other personal needs.

Limit the resident with CLI to one room

- Only people who are providing care for the resident with CLI should enter the room or designated area.
- Assign a separate bathroom, if available. If the bathroom is shared, clean and disinfect after each use. Focus on frequently touched surfaces (such as door handles, sinks, paper towel dispenser, hand dryer).

Promote frequent hand washing

- All residents and staff should wash hands often and thoroughly with soap and water for at least 20 seconds. Use an alcohol-based hand sanitizer if soap and water are not available. Do not touch eyes, nose or mouth with unwashed hands. Always wash hands before and after going into the residents' bedrooms.

Avoid sharing common items

- You should not share dishes, drinking glasses, cups, eating utensils, towels, bedding or other personal items. After the person uses these items, you should wash them thoroughly.

Monitor the ill individual's symptoms

- If they are getting sicker, notify someone at the facility or call their health care provider to arrange to have them seen. Make sure the provider is aware the person has or may have COVID-19 so that they can put appropriate infection-control measures in place.

Monitor yourself

- Caregivers and others in close contact with the person should monitor their own health for signs or symptoms of fever, a new cough, new shortness of breath or new sore throat. If that occurs, the caregiver will need to be isolated.

The NYC Health Department may change recommendations as the situation evolves. 4.22.20

Solutions for Today and Tomorrow
HSU

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Homeless Services United Testimony before the NYC Council Committee on General Welfare

Oversight Hearing: (T2020-6093) COVID-19 Relief Package - Private rooms for single adults

April 23rd, 2020

My name is Eric Lee and I'm the director of policy and planning at Homeless Services United. Homeless Services United (HSU) is a coalition representing the mission-driven, homeless service providers in New York City. HSU advocates for expansion of affordable housing and prevention services and for immediate access to safe, decent, emergency and transitional housing, outreach and drop-in services for homeless New Yorkers. Thank you Chair Levin and Members of the General Welfare Committee for allowing us to testify before you today.

HSU strongly supports the creation of additional isolation capacity to enable anyone placed in a congregate or shared shelter space with the opportunity to self-isolate**.** This options should extend not only to those in the DHS shelter system but also to those sheltered in HRA DV shelters in shared units as well as those in DYCD shelters. **In order to best protect the health and safety of our clients and staff, the City must provide opportunities to maintain social distance throughout all residential settings.**

Without universal access to PPE equipment and ample testing for staff and clients, social distancing is the only effective way to stop the spread of COVID-19. **We are heartened that the bill calls for private rooms for individuals, as shared rooms do not go far enough to prevent spreading from asymptomatic carriers.** We have heard disconcerting accounts from street homeless individuals who did not feel safe sharing hotel rooms; some reported being placed with another person with a hacking cough. Our shelter providers were hesitant to send elder and other elevated risk clients to hotels out of concern that they might be placed with someone who could endanger their health.

Hotel capacity should be brought online Citywide to ensure that clients are able to stay in close proximity to their areas of support. Individuals are less likely to accept a hotel room if they do not know where they are going, and it's far away from anything familiar. In terms of logistics, transportation to and from isolation hotels has been a major bottleneck that clogs DHS' COVID hotline, and having hotels nearby the referring program could alleviate this issue.

While we strongly endorse the expansion of additional hotel capacity, significant new funding for staffing is needed to bring these units online in a timely manner. Given the physical layout differences of hotels compared to shelters, securing and regularly checking on people in private rooms takes more person-power than providers currently have, and DHS must provide incentive wages for ALL direct service staff, including security and residential aides in order to staff up these roles. Without adequate funding for personnel, expanding DHS hotel capacity will be take substantially longer.

This challenge staffing hotels belies the larger challenge our non-profit providers face managing essential staff without the proper recognition or resources needed from the City. Shelter providers are seriously struggling with maintaining staffing at their programs as staff become sick or call out for fear of becoming ill**. OMB has committed to incentive pay for direct-service staff lines, but is so narrowly defining it that agencies estimates that only 20% to 40% of their shelter staff would receive an increase.** It's so small a percentage of staff that providers are actually concerned that giving it would

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only further demoralize their workforce. Security and front desk attendants that ascertain that every person entering the shelter is not a health risk to other residents, facilities staff that clean and sterilize the rooms and public spaces, and residential aides who check on the well-being of the clients would not receive an increase. **Homeless services staff are risking their lives, are not given hazard pay, and must do so without adequate supplies of PPE equipment.** Being called "essential staff" rings hollow when it's words not action.

We are grateful to the Council for recognizing these profound challenges and appreciate your support in righting these wrongs. Giving residents the option to have a private room to self-isolate is an important step and, if coupled with appropriate support for the nonprofits who would staff and operate these hotels, is something we believe could protect the health and safety of thousands of New Yorkers as we continue to grapple with this crisis. Thank you for the opportunity to testify.

Testimony of Housing Works
Before
The New York City Council General Welfare Committee

Regarding
Int 1927-2020: COVID-19 Relief Package - Private rooms for single adults
April 23, 2020

Thank you, Chairperson Levin and members of the General Welfare Committee, for this opportunity to present testimony in support of legislation introduced by Chairperson Levin and Speaker Corey Johnson to address the impact of the COVID-19 crisis on some of our most vulnerable neighbors—individual New Yorkers experiencing homelessness, who have no home where they can keep themselves safe and well. My name is Charles King and I am here representing Housing Works—a healing community of people living with and affected by HIV/AIDS. Founded in 1990, we are the largest community-based HIV service organization in the United States and provide a range of integrated services for low-income New Yorkers living with or vulnerable to HIV/AIDS—from housing, to medical and behavioral health care, to job training. Our mission is to end the dual crises of homelessness and AIDS through relentless advocacy, the provision of life saving services, and entrepreneurial business that sustain our efforts.

As many of you know, we established Housing Works in the midst of another deadly epidemic, to meet the needs of homeless New Yorkers with HIV-related immunosuppression, whose lack of safe housing put them at great risk for tuberculosis and other life-threatening infections unavoidable in crowded congregate shelters or while living on the streets. When we created Housing Works in 1990, we were still years away from effective antiretroviral therapy. I am deeply grateful, therefore, that access to safe housing kept many of our early Housing Works clients alive long enough to benefit from those treatments, and that a number of them are still active members of our Housing Works community—as staff members, volunteers and clients.

In 2020 we face another disease for which we as yet have no treatment or prevention, one that is especially deadly for persons vulnerable due to age or underlying health conditions, and one that poses a particular threat to persons in congregate settings such as shelters and jails where it is easily transmitted. Sadly, the COVID-19 and HIV epidemics are similar in another way—like HIV, New York City Department of Health and Mental Hygiene (DOHMH) COVID-19 data shows that certain New Yorkers–especially low-income Hispanic/Latino and Black/African-American community members–are facing a disproportionate burden of disease. These disparities reflect deep-seated racial and ethnic health inequities that must be addressed even, or perhaps especially, while we are in the throes of an unprecedented and frightening public health emergency.

It is simply unacceptable to leave New Yorkers experiencing homelessness at heightened risk of COVID-19 infection and poor health outcomes in congregate shelters or on the streets, and for that reason Housing Works strongly supports Int 1927-2020. There is an urgent and immediate need to provide appropriate emergency housing situations (such as private hotel rooms) for individuals experiencing homelessness, in order to: prevent the spread of COVID-19 among an extremely vulnerable population that includes a high proportion of older persons and persons with underlying chronic health conditions that increase fatality rates when combined with COVID-19; reduce the severity of illness for people in need of a private space to care for themselves but who do not

require hospitalization; and help prevent overcrowding and virus transmission in hospital inpatient units and emergency departments due to a lack of appropriate discharge options.

Housing Works is pleased that the Department of Homeless Services and the City's Office of Emergency Management have taken steps to provide hotel placements for persons experiencing homelessness who have confirmed or presumed COVID-19 infection but do not require hospitalization, and we are grateful to have the opportunity to operate a DHS isolation shelter that provides New Yorkers experiencing homelessness a safe, appropriate room in which to recover from COVID-19, 24-hour medical staff provided in collaboration with Callen-Lorde Community Health Center, three meals a day, and behavioral health care as needed. We are deeply concerned, however, that the City has only 700 such isolation shelter beds available, and that some of these facilities lack the medical and behavioral health staff required to monitor residents to ensure that their condition does not worsen and that other health needs are met. It is critical to ensure that adequate beds are in place to provide care for every person in need of a safe and appropriate place to recover from COVID-19 infection, that each facility providing this care is adequately staffed, including 24-hour medical coverage, and that systems are in place to ensure that all the health needs of residents are addressed, including chronic health conditions and mental health issues.

We also understand that steps have been taken to move some elderly persons out of the congregate homeless shelters into hotel rooms or other appropriate accommodations. However, efforts to date fall far short of real need, and the overwhelming majority of single adults experiencing homelessness have no alternative to crowded shelters or the streets. Homelessness remains at record levels in NYC, with approximately 70,000 persons sleeping in City shelters each night, including over 19,000 single adults in congregate settings where numerous persons sleep in a single room and share bathrooms and other common areas. Thousands more New Yorkers are struggling to survive on the streets or other places not intended for sleeping, while contending with a drastic reduction in access to food, bathrooms, showers, and other resources typically provided by drop-in centers and other settings now closed to them.

We must act immediately to ensure that every single homeless adult—whether in shelter or on the street—has the option of safe private accommodation for the duration of the COVID-19 crisis, and that simple, clear and widely communicated policies and procedures are put in place to rapidly make this housing available. Housing Works operates four Federally Qualified Health Centers (FQHCs) in medically underserved NYC communities, and we stand ready to make referrals for our homeless patients in need of safe spaces. For those who remain in congregate settings, it is critically important that these facilities put in place measures to maximize the ability of residents to practice social distancing, and to quickly identify those with COVID-19 symptoms and those with a known exposure to someone with diagnosed infection.

Finally, as a member of the New York COVID-19 Working Group, a coalition of health and human services providers working together to address the epidemic, we urge the Council to broaden the eligibility for safe spaces beyond persons experiencing homelessness, to any New Yorker living with presumed or diagnosed mild to moderate COVID-19 disease, or whose age or underlying conditions place them at risk of poor COVID-19 health outcomes, who is unable to safely self-isolate at home due to crowded living conditions or the inability to care for themselves. Offering the option to be voluntarily isolated in a supportive environment would provide the affected individual with the support they need while preventing the transmission to their families and loved ones.

We thank the City Council for efforts to address the current COVID-19 crisis and offer you the continued partnership of Housing Works as we work together to mitigate the impact of the epidemic for every New Yorker.

meeting and proposed stay of evictions

I have been practicing Landlord Tenant law for almost 40 years, initially representing Landlords and Tenants but now just for Landlord

What the members of the NYC Council must realize is that not every Tenant is "worthy" of any additional protection or Stay of Eviction just as not every Landlord is evil incarnate. There are consequences to all knee jerk reactions.
This ill advised suggestion by the Speaker is an example.

I myself have had and now have cases where seniors were duped into sharing their apartment by miscreants leading to elder abuse which is unchecked in this City.
Yes the police will not help seniors who are being abused and threatened,

I have an at risk seniors NOW, out of Possession of her apartment, destitute, awaiting an eviction that can not occur.
Do not suggest otherwise as the proof is in what the system will do to help.
OCA, the DOI and our Civil Court administration do not care about them. They are the true victims of our court system every day, thousands of them.

I have cases where occupants of illegal apartments continue to destroy an entire house. Where the occupant is running the water 24/7 causing violations and fines to Owner who is powerless to restore the premises

Dozens of cases where tenants simply do not pay and their EED dates have passed, yet because Warrants can not get submitted or signed the small Landlord is out $10-15000 or more. How can a small owner of 2-5 family dwelling recover from this unconstitutional taking without due process?

In this City we have thousands of professional tenants who search out basement spaces, often with the help of either section 8 cityfeps and other agencies complicit with real estate brokers. They pay one month then nothing.

Nobody is looking out for the small owner who is the backbone of NYC What was the american dream?

It was to scrimp and save and buy a small house so that the rent could pay the mortgage and taxes until such time as that mortgage was paid off
That house was to be the pension for thousands of small owners, many 1st and 2nd generation immigrants

Lip service to diversity means nothing if not helping the base which supports you and this great city.

Not only is any proposed moratorium unconstitutional, I submit it is depraved as it prevents city marshals from even submitting warrant applications where suffering is ongoing. Add to this the injustice that outside of NYC we can get a Judgment and Warrant in days. In NYC it takes two or more months. A Judge already can keep a bad destructive tenant in an apartment a whole year of more AFTER that case is finally won

Not only is any moratorium wrong, I submit that it is morally corrupt under the guise of benevolence

We must open court for processing warrants and address the real issues.

Allow tenants to zoom conference with the court attorney, with the judge and attorneys NOW

Do not apply one broad brush to a wide variety of issues in the name of compassion as such is neither fair nor compassionate.--

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Testimony before the New York City Council Committee on General Welfare
Corey Johnson, Speaker of New York City Council
Stephen Levin, Chair of the Committee on General Welfare
April 23, 2020

My name is Andrea Bowen, Principal of Bowen Public Affairs Consulting. I advocate on policy matters that advance the cause of economic justice. I'm also a transgender woman, and a coordinator of the transgender, gender non-conforming, and non-binary, or TGNCNB, Solutions Coalition, which advocates for community-based economic justice and anti-violence strategies to support TGNCNB New Yorkers. Thank you, Speaker Johnson, Chair Levin, Council members and staff of the Committee on General Welfare, for this hearing, and for the opportunity to speak today.

I have worked alongside colleagues at New York City Anti-Violence Project (which is a client of my firm), and other advocates in the TGNCNB Solutions Coalition, to gather information to inform my testimony for Intro No. 1927. I speak for myself, but informed by my colleagues' perspectives.

Members of the Solutions Coalition have, after close work with shelter residents and others with firsthand experience of our housing and shelter systems, decisively turned to a straightforward position: our City needs to stop warehousing people, and provide secure, private spaces for people to live with dignity. While moving away from warehousing is not an immediate process, and we need to provide safety in shelters and carceral institutions for

vulnerable populations while they still exist, we want to move toward safe, private housing for vulnerable people. We are heartened that this is the core of the approach in Intro. No. 1927.

We approve of private rooms for single adults in the DHS shelter system, as well as single adults experiencing homelessness and who are currently unsheltered. The details of this bill are inherently a harm reduction approach to a broader system whose faults—too close of quarters, and the lack of safety that comes with that—are exposed clearly by COVID-19.

Along with the COVID-19 Working Group, we agree that—quoting a letter of theirs—"individuals with a high risk of exposure or confirmed COVID-19 with mild to moderate disease who are unable to self-isolate at home be offered the option—by New York State or New York City—of safe spaces where they can voluntarily be isolated in a supportive environment." In other words, private housing should be available to all people who cannot safely self-isolate at home.

Beyond this, we welcome Council's broader push throughout this budget season on safe, permanent housing, and urge that we use a major lesson of this crisis—that warehousing is inhumane and puts people at profound risk of infections, violence, and so many other dehumanizing and dangerous conditions—to deeply invest in permanent supportive housing for at risk populations, with supportive housing services geared toward specific populations, including TGNCNB people; people living with various health conditions that make them vulnerable to COVID-19 and other deadly conditions; those who were formerly incarcerated; veterans; survivors of violence, including Intimate Partner Violence; sex workers; etc.

I appreciate the opportunity to go on the record presently and outline this issue and request. You can ask me further questions at andy@bowenpublicaffairs.com.

April 28, 2020

Testimony before the New York City Council
Committee on General Welfare—COVID-19 Relief Package - Private rooms for single adults
Kelly Doran, MD, MHS

I am a practicing emergency physician in NYC and a faculty member in the Departments of Emergency Medicine and Population Health at the NYU School of Medicine, where I study the intersection of homelessness and health. I have been an emergency physician for over ten years and have done work related to homelessness for more than twenty. My experience in both of these settings informs my testimony today. My testimony is on my own behalf. Thank you to Chairman Stephen Levin, and members of the Committee on General Welfare: Council Members Torres, Gibson, Salamanca, Grodenchik, Holden, Reynoso, Lander, and Treyger for the opportunity to discuss this issue.

I am grateful for the attention that City Council has given to this pressing issue, and the efforts to support homeless individuals during the COVID-19 pandemic. The proposed legislation, Int. No. 1927, would require the Department of Homeless Services to provide all single adults in the DHS shelter system as well as single adults experiencing homelessness who are currently unsheltered with the option of a private room for the duration of the COVID-19 pandemic.

I appreciate the large amount of work that the NYC Department of Social Services has done in response to COVID-19, but the enormity of this pandemic requires that we do even more. Along with 502 other frontline health care professionals, I recently signed a letter addressed to Mayor de Blasio, Governor Cuomo, Commissioner Banks and others that expressed significant concerns regarding the thousands of New Yorkers who cannot follow our advice to "just stay home" because they have no home.[1] The proposed legislation takes a step in the right direction toward better protecting New Yorkers experiencing homelessness. I would like to offer some further reflections in support of this legislative effort as well as point out some nuances that may improve the legislation.

First, evidence is increasingly clear that congregate settings including homeless shelters are potential tinderboxes for infection. Obtaining adequate social distancing in congregate shelters—even when attempting to follow official guidance such as keeping beds six feet apart—is challenging, and in my opinion will rarely be adequate to fully prevent spread of infection. Cities that have done universal COVID-19 testing in their shelters have found very high rates of COVID-19 infections. A recent report from the CDC compiled findings from universal shelter testing across several cities. At shelters in which a "cluster" of COVID-19 (defined as 2 or more cases) had been identified, "high proportions of residents and staff members had positive test results for SARS-CoV-2 in Seattle (17% of residents; 17% of staff members), Boston (36%; 30%), and San

[1] https://healthandhousingconsortium.org/wp-content/uploads/2020/04/A-Letter-from-Hospital-Providers-Regarding-COVID-19-and-Homelessness-in-New-York-City-4.15.2020.pdf.

Francisco (66%; 16%)."[2] It should be noted that in several of these shelters, attempts at social distancing and symptomatic screening for COVID-19 (similar to what NYC is doing) was occurring and still these high rates were observed, not just among residents but also among staff. Also of note, the majority of individuals positive for COVID-19 in these studies was asymptomatic, suggesting that any strategy (such as NYC's) centered on screening for symptoms to identify COVID-19 will be inadequate.

Further, due to very limited COVID-19 testing in NYC, the reported number of people experiencing homelessness with test-confirmed COVID-19 is undoubtedly a gross underestimate of the actual number who have been infected. These numbers should not be touted as evidence of effectiveness of NYC's strategies; they more likely simply indicate lack of testing. Even still, it was notable that per Deputy Commissioner Drinkwater's April 21 testimony, 453 of 556 (81.5%) shelter residents known to have COVID-19 were from the single adult shelter system. As the Council knows, single adults represent only 30% of NYC shelter residents (46.5% of all adult shelter residents) and single adult shelters are generally congregate settings whereas family shelters offer more private dwellings. While this is not necessarily evidence of causation, the fact that 81.5% of known sheltered COVID-19 cases are among single individuals, even though such individuals make up the minority of NYC's shelter population, certainly seems concerning regarding the potential danger of congregate shelters.

Second, people who are homeless are particularly vulnerable not only to contracting COVID-19 but also to experiencing severe and potentially deadly illness. People experiencing homelessness have above average rates of many of the same chronic medical conditions, such as chronic lung disease and diabetes, that put people at risk for poor outcomes from COVID-19. Further, we know that the homeless population in NYC has been aging over the past several years.[3] Recent Department of Homeless Services' data shows that 39% of people living on the streets or subways is 55 or older. We know from past research that people experiencing homelessness who are in their 50s are essentially geriatric—they have health profiles that look more similar to people who are not homeless who are in their 70s or 80s.[4] While NYC does not track accurate data on health conditions among people experiencing homelessness, if one were to add the number of people experiencing homelessness who are *either* over the age of 50 or had at least one of the CDC-defined high risk conditions (including very common conditions such as diabetes and obesity) it would add to many thousands of homeless individuals.

In the emergency department I frequently see patients who are homeless and elderly, many of them living on the streets. In the past months since the COVID-19 pandemic hit NYC, I have continued to see unsheltered homeless patients in their 50s and 60s coming into the ED. They are frail beyond their years. I have no good option to offer those who do not have symptoms of COVID-19 because the city has not created a safe option for them (such as hotel rooms that I could refer them to). I ask each one if they would like to go to the intake shelter located just a few blocks from my ED. Almost invariably they say

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[2] https://www.cdc.gov/mmwr/volumes/69/wr/mm6917e1.htm.

[3] https://www.aisp.upenn.edu/aginghomelessness/.

[4] https://journals.plos.org/plosone/article/comments?id=10.1371/journal.pone.0221020.

they do not want to go to the shelter; they have tried it before and have had a wide variety of negative experiences. If there is no reason for me to admit them to the hospital and if they do not have COVID-19 symptoms (in which case I could refer them to one of the isolation hotels), I am left with no option but to discharge them back to the streets or subways. This is a cruel situation during the best of times, but during a pandemic is a striking moral failure of our city's response to homelessness.

The proposed legislation to provide private rooms to single homeless adults is aligned with guidance that I recently co-authored with several leading national experts on homelessness, which may be informative for the Council to review.[5] We wrote (see Figure 1): "Individuals who do not yet have COVID-19 should be moved from congregate shelters or unsheltered locations to private rooms, such as in motels, with appropriate supervision and support services."

Given the scale of such an undertaking to provide hotel rooms for what some groups have estimated to be nearly 30,000 New Yorkers, it may be necessary for the City to prioritize individuals based on vulnerability for movement into private rooms. The CDC provides guidance about who is at higher risk for severe illness specific to COVID-19. City Council and agencies may find this guidance useful.[6] Specific to the homeless population, however, people aged 50 and older should be considered at higher risk (versus 65+) given the research on aging and homelessness previously described. NYC DOHMH recognized this risk for homeless adults over the age of 50 in its most recent guidance for homeless shelters.[7]

While prioritizing *the order* of movement into hotels based on risk is smart, ultimately our responsibility as a City is to protect everyone rather than to ration safety. As an emergency physician, I was thankful that our Mayor and Governor did everything in their power to get more ventilators to NYC, so my colleagues and I did not need to make difficult choices about rationing who gets to live and who does not. Should we not expect similar action so that health and safety is not rationed for homeless New Yorkers?

Another critical factor to consider is what services individuals may need while they are in hotels. City Council and others may also find a recent report (*For the Good of Us All: Addressing the Needs of Our Unhoused Neighbors During the COVID-19 Pandemic*) written by experts at University of California Berkeley School of Public Health useful.[8] Specifically, the report notes: "Placements and staffing should match needs. Most people experiencing homelessness could be rapidly placed into 'low-needs' hotels with little more than a typical hotel staff and food service. However, a significant group of others, particularly the most vulnerable and chronically homeless, will require 'high-needs' staffing and assistance, including nursing and behavioral health staff, among other contracted services. These staffing needs should not slow the housing of other 'low-needs' people experiencing homelessness." I understand that it is challenging but do not

[5] https://deepblue.lib.umich.edu/handle/2027.42/154767.
[6] https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html
[7] https://www1.nyc.gov/assets/doh/downloads/pdf/imm/guidance-for-homeless-shelters-covid19.pdf.
[8] https://publichealth.berkeley.edu/wp-content/uploads/2020/04/For-the-Good-of-Us-All-Report.pdf.

believe it is impossible to provide appropriate support, even for people with serious mental illness and substance use disorders, in a setting with private rooms. Permanent supportive housing residences in NYC do this and may be good models (or perhaps the highest need shelter residents could be moved directly to permanent supportive housing). Of course, placement should respect the wishes of individual clients, assuming they are given good options and those options (including risks and benefits) are clearly explained.

The City Council should also consider with some nuance the different responses needed for different groups of individuals, including those who: 1) currently have COVID-19, 2) have recovered from COVID-19, and 3) have not yet had COVID-19. The last group is likely that which most needs private rooms to be *protected from* COVID-19. People who have current test-confirmed COVID-19 can safely be cohorted together. Indeed, individuals with active COVID-19 infections might be better served in non-shelter congregate settings where they can receive closer monitoring than possible in hotel rooms, such as the facilities created in Boston for people who are homeless and have COVID-19 but who do not require hospitalization.[9]

Ideally, people who have *not* had COVID-19 would be placed in individual rooms in separate hotels from those who do have COVID-19, as some degree of mixing could occur even when people have private rooms (e.g., in shared elevators). Given that we know a large number of people with COVID-19 are presymptomatic and asymptomatic, accurate separation would require widespread testing for COVID-19 (viral PCR) in single adult shelters and for unsheltered people. While DOHMH recommends against routine COVID-19 testing for people not sick enough to require hospitalization, particularly if the proposed legislation passes, conducting more widespread testing may allow for improved triage of individuals to the safest locations for them and preservation of hotel resources for those who most need them. Implications of COVID-19 testing are complex and decisions should involve appropriate health experts.

Knowing what to do for individuals who have had confirmed COVID-19 and are now recovered is also challenging. The WHO suggests that individuals recovered from COVID-19 will have some degree of immunity from future infection but that this may not be guaranteed.[10] Further, as DOHMH has advised, *antibody testing* (distinct from viral PCR) is not yet able to accurately determine immune status.[11] All this to say that robust and continuing conversation with health experts (e.g., DOHMH) as the science evolves is recommended.

The City may find it beneficial to look at what other cities have done to respond in a nuanced fashion to COVID-19 infection and risk among their homeless populations. For example, in Oakland, California, a system has been implemented utilizing two models—

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[9] https://www.bostonglobe.com/2020/04/26/metro/when-covid-19-patients-need-recuperate-home-have-no-home/?event=event25.
[10] https://twitter.com/WHO/status/1254160937805926405/photo/1.
[11] https://www1.nyc.gov/assets/doh/downloads/pdf/han/alert/2020/covid-19-status-of-serologic-testing.pdf.

one for people with COVID-19 and one for individuals not yet infected who they are aiming to proactively protect.[12]

Please also consider referral pathways and transparency when crafting the final legislation. For example, hospital emergency departments see many vulnerable unsheltered homeless individuals who are not "in the DHS system." There should be clear pathways for these individuals to be placed into protective hotel rooms by DHS as well. The criteria and processes for hotel placement should be transparent.

Last, I would like to encourage the Council to consider what happens beyond the pandemic. While hotel rooms to allow for social distancing are necessary now, it would seem a shame for thousands to simply return to shelters or the streets when the pandemic has passed. I hope that the City strives to move people from hotels not back into homelessness but into appropriate housing. Thank you again for the opportunity to testify.

[12] https://mcusercontent.com/d477f3e2e075003c9d2f335a3/files/7a700a11-4a88-4f17-8b85-bc29c0c94669/Alameda_County_Draft_Isolation_Hotel_PPs_manual_v_3_1___04_09_20.pdf