



COMMUNITY
ACTION
TEAM



Innovations
for Youth

For the Good of Us All

Addressing the Needs of Our Unhoused Neighbors During the COVID-19 Pandemic

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Berkeley Public Health

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Terms and Abbreviations

AIDS	acquired immunodeficiency syndrome
CDC	Centers for Disease Control and Prevention
CDPH	California Department of Public Health
COVID-19	coronavirus disease
CSU	California State University
FEMA	Federal Emergency Management Agency
HIV	human immunodeficiency virus
ICU	intensive care unit
MERS	Middle East respiratory syndrome
PEH	people experiencing homelessness
PUI	person under investigation
PPE	personal protective equipment
RT-PCR	reverse transcription polymerase chain reaction
SARS	severe acute respiratory syndrome
SARS-CoV-2	severe acute respiratory syndrome coronavirus 2
SRO	single room occupancy
SUD	substance use disorder
UC	University of California
UN	United Nations
WHO	World Health Organization
YEH	youth experiencing homelessness

Table of Contents

Executive Summary	6
Introduction	
A Clash of Paradigms for Evidence-Based Care	8
Dealing With Staggered Epidemics	9
Contents of Our Report	11
Part I: Background	
Principles for Limiting Novel Coronavirus (SARS-CoV-2) Infection	13
Decreasing the Contact Rate	13
Decreasing the Likelihood of Transmission	14
Protecting Medically Vulnerable Populations	14
Current Literature About SARS-CoV-2 and Its Infectiousness	16
Why Unhoused Individuals are Especially Vulnerable	17
Pre-Pandemic: Contextualizing the Health of PEH	17
COVID-19 and Its Implications	18
The Health of Sheltered and Unsheltered PEH	19
Sheltered Settings	19
Unsheltered Settings	21
Additional Considerations for Specific Populations	22
Families	22
Unaccompanied Minors and Youth	23
Postsecondary Students	24
Part II: Guidelines and Practices	
Existing Guidelines from Public Health Agencies	26
Community Responses to Homelessness and COVID-19	26
Hotels and Single-Occupancy Units	27
PEH in Sheltered Settings	27
PEH in Unsheltered Settings	28

Part III: Recommendations

Limitations of Existing Guidelines	32
Overall Testing Recommendations for PEH	33
Overall Recommendations for Housing of PEH by Infection or Exposure Status	35
Housing Guidelines by Demographic Group of PEH	38
Single Adults in High-Density Shelters	38
People in Unsafe Living Situations/At Risk of Homelessness	38
Families	38
Unaccompanied Minors and Youth	39
Unstably Housed and Homeless Students	40
Guidelines for People Who Choose to Remain in Encampments or Shelter in Their Cars	40
Encampment Residents	40
People Living in Cars	41
Sanitation	41
Recommendations for People With Substance Use Disorders	42
Staffing Recommendations	43
Protecting Staff and Promoting Staff Effectiveness	43
Meeting Increased Demand for Staffing	43
Maximizing Feasibility, Acceptability, and Effectiveness of Recommendations	44
Acknowledgments	46
References	47
Appendices	
Appendix A: Bay Area Responses to Addressing the Needs of PEH	55
Appendix B: Other Community Responses to Addressing the Needs of PEH	61

Executive Summary

As medical practitioners, public health professionals, and social scientists who are members of the UC Berkeley School of Public Health Community Action Team, we are committed to bridging the gap between scientific evidence and the community in an effort to ensure the health and wellbeing of people experiencing homelessness (PEH) during the COVID-19 pandemic.

In our report, based on a review of a wide range of evidence, we summarize the relevant public health principles and knowledge about SARS-CoV-2 and its associated illness, COVID-19. We then highlight the reasons for the greater rates of illness and mortality of PEH before the pandemic. We link these causes to their higher vulnerability to SARS-CoV-2 infection, severe disease and mortality. We then provide an overview of the latest policy developments in the COVID-19 response to homelessness in the San Francisco Bay Area and in six other cities. We conclude with recommendations regarding testing and housing to protect society's most vulnerable people and the broader communities in which they live from preventable morbidity and mortality.

Some of our key conclusions include:

1. The public health paradigm requires that all of us physically distance/shelter in place, practice good hygiene and wear masks. However, it is clear that PEH cannot follow these directives in encampments, on the street, or in large congregate shelters.
2. PEH should be given access to housing and support so they can safely shelter in place, quarantine, or medically isolate. For most individuals this will require low-barrier hotel rooms or single-occupancy units. For others, this will require resources and supports to safely shelter in place in their current housing.
3. Hotels rooms or other forms of single-occupancy units should be employed as prevention to prevent viral spread, not just for quarantine or isolation. Similarly, housing should not depend on test results.
4. Provide hotel rooms with accommodations to make them appropriate for PEH, including safe transportation, storage of personal belongings, accommodations for pets and/or families, trauma-informed protocols, and adopting a low-barrier approach.
5. We recommend expanded testing, not only in shelters, but also to unsheltered PEH. Surveillance testing is urgently needed to guide our policy.
6. Communities' response to COVID-19 must urgently address the needs for all PEH. This response should include families, unaccompanied minors and youth, and post-secondary students, as well as single adults. Similarly, the response should include individuals who are living outside, in tents, in encampments or in cars, as well as people in shelters. It should incorporate adequate access to sanitation and harm reduction principles.

7. To allow PEH to shelter in place and to keep non-violent offenders out of jail and the courts, enforcement of laws that criminalize PEH, such as laws regarding panhandling and sit/lie, as well as property confiscation, ticketing and towing of cars where people are sheltering need to be suspended.
8. Staff caring for PEH are first responders, who should have access to support to be able to perform their job in ways that will keep both them and their clients safe.

Ensuring that all PEH can properly shelter in place will:

- further “flatten the curve”;
- decrease the demand for services from hospitals;
- protect our 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 those who are not infected to resume normal activities with minimal risk of infection when shelter-in-place orders are lifted.

Introduction

The COVID-19 pandemic poses the latest and the most imminent threat to the wellbeing, health, and lives of the most vulnerable and marginalized among us: the elderly, adults, youth, and children who struggle to obtain and maintain consistent shelter, a basic need for their survival and a recognized human right.

As faculty members and students with the University of California, a public university, it is our duty to try to bridge the gap between scientific evidence and the community in order to offer support to our leaders, policymakers and frontline providers. In that spirit, we offer the following evidence-based recommendations for the sheltering and care of people experiencing homelessness in the Bay Area and, we hope, nationally. We are members of the UC Berkeley School of Public Health COVID-19 Community Action Team. We bring to this project not only our expertise in public health (including epidemiology, social epidemiology, infectious disease epidemiology and environmental health) and medicine, but also in anthropology, sociology, and social welfare.

Based on prior evidence-based public health practice and the latest data regarding the novel coronavirus and its resultant disease, COVID-19, one can only conclude that ensuring that all PEH can properly shelter in place will further “flatten the curve,” decrease the demand for services from hospitals, protect our 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 those who are not infected to resume normal activities with minimal risk of infection when shelter-in-place orders are lifted.

“We are all a human chain. We are all connected to each other. I know that sounds like a platitude, but in this case, when it’s a respiratory infection that’s easily transmitted, the health of our city is dependent on having as healthy an environment for everyone as possible.”

*- Dr. Susan Philip
Director of Disease
Prevention and Control,
San Francisco
Department of Public
Health*

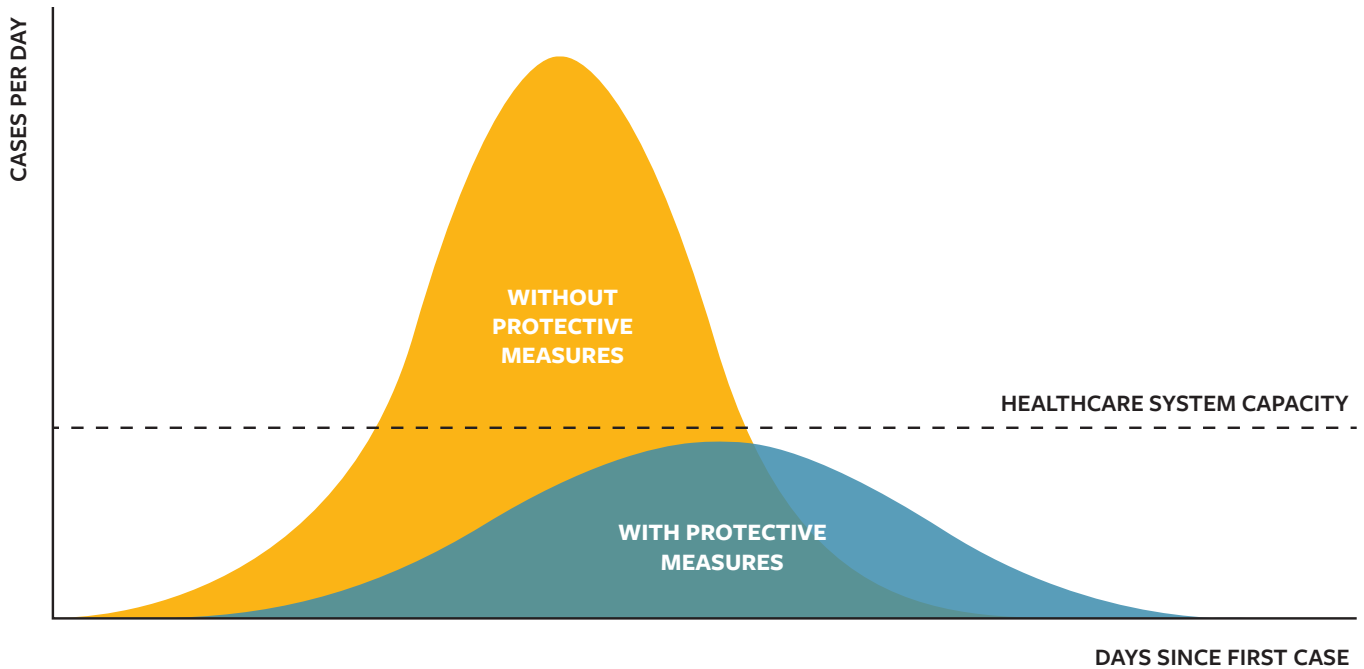
A Clash of Paradigms for Evidence-Based Care

The multiple paradigms informing evidence-based planning for the well-being of people experiencing homelessness present a challenge to coming to a single solution.

The medical paradigm is focused on who is sickest, who is most likely to die, and how we can care for them. In public health and epidemiology, we are focused on who is infectious, who is susceptible, how we can prevent transmission and minimize the number of cases in a population. Housing for the homeless is focused on where people can live in the short term and how to find solutions to where people can live long-term with dignity while factoring in client choice. The current coordinated entry system is focused on housing according to need and scoring. The human rights model upholds that all lives are equally valuable and that shelter, health care and the right to agency in one’s life are all human rights.

When faced with an pandemic and tremendous urgency and fear, against the backdrop of widespread discrimination against our unsheltered neighbors, it is no wonder that it is

BOX INTRO-1 | FLATTENING THE CURVE



SOURCE: CDC

“Flatten the curve” is a phrase used to convey the need to prevent a spike in cases by implementing protective measures. These interventions can include hygiene and safety measures like washing your hands, physical distancing, and regular cleaning of surfaces.

Flattening the curve means hospitals and healthcare systems will be less strained at a given point of time during the pandemic. It also means we will see a reduction in the total number of cases.

challenging to coordinate a rapid and scaled response.

We have endeavored to provide some recommendations with the goals of minimizing morbidity and deaths among PEH and in the broader population, minimizing the length of sheltering in place and maximizing public safety when it is lifted, minimizing the burden on hospitals and on frontline health care providers, and maximizing the wellbeing for PEH after the pandemic, with the hope that they will be able to exit homelessness and be reintegrated in our communities.

Dealing With Staggered Epidemics

In current epicenters of the outbreak such as New York City, Boston, Los Angeles, and the Bay Area, where widespread testing is still limited, it is likely that a significant percentage of the homeless population is already infected and that the numbers of cases among PEH will continue to soar. In such densely populated locations, the CDC has recommended that individuals maintain safe personal hygiene, practice physical distancing, shelter in

BOX INTRO-2 | NAMING CONVENTIONS

In this report and elsewhere, a number of terms are used to refer to the coronavirus disease and the virus that causes it. A brief explanation of these terms is provided here.

Coronaviruses are a family of viruses linked to respiratory disease in animals and humans. A **novel coronavirus** refers to a strain of coronavirus that has not been previously identified in humans.

Severe acute respiratory syndrome coronavirus 2, or **SARS-CoV-2**, is the name of the viral agent responsible for causing coronavirus disease. Before being named SARS-CoV-2 by the International Committee on Taxonomy of Viruses, the pathogen was named **2019-nCoV** — nCoV for novel coronavirus.

Coronavirus disease, or **COVID-19**, is the name of the disease caused by the SARS-CoV-2 pathogen. It was tentatively referred to as **2019-nCoV acute respiratory disease** before the World Health Organization announced the disease's current, official name.

place, and quarantine if symptomatic. These measures are all the more urgent given the absence of contact-tracing, limited testing, and the lack of a vaccine. Unhoused individuals living in congregate settings, encampments, and on the streets do not have the option to follow these recommendations. Rapid measures need to be taken to isolate unhoused individuals who are uninfected or asymptomatic, quarantine and monitor large numbers of individuals with minor or early symptoms to prevent severe illness, and hospitalize those in need of immediate medical attention. For most PEH, the implementation of this plan will require for most the provision of single-occupancy units with private bathrooms, in hotels or dormitories, with basic needs and with basic needs and appropriate staffing and harm reduction strategies.

In the cities with relatively lower rates of infection, the opportunity may still exist to prevent infection of the majority of PEH, through rapid placement into hotels, single-occupancy units, or dormitories. Doing so can prevent the need for field hospitals to manage those who are ill, minimizing hospitalizations and reducing the need for ICU care. We urge these cities to implement proactive measures urgently, as the difference of a few days to a week can be a limiting exposure and save lives.

While the recommendations included in this report have been developed in response to the current COVID-19 crisis, we nevertheless hold out the hope that this large-scale tragedy might not only be mitigated, but also offer the opportunity to fundamentally define a new baseline standard of care and support for PEH in the near future. The health, hygiene, and safety conditions faced by this population are not limited to this pandemic, but, in fact, are routine for PEH. Sustainable access to health care, food, sanitation, and shelter would have drastic implications for the well-being of this community beyond the pandemic.

Contents of Our Report

We have reviewed information and guidance from accepted public health practice; published literature; pre-prints of the newest research; guidelines from the Centers for Disease Control and Prevention, the California Department of Public Health, and local public health agencies; as well as the media and grey literature online. We have spoken to providers and volunteers at the front lines in medical care, public health and in service provision in the Bay Area, especially in Alameda and San Francisco Counties. Given the stresses and challenges of working at the frontlines in a time of high stakes and scarcity, they will not be named.

We have also spoken to a small number of individuals who are currently unstably housed regarding these recommendations. While their input has been influential, it would be overstated to claim that this document was developed in collaboration with PEH.

We have complemented these data with what summaries of the very fluid situations in six additional cities across six states. We hope that our interdisciplinary input from multiple sectors, vantage points, and geographic locations will give our recommendations greater relevance in the navigation of a complex and ever-changing problem, hopefully creating more opportunities to emerge from this crisis with lasting, positive systemic change.

In Part I, we provide critical background information about reducing viral transmission and the health of PEH. We begin by summarizing key public health principles necessary to limit the transmission and spread of SARS-CoV-2. This part also includes some key lessons about viral infectiousness that will be fundamental to later parts. We then introduce the unique conditions that PEH experience that make them particularly susceptible to infection. The bottom line: PEH face many structural and social determinants of health that make them especially vulnerable during the COVID-19 pandemic.

In Part II, we review current efforts by public health agencies and counties across the United States in addressing the needs of sheltered and unsheltered individuals during the pandemic. Our aim is to summarize responses to date, current challenges, and how approaches might need to evolve moving forward.

In Part III, we present a series of evidence-based recommendations to inform action to protect PEH in response to the COVID-19 pandemic. This part includes recommendations regarding testing, housing and shelter, sanitation, staffing, and maximizing the feasibility and acceptability of our proposed interventions.

What next? Our guidelines are focused on the present phase of the pandemic. Many aspects will change, including, we hope, rapid tests, a reliable antibody test, a robust contact tracing system, and a vaccine that provides sustained immunity. However, based on current evidence, it appears that we will need to provide people experiencing homelessness with the resources and supports to shelter in place until all of us, including the most medically vulnerable, no longer need to do so. We hope that this report will not only provide support to jurisdictions in addressing the enormous demands of the present moment, but also seed plans to mindfully prepare for the next phases of the pandemic.

BOX INTRO-3 | NOTE FROM THE AUTHORS

Given that the pandemic presents us with a rapidly evolving situation that indeed changes every 12 hours, we are presenting the most up-to-date data available at the time of release. We believe the overall intent of these recommendations will continue to be a useful guide but acknowledge that the specifics recommended here will need to be changed and adapted to fit new information and local needs.

PART I

Background

Principles for Limiting Novel Coronavirus (SARS-CoV-2) Infection

Until we have an effective vaccine, our best tools to limit coronavirus infections overall and resulting morbidity/illness and mortality/death are to decrease the contact rate (the number of times people are in physical proximity or contact with each other), to decrease the likelihood of transmission of the virus when people do come in contact, and to be particularly vigilant in protecting medically vulnerable populations.

DECREASING THE CONTACT RATE

Decreasing the contact rate between people decreases the likelihood that uninfected people are exposed to people who are infected. Our primary measures for decreasing the contact rate are physical distancing when in public settings, sheltering in place to avoid non-essential contact with others, quarantining people who may have been exposed to prevent transmission should they be infected, and isolation of people who are infected from people who are presumed uninfected. For simplicity, this document will refer to physical distancing and sheltering in place interchangeably to refer to all four of these practices.

Physical distancing decreases the number of new infections and flattens the curve.

Each individual infected with coronavirus overall infects approximately 2.5 new cases.⁴ This number can and has been reduced with physical distancing.⁵⁻⁷ The number of new cases due to a single infected individual is likely much higher in unsheltered populations, due to their medical vulnerability and their inability to reduce their contacts with others in congregate settings or public spaces.

Physical distancing will be most effective if it is implemented universally, not simply by a subset of the population. Over 100 days, physical distancing exclusively by individuals over the age of 60 will only reduce the total number of cases by 21 percent, while physical distancing by all age groups, even with imperfect compliance, can reduce the number of cases by 94 percent.⁷

Physical distancing will be most effective if it is implemented rapidly and lifted slowly.

With physical distancing measures implemented within two weeks of the first case in a population, only 7 percent of the population will be infected; at four weeks, 47 percent of the population will be infected; and if we wait six weeks for intervention, 64 percent of the population will be infected.⁸ Based on limited data with the unsheltered population and the novel coronavirus, these findings underestimate the speed and total proportion of infection in the unsheltered population.

The protection of unhoused people is essential to the long-term effectiveness of the order to shelter in place. While the San Francisco Bay Area was the first region in the United States to implement shelter-in-place orders, the long-term success of this strategy will be decreased if PEH do not receive adequate and timely resources to decrease their contact rate and probability of transmission. This population could become a reservoir for the virus that would enable the virus to spread amongst the entire population after the shelter-in-place order has concluded, which has been previously demonstrated with bacterial infections in unhoused communities.⁹

DECREASING THE LIKELIHOOD OF TRANSMISSION

Decreasing the likelihood of transmission from someone infected to someone uninfected is can be accomplished with (1) hygiene, particularly frequent access to handwashing or hand sanitizer, and (2) barriers, such as cloth masks for everyone who is uninfected or asymptomatic and surgical masks for people who are sick.

PROTECTING MEDICALLY VULNERABLE POPULATIONS

Another tool to decrease mortality due to the pandemic is to do all we can to protect people who are medically vulnerable, primarily by encouraging them to exclusively shelter in place and completely avoid public settings, such as supermarkets. Table I-1 illustrates who is considered medically vulnerable, based primarily on CDC guidelines. We have also included a list of populations who are structurally vulnerable — populations who, through no fault of their own, are unable or face obstacles to sheltering in place.

BOX I-1 | TERMINOLOGY REGARDING DISTANCING MEASURES

Physical distancing means maintaining a distance between people outside of your home or residence. This also means staying away from crowded places, gatherings, and groups. The CDC has recommended physical distancing as a way to reduce transmission of the novel coronavirus for all people, including those who do not have symptoms or may not be considered medically vulnerable.¹⁴

Social distancing is used interchangeably with physical distancing. The WHO publicly announced its preference for the phrase “physical distancing” by stating that maintaining physical distance does not mean having to disconnect socially from friends, family, and loved ones.¹⁴

Shelter in place calls for the restriction of movement for the general population. It includes staying at home as much as possible, leaving only for essential activities, and not hosting or attending gatherings of any size.¹⁵

Quarantine calls for the separation and the restriction of movement of people exposed to a contagious disease to see if they become sick.¹⁴

Isolation calls for the separation and the restriction of movement of people who are sick with a contagious disease away from those who are not sick.¹⁴

TABLE I-1 | DEFINITIONS OF VULNERABLE POPULATIONS

VULNERABLE DUE TO HIGH RISK OF SEVERE ILLNESS	People with chronic lung disease or moderate to severe asthma ^{A, B, C, D}
	People who have serious heart conditions, including hypertension ^{A, B, C}
	People who are immunocompromised, such as those with the following conditions: cancer treatment, smoking, bone marrow or organ transplantation, immune deficiencies, HIV or AIDS, and prolonged use of corticosteroids and other immune-suppressing medications ^{A, B, C}
	People with chronic kidney disease undergoing dialysis ^{A, B, C}
	People with diabetes ^{A, B, C}
	People 65 years and older ^{A, B}
	People with liver disease ^A
	People with severe obesity (body mass index of 40 or higher) ^A
	People who live in a nursing home or long-term care facility ^A
	Pregnant women ^A
	Infants under one year of age ^E
VULNERABLE DUE TO STRUCTURAL CONDITIONS	Pregnant women ^A
	People with disabilities ^A
	People who live in a nursing home or long-term care facility ^A

^A The CDC website considers these groups to be at higher risk for severe illness.¹⁰

^B FEMA lists these groups as examples of those who may benefit from non-congregate medical sheltering, eligible for FEMA Public Assistance reimbursement.¹¹

^C The SF Department of Homelessness and Supportive Housing defines these groups to be at “high risk of COVID-19” and qualifies them for hotel rooms due to underlying conditions.

^D Preliminary findings suggest that asthma may not affect the risk of SARS-CoV-2 infection as much as previously thought.¹²

^E Preliminary findings suggest that young children, particularly infants, are vulnerable to infection.¹³

Current Literature About SARS-CoV-2 and Its Infectiousness

SARS-CoV-2 is highly infectious. Early data suggests a rate of transmission faster than that seen with the original SARS virus. The number of infections generated by a new case of SARS-CoV-2 may be anywhere between 2.43 and 6.49,⁴ versus a range between 2 to 5 for SARS⁶ and less than 1 for MERS.¹⁶

The infectiousness of the virus has been aided by its ability to spread not only from people who are infected, but also via pre-symptomatic spread of the virus up to two days before someone exhibits symptoms as well as asymptomatic spread, spread by individuals who never have symptoms or have only minor symptoms that are not recognized. Approximately 12.6 percent of new cases in Wuhan, China, were infected by sources that were not yet symptomatic.¹⁷ SARS-CoV-2 has been found to spread among persons who do not demonstrate symptoms at all in King County, Washington.¹⁸ Many cases are also unrecognized or not confirmed by testing. A recent seroprevalence study in Santa Clara County estimates the true number of people who have had COVID-19 may be 50 to 85 times higher than the number of cases confirmed through diagnostic testing.¹⁹ These characteristics of the virus further underscore the importance of universal and rigorous implementation of shelter-in-place practices.

Another factor contributing to the infectiousness of the virus is its ability to be transmitted both directly, from one individual to another, and indirectly, through a contaminated environment or surface.

Modes of direct transmission includes direct contact and droplet spread. Direct contact occurs through skin-to-skin contact, such as handshakes. Droplet spread occurs through spray that is produced by talking, sneezing, coughing, and breathing. Droplet spread specifically refers to large, short-range droplets that do not remain in the air for long periods of time. Six feet is often cited as the average range droplets travel from coughing and sneezing. However, other work has suggested that these forms of expiration can propel droplets up to 27 feet.²⁰

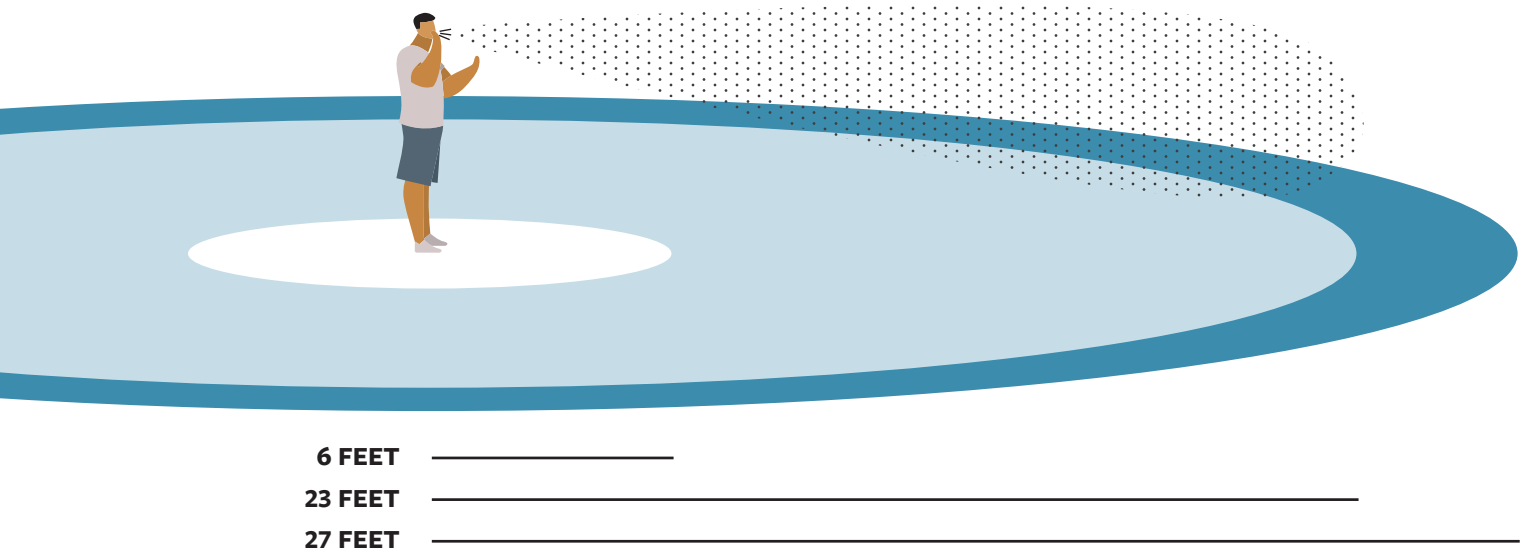
Indirect transmission includes airborne transmission and vehicle-borne transmission.²¹ Airborne transmission occurs when pathogens are carried by dust or evaporated droplets and, due to their small size, remain suspended in air for long periods of time. Vehicles are simply objects that may passively carry an infectious agent, such as contaminated surfaces.

Data have demonstrated that the virus can be transmitted in an aerosolized form, meaning that the virus may transit through the air independently without being bound to a droplet or some other type of particulate matter.²² This expands the physical range of viral transmission from infected hosts significantly.

The virus has been shown to be stable on surfaces, thus facilitating indirect transmission.²³ Should the virus land on a surface, it can survive for hours to days and infect those who come into contact with it. Finally, some studies have suggested possible fecal-oral spread, but this has not yet been widely confirmed.²⁴

FIGURE I-1 | DISTANCE OF A SNEEZE

Public health agencies often cite six feet as the minimum distance individuals should maintain between themselves and others. However, new research suggests that droplets may travel as far as 23 to 27 feet after sneezing or coughing.²⁰



Why Unhoused Individuals are Especially Vulnerable

PRE-PANDEMIC: CONTEXTUALIZING THE HEALTH OF PEH

Housing is an especially impactful social determinant of health. Homelessness has been identified as a driving factor for poor health and mortality independent of other social determinants or other illnesses.²⁵ In addition to the lack of housing, discrimination and stigma against PEH is another important social determinant of health contributing to their worse physical and psychosocial wellbeing.^{26, 27}

Social determinants of health are the conditions in which people are born, grow, live, work, and age — factors such as income, wealth, education, housing, food security, and the surrounding environment.^{28, 29} In addition to being fundamental drivers of health, these determinants also impact health regardless of individual risk behaviors.

Structural racism, the social and historical forces that have led to and maintain poor health by race, contributes both to the disproportionate representation of Blacks in the population of PEH and the particularly poor health of PEH who are Black.³⁰ This includes historical and ongoing practices of discrimination within housing markets, urban policy, and planning more widely.

The effects are striking in the Bay Area, as they are nationwide. In San Francisco, a city that

is 5 percent Black,³¹ 37 percent of PEH are Black.³² In Berkeley, which is 8 percent Black, 57 percent of PEH are Black.³³ In Oakland, which is 24 percent Black, 70 percent of PEH are Black.³⁴

PEH tend to be older, sicker, sicker at younger ages, and at a significantly higher risk of mortality from diseases that also affect the US population at large, including cardiovascular disease and cancer. These observations have led experts to assert that PEH experience “accelerated aging.” Over half of Bay Area PEH are over 50 years of age. They have higher rates of smoking, alcohol, and other drug use;³⁵ cardiovascular and lung diseases;³⁶ and higher rates of immune function-altering conditions such as HIV and other chronic conditions.³⁷ It should be noted that the health impacts of homelessness are not confined to adults: increased mortality has been well-documented amongst youth aged 15 to 24 experiencing homelessness, as well as for children in families experiencing homelessness.³⁸

Most relevant to this report is the ample evidence that PEH are disproportionately impacted by infectious disease outbreaks, including HIV/AIDS and hepatitis A. As the HIV/AIDS epidemic unfolded, PEH were found to be at much higher risk for infection.³⁷ This trend repeated itself in 2016 to 2018 with the hepatitis A outbreak in San Diego, during which PEH had markedly higher odds of infection, hospitalization, and death when compared to housed persons.³⁹ PEH also have a higher rate of tuberculosis, at around 40 times that of the US population.⁴⁰ PEH with SUDs represent another group at risk for infectious diseases. PEH are disproportionately impacted by substance use disorders relative to the general population. Thirty percent of PEH in Alameda County report having challenges with drug or alcohol use.⁴¹ In San Francisco, that number is 42 percent.³² The sharing of injection and smoking equipment can transmit hepatitis C and HIV. Furthermore, people with SUDs have been found to have depressed immune function which increases their susceptibility to disease.⁴²

COVID-19 AND ITS IMPLICATIONS

The social determinants of health that placed PEH at risk of greater illness and death before the pandemic also render them particularly vulnerable to coronavirus infection, severe disease, and mortality secondary to COVID-19.^{5, 43, 44} Early data have clearly shown that COVID-19 is having a devastating and disproportionate impact on Black communities and other communities of color, who are, as noted above, disproportionately represented among PEH.⁴⁵ The increasingly aging population of PEH are rendered more vulnerable to symptomatic infection, severe illness, and death due to their age.^{46, 47} Finally, the higher likelihood that PEH fall into one of the medically vulnerable categories render them more likely to have poor outcomes.⁴⁸⁻⁵¹

Although sparse, data regarding the infection rates and speed of transmission of the coronavirus infection in homeless populations are alarming. In New York City, the epicenter of the US outbreak, 537 PEH had tested positive for COVID-19 and 33 had died as of April 16.⁵² These numbers are likely underestimates due to a lack of testing. Nearly all of New York City’s homeless are sheltered due to the state’s right to shelter and therefore nearly all cases and deaths have been among sheltered individuals. The hospitalization rates of PEH in New York City who tested positive are between 30 to 40 percent.⁵³ In Seattle, 27 PEH have tested positive across 12 homeless shelters, including a newly opened shelter designed specifically to meet CDC guidelines.⁵⁴ Some of these shelters implemented 14-

day lockdowns after guests tested positive. After discovering a cluster of COVID-19 cases at a shelter in Boston, the Department of Public Health tested all 397 residents of a single shelter and found that 146 people, or 37 percent of all residents, had been infected.⁵⁵ Similar shelter-wide testing occurred in San Francisco's largest shelter after a cluster of positive cases arose. After testing 144 residents, officials found five positive cases. Two days later, 70 of 144 tested positive. Five days after the first screening, 92 shelter guests and 10 staff had tested positive; of 181 tested guests and staff, 56 percent were positive.⁵⁶

In addition, current data and models specific to coronavirus infection in PEH suggest that PEH are more likely to become infected, require hospitalization, require ICU care, and die. According to a study by researchers at the University of Pennsylvania, UCLA, and Boston University, PEH are projected to be 2 to 3 times more likely to require hospitalization, 2 to 4 times more likely to require critical care in an ICU, and twice as likely to die.⁵⁷ The speed and intensity with which the infection travels among PEH and the severity of disease in the population make it particularly urgent to deploy a rapid and large-scale response. Incremental solutions will be unsuccessful and will place PEH and the surrounding community in harm's way. If not contained, the increased disease severity in PEH has the potential to further strain our medical system through higher rates of hospitalization and ICU bed availability, availability of resources like PPE and ventilators, and healthcare worker burden.

PEH cannot reduce their contact rate in encampments, on the street, in large congregate shelters, or if unstably housed under conditions where they cannot physically distance, such as when trading sex for a place to stay or for other basic needs. In addition, PEH cannot reduce their transmission probability because they do not have access to necessary resources, such as face masks or facilities to wash their hands properly and frequently.

The following sections review the barriers to applying our primary tools, decreased contacts and protection from transmission, to combat disease spread to PEH as well as the increased medical and structural vulnerabilities they face.

The Health of Sheltered and Unsheltered PEH

COVID-19 presents unique risks to PEH who live in congregate shelters and those who remain unsheltered in public space.

SHELTERED SETTINGS

LARGE CONGREGATE SHELTERS: Residents of large congregate shelters cannot apply our primary tools to protect themselves and decrease overall viral transmission because they cannot physically distance. The figures on the next page illustrate this challenge. The first is from MSC South in San Francisco, a large congregate shelter which experienced a rapid outbreak of COVID-19. This layout is typical of most San Francisco shelters. The second is from a new shelter space in San Francisco that was planned to shelter PEH during COVID-19, based directly on CDC recommended guidelines. Both present serious dangers to COVID-19 containment.

With beds bunked, spaced two to three feet apart, and with up to 200 people on a single open floor, a typical shelter represents a high-risk setting for the viral spread of COVID-19.



FIGURES I-2 AND I-3 | LARGE CONGREGATE SHELTER SETTINGS

On the left, a photo of MSC South, site of San Francisco’s first COVID-19 shelter outbreak. On the right, a photo of Moscone Center West, a conference center room in San Francisco designed to meet CDC shelter guidelines to de-intensify existing shelters in the city.

However, even the COVID-19 improved shelter photographed at a San Francisco convention center, which reflects similar designs in Los Angeles, Seattle, San Diego, and elsewhere, presents serious risks of COVID-19 transmission.

As noted in earlier sections, SARS-CoV-2 can be transmitted through surfaces and respiratory droplets, with recent studies further suggesting possible aerosol and fecal-oral routes. The virus is viable on various surfaces for hours to days and respiratory droplets may travel up to 27 feet during coughs and sneezes, which may remain in the air for over three hours.²³ Even if beds are placed the recommended six feet apart, they are still within range of heavy droplets emitted through coughs and sneezes. In addition, as people inevitably get off of their bed or mat to access bathrooms or leave for a walk, they would instantly be within one to four feet of other people, making physical distancing impossible even in “decompressed” congregate settings. Shared bathrooms also present risks of viral spread by increasing the number of shared surfaces PEH are required to touch during daily routines. Masks are increasingly being provided, but require 24-hour compliance in such close quarters. Few, if any, other populations are being asked to wear a mask round the clock, a directive which is likely neither feasible nor acceptable.

“I was extremely nervous in the shelter once the city started to shut down. Every cough would set me off. Beds are two feet apart and there’s no place safe. You’re just hoping for the best.”

- Shelter resident at MSC South before the outbreak

Although screening for symptoms of COVID-19 or temperature checks in many congregate shelters have been implemented according to CDC guidelines, such screening cannot detect individuals who may be asymptotically or pre-symptomatically infected. Even with screening implemented, the shelters in Boston and San Francisco experienced outbreaks where the majority of positive cases were asymptomatic.⁵⁵ Even should universal testing be implemented to screen people in shelters, the low sensitivity of the test translates to missing 10 to 40 percent of those who are actually positive at any one time, leaving many undetected individuals able to unknowingly transmit the virus.

OTHER CONGREGATE SETTINGS: Congregate settings are not all the same. Some smaller congregate settings or transitional housing census have a combination of a stable census or semi-privacy, but may be limited in their safety by a shared kitchen or bathroom. These likely require different measures than large congregate settings to keep residents safe.

UNSHELTERED SETTINGS

Unsheltered PEH also face enormous challenges to reducing contacts and maintaining personal hygiene. It is well documented that PEH already experience negative health outcomes due to poor access to sanitation and hygiene facilities. Many PEH do not have the level of access to water and toilets that is required by international standards for refugee camps, despite the fact that the State of California officially recognized adequate access to water and sanitation as a basic human right in Assembly Bill 685.⁵⁹ Reports carried out in Berkeley, Oakland, Sacramento,⁶⁰ and Los Angeles⁶¹ have documented a general lack of public restrooms, particularly in areas that host large homeless populations. Of the facilities that do exist, many do not offer 24-hour access, are out of order, and/or are not sufficiently maintained or stocked with necessary supplies such as soap, toilet paper, and paper towels so that they can be used safely. Because many PEH live with chronic health problems that can limit mobility or cause bowel urgency, the inability to travel long distances to reach a toilet can exacerbate these barriers to access.⁶² As a result, PEH are often forced to defecate and urinate outdoors and may be unable to wash their hands and clean their bodies afterwards.

Such conditions facilitate the spread of infectious diseases. Insufficient access to hygiene and sanitation facilities contributed to the hepatitis A outbreak in San Diego between 2016 and 2018 referenced earlier.⁶³ The same conditions increase the risk of spread of COVID-19. The pre-existing lack of restroom access for unsheltered PEH has been further exacerbated by closures in the wake of COVID-19 shelter-in-place orders. Some public restrooms that previously served large segments of the homeless population, such as restrooms in public libraries or on college campuses, are now closed. Although many private businesses enforce customer-only policies for restroom access, they nonetheless provided PEH with a potential restroom access an important source of sanitation facilities that are no longer available. As such, the few remaining available public restrooms are being utilized with much greater intensity than before, increasing the need for regular cleaning, maintenance, and restocking. Given the virulence of COVID-19 and its persistence on inanimate surfaces, it is clear that these shared facilities could actually become sources of exposure if not properly maintained, rather than preventing disease.

BOX I-2 | SHELTERED AND UNSHELTERED PEH

People experiencing homelessness are broadly categorized as “sheltered” or “unsheltered” by the Department of Housing and Urban Development.

An individual or family is considered **unsheltered** if their primary nighttime residence is “a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings.” This includes cars, parks, tents, abandoned buildings, buses or train stations, airports, or camping grounds.

An individual or family is considered **sheltered** if they live in “a supervised publicly or privately operated shelter designated to provide temporary living arrangement.” This includes congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low-income individuals.

Other pressing challenges for PEH in encampments and on the street include the lack of food, drinking water, and other living necessities such as clothes, harm reduction kits, and medical supplies. Most PEH residing on the streets do not have access to masks or gloves.

Furthermore, many charitable organizations have halted operations and facilities such as soup kitchens and recycling centers have closed as a consequence of shelter-in-place protocols, which prevents PEH from earning income or utilizing services that they have in the past. PEH also now have restricted access to indoor public spaces such as libraries and cafes, where they may have obtained resources or fulfilled their basic needs. Unsheltered PEH may now have to spend more time and cover more distance travelling to meet these same needs, thereby coming in contact with more people than if they could shelter in place.

“Once the city shut down, things have been much harder. There’s no library or cafes to go in during the rains. It’s impossible to charge your phone. Everyone’s real tense. It’s just like we’re being told to stay at home, but when you don’t have one, how can you?”

- Tenderloin homeless resident

There are also concerns that unsheltered PEH may avoid seeking medical attention or testing when symptoms arise for a number of reasons. Compared to the general population, PEH may be less informed about the symptoms and dangers of COVID-19, how it is transmitted, and how to prevent its spread due to their lack of access to media and to accurate information. Studies conducted before the COVID-19 pandemic found that counties’ practices of confiscating tents and property lead some to avoid visiting clinics or hospitals.^{64, 65} Those experiencing mild symptoms may decide to ignore the symptoms to avoid testing and potential quarantine, particularly if they have jobs, if quarantine settings are perceived as overly restrictive, or if they fear losing the companionship of their partners or pets or access to their property.

Additional Considerations for Specific Populations

FAMILIES

Families experiencing housing instability face enormous obstacles to sheltering in place. In addition, they experience disparities in both structural and medical vulnerabilities to coronavirus infection and its complications.

Given the lack of an adequate stock of affordable housing, shelter spaces for families were already insufficient to meet baseline needs.⁶⁶⁻⁶⁸ Some shelters are now closing to new families under shelter-in-place orders. In addition, families often do not qualify for programs to house PEH in hotels or single-occupancy units. Thus, unstably housed and homeless families continue to have little choice but to take refuge with other families (termed “doubling up”), in a car, or occasionally, outside. Families increase their risk of exposure at the time of doubling up, particularly to asymptomatic infection which is particularly common in children.^{13, 47, 69} Adults in low-income families are less likely to be working remotely during shelter-in-place orders and are more likely to have jobs — custodial, in-home aides, restaurants, day labor — that place them at risk of infection.⁷⁰ Families are thus exposed to increased risk from the adults who are working outside of the home, often relying on public transportation and without sufficient PPE to protect themselves from transmission. Finally, limited shared space, especially bathrooms, for several families in a single-family home may contribute to increased transmission in the home.

Families living in cars cannot distance themselves physically from others. They must use public restrooms and find meals in public places. Families sleeping in their car also struggle with adequate hygiene necessary to stay safe and healthy, including difficulty with proper hand washing before and after eating, and using the bathroom. Families with children in diapers face enormous obstacles to proper hygiene.

Similarly, neither families who are doubled-up nor families in cars have the ability to quarantine family members who become sick, thus increasing the risk of transmission to the whole family and to members of the larger community with whom they are in contact.

Families experiencing homelessness face significant structural vulnerabilities, including pregnancy, domestic violence, or child abuse. Parents are navigating obstacles due to poverty, acute financial strain or job loss, lack of social support, decreased access to services, along with higher rates of mental and physical illness.⁷¹ With schools and childcare centers closed and limited primary care medical visits, unstably housed children have lost their primary place of stability and consistency, and contact with other adults who can monitor their wellbeing. Schools are often a site from which children receive a number of school-based services to support their learning, their nutrition, and their mental health.⁷¹ Children who are homeless now have decreased access to distance or virtual learning opportunities from either their school or outside school resources, which risks further worsening the achievement gap that homeless children experience relative to stably housed peers living in poverty.⁷² In addition, many children are struggling with worsening emotional and behavioral problems. These challenges compound the already higher level of stress that parents and children are feeling.⁷³ These sustained levels of stress may increase the risk for infection in family members and for violence in the home.

Finally, parents in families experiencing homelessness worry about who will take care of their children if they, the parents, become ill. These same parents are more likely to be medically vulnerable which increases their risk of severe illness or death if infected.

UNACCOMPANIED MINORS AND YOUTH

Unaccompanied minors and youth experiencing homelessness, whom we will refer to collectively here as YEH, are not able to shelter in place or decrease transmission in case of contact with someone infected due to factors beyond their control. Like other PEH, they are more likely than their sheltered peers to experience structural or medical vulnerabilities that increase their risk of being infected with SARS-CoV-2 and their risk of becoming severely ill if infected. Providers in the Bay Area were already reporting a steep rise in youth seeking services prior to the imposition of shelter-in-place orders.

Youth preferences for where they spend the night differ from adult preferences. More youth are unsheltered or couch surfing relative to adults and far fewer are in shelters. Nevertheless, many of the obstacles to preventing infection described for other groups of PEH above apply to YEH. We will describe additional obstacles that apply to YEH here in those three types of settings.

Many youth are unsheltered. National Point-in-Time data from 2019 found that approximately 50 percent of unaccompanied youth experiencing homelessness were unsheltered.⁷⁴ This number is likely an undercount given the particular challenges to counting unsheltered YEH.⁷⁵ Like adults in encampments, unsheltered YEH face barriers to preventing transmission due to lack of access to sanitation. However, youth are more likely to stay in smaller groups, which is protective. Youth's risk of infection is increased by their tendency to have to frequently change where they are sleeping, to be intermittently unsheltered, and to change with whom they are sheltering. The risk to YEH of becoming infected and transmitting infection to their peers or to others is likely high. The lack of

“Sometimes we go to the storage place where our stuff is so my kids can change their clothes. But I don’t want to go there too much [because of a fear of getting sick]. I take them to a public bathroom to wash their hands and faces, but I’m so scared that they are going to get sick there from coronavirus. We need a place to stay but we can’t afford anything.”

- A mother sleeping in her car with her children

surveillance data hampers our ability to make estimates as to how high.

Many youth couch surf — that is, move from one home to another for survival. This may include staying with a family member, friend, or acquaintance for a few days or trading sex for a place to sleep. Among YEH, minors and youth of color are disproportionately likely to couch surf. Couch surfing increases the number of contacts that an individual has as well as the number of households to which they might carry an infection if they are infected. Finally, families who may have taken in an unsheltered youth in order to provide them a safer place to stay in the midst of this crisis are likely to be facing their own financial strain and may not be able to sustainably keep them housed.

Youth who rely on shelters face different challenges than unsheltered youth or couch-surfing youth. Shelters for youth also often differ from shelters for adults. Shelters and programs for YEH are far more scarce than shelters and programs for homeless adults. Programs for youth are more likely to have shut their doors due to limitations in resources and training to keep both staff and youth safe. Although many shelters for youth are congregate in nature and pose the potential risks described earlier, they are often small with a more consistent census. They can thus be more easily adapted to meet shelter-in-place protocols with adequate resources and measures, thereby offering youth the consistent relationships that will keep them stable. Many of these shelters were only open 12 hours per day, closed during the day and offered limited meals. Shelters face enormous challenges to being equipped, funded, and staffed to provide space and support as well as three meals per day, seven days per week.

“The way we would use a hotel or SRO for an adult is really different from how we’d use it for youth. Youth still need staff on site.”

*- Aisha Mays
Dreamcatcher and
Roots Clinic*

In addition to facing challenges to limiting their risk of infection, YEH, like other PEH, are more likely than their peers to be medically vulnerable. In particular, YEH are more likely than their peers to have asthma and other chronic illnesses. In addition, LGBTQ youth, particularly LGBTQ youth of color, are disproportionately HIV-infected and so are more vulnerable to infection.³⁷

POSTSECONDARY STUDENTS

Many postsecondary students are already experiencing homelessness.^{74, 76, 77} California’s students have some of the highest rates of homelessness, unstable housing, and food insecurity in the country. Locally, 20 percent of Bay Area community college students experienced homelessness in the previous year, making the Bay Area the region with the second highest rates of housing instability among community college students in the state.⁷⁸ Across the state, 5 percent of UC students, 11 percent of CSU students, and 20 percent of community college students have experienced homelessness.⁷⁹ Nationally, 9 percent of university students and 12 percent of community college students experienced homelessness.⁸⁰

Many more students face an increased risk of becoming unhoused or unsheltered during this pandemic. Like other PEH, postsecondary students experiencing homelessness face numerous barriers to following shelter-in-place and physical distancing guidelines and therefore are at risk for infection and transmitting the virus.

Youth living on campus may not be able to return to a family home after living in an on-campus facility: some students are unaccompanied minors, have exited the foster care

system, are coming from unsafe or abusive home environments, would pose a substantial financial burden for their families, cannot afford to travel distances, or rely on mass transit which are unsafe during the pandemic or which may be expensive to access for low-income students. For students trying to maintain their grades and coursework, being displaced to a location without accessible and dependable internet and working space is an added burden. For these reasons, some postsecondary students are at an increased risk of becoming unhoused or unsheltered when on-campus dormitories close.

Loss of income is another factor that puts students at risk of becoming unhoused. Reduced wages, food insecurity, reliance on congregate shelters, couch surfing, or living in vehicles compromises their ability to practice safe physical distancing and shelter-in-place guidelines.

Currently, the UC system has declared it will keep some on-campus housing and dining options available for students who were residing in dormitories prior to campus shutdowns.⁸¹ California's community colleges have few programs to support students with unstable housing and are less likely to provide prepared meals, food pantries, or emergency funds.⁷⁸ Community colleges do not offer dormitory housing.

For these reasons, students may need additional housing resources for the remainder of the spring semester and for as long as the pandemic continues. These needs have increased in urgency given the unique conditions that are increasing homelessness among at-risk postsecondary students, in addition to the students who are already unhoused.

“We had more students apply for the rental assistance program within a 24-hour time frame than we did in an entire month — so that just gives you a sense of the scale of students in need. ... There’s a lot of concerns around the conversation around wage justice. So many students who have both on and off campus jobs have either had a total loss of employment or a serious reduction of hours so there’s an inability to pay for food, pay for rent.”

*- Kiyoko Thomas, MSW
UC Berkeley
Basic Needs Center*

PART II

Guidelines and Practices

Existing Guidelines from Public Health Agencies

The CDC has provided guidelines for counties addressing the needs of sheltered⁸² and unsheltered⁸³ individuals during the pandemic. The California Department of Public Health (CDPH) has also provided guidelines.⁸⁴

The primary strategic approach recommended by the CDPH is to focus on intensive infection prevention by providing single occupancy housing, prioritizing those most likely to develop severe complications from COVID-19. If resources permit, the CDPH recommends expanding categories of eligibility.

For sheltered PEH, CDC and CDPH guidelines recommend decreasing the density of congregate shelters, which may require creating auxiliary spaces to sustain the number of beds. They also recommend frequent disinfection and daily temperature checks and screening of guests for symptoms.

According to the CDC and CDPH, unless individual housing units, such as hotel rooms and single-occupancy units, are available, communities should not be clearing encampments and dispersing people throughout the community. If a community is unable to provide hotel rooms or single-occupancy units to encampment dwellers and a client is not suspected of being infected, then communities should provide outreach services, such as screening, food, and hygiene services, and ensure that recommended physical distancing is feasible.

Given the extent of the crisis, the effective implementation of federal and state guidelines requires substituting existing mechanisms for prioritization of PEH into housing, like coordinated entry, for mechanisms based on public health guidelines.

Community Responses to Homelessness and COVID-19

Many cities across the United States have made efforts to address the needs of PEH in the face of this crisis, employing strategies to minimize disease transmission. We summarize these efforts in this section. Although we have frequently updated our findings, they may be out of date by the time this report is released. Given the lack of data and the numbers of cities served, and the lack of easily available public data about policy decisions, our picture of responses is limited.

Our emphasis is on the Bay Area with attention to other cities' responses. A more detailed

description of the communities discussed is included in Appendices A and B. Table II-1 at the end of this section includes key components of CDC and CDPH recommendations in comparison to the current policies of San Francisco, Berkeley, Oakland, and San Jose. In some cases, CDPH guidelines go beyond CDC guidelines and the table reflects these more robust guidelines. Again, we note that this is a picture in time of a very fluid situation.

HOTELS AND SINGLE-OCCUPANCY UNITS

Recognizing that high-density congregate settings may be leading to increased transmission, as now being seen in San Francisco, New York, and Boston, cities have made efforts to acquire individual units for PEH, such as hotel rooms, recreational vehicles, and FEMA trailers. The vast majority of these rooms are for COVID-19 patients who would otherwise be unable to self-quarantine. This use of hotels and single-occupancy units for containment and recovery is proving successful in allowing infectious people who would otherwise be discharged to streets and congregate settings to safely recover in private settings. This addresses the health needs of the infected individual and decreases the transmission of the virus.

A growing number of states and counties are also slowly beginning to house people in individual units as a preventative measure. Thousands of PEH have been moved into hotels in a number of communities, including New York, New Orleans, Los Angeles and in Boston. The state of California has announced funding for 15,000 hotel rooms. However, the use of hotels and single-occupancy units as a preventative measure is currently limited to medically vulnerable individuals.

Yet, public health evidence outlined earlier in this report strongly suggests that PEH are all especially vulnerable to contracting the virus and could therefore all be considered high risk. Moreover, due to the weathering effects and accelerated aging described previously, PEH are likely at increased risk for severe illness at a younger age than housed individuals, suggesting the need for a lower age cut-off as reflected in CDPH guidelines. The slower progress in some areas has largely been attributed to logistical barriers, social stigma, ineffective outreach, and lack of compliance from hotels.

In sum, under the current plans in most cities, most PEH will not be able to access hotel rooms or individual units until they contract COVID-19, if at all. In California, the San Francisco's Board of Supervisors unanimously passed legislation for a preventative approach designed to move most PEH into hotel rooms before becoming sick, but it has yet to be enacted by the Mayor.⁸⁵ Similarly, the Oakland City Council passed a resolution to "acquire buildings, facilities, and supplies for the provision of aid and housing to homeless residents," that has not been enacted by the City Administrator.⁸⁶

PEH IN SHELTERED SETTINGS

Most cities are trying to meet CDC guidelines in existing shelters by decreasing shelter density, slowing or stopping shelter intake, and placing beds three to six feet apart. Since guidelines have been changed, shelters are gradually placing beds further apart and transforming from overnight to 24-hour shelters to allow residents to shelter during the day. Such protective measures are essential for PEH in congregate shelters. Use of masks is also increasing.

Cities such as Los Angeles are opening up new shelters that comply with minimal CDC guidelines to bring people currently residing outside into congregate shelters. Other cities, including Seattle and Chicago, are opening up additional shelters to disperse residents from existing shelters to better meet CDC guidelines. However, they are not expanding shelters to house currently unsheltered PEH. Other cities, such as San Francisco, have decided against opening up any new congregate shelters due to the risk of viral spread in these spaces, and have instead opted to de-intensify shelters by removing large portions of high-risk individuals into hotels.

There are also varied policies on shelter regulations. Seattle and San Francisco are no longer accepting new guests into shelters. This will allow them to de-intensify their shelters to better meet CDC guidelines of physical distancing and hygiene. However, it is also resulting in a growing proportion of unsheltered people in each city. Furthermore, hospitals and jails are reporting that they are now unable to discharge non-COVID-19 patients to shelters and are now discharging them to the streets.

Some shelters continue to allow guests to come and go as they please, wherein many are outside of the facility for most of the day. While such a policy encourages people who may otherwise remain on the street to stay in shelters where they can receive services and have symptoms monitored, the coming and going of guests increases the chances of viral spread. Other shelters are allowing residents only one hour outside each day, though many are not well equipped with amenities to adequately provide 24-hour accommodations, such as spaces for recreation and entertainment. In San Francisco and other cities in the Bay Area, this has contributed to some people leaving the shelters altogether, which again results in a growing number of unsheltered people in each city.

The response to shelter guests testing positive has also varied. In Seattle and Los Angeles some shelters have implemented 14-day lockdowns preventing entry and exit of all guests and staff from specific floors or entire shelters. After the outbreak in San Francisco's largest shelter, all residents were moved into differentiated hotels: one for those who tested positive and another for those who tested negative.

PEH IN UNSHELTERED SETTINGS

For PEH who are unsheltered, some cities have complied with CDC guidelines of halting tent confiscation and encampment evictions by enacting official, written moratoriums. Challenges to enforcing the moratorium remain because police who usually enforce these encampment evictions and sweeps are under different jurisdictions than public health departments. Because of barriers to keeping PEH informed, they may not be aware of their right. Some cities have not enacted moratoriums.

There have been efforts in some counties to increase the number of handwashing stations, accessible bathrooms, garbage collection, showers, and needle disposals and exchanges at large encampments. For example, San Francisco's Pit Program, which provides public toilets staffed with attendants and equipped with needle and trash disposal sites, has been temporarily expanded with 15 additional restrooms, all open around the clock.⁸⁷ Distribution of hand sanitizer and hygiene kits by outreach teams has also been widely adopted, both by local governments and charitable organizations.⁸⁸ Despite these improvements, there is still an urgent need for more public hygiene facilities that are regularly serviced and stocked.

Closure of previously open restrooms, such as those in parks and libraries, has reduced access in some cities. In addition, reports of portable restrooms and handwashing stations placed in relatively inaccessible locations are widespread, as is insufficient maintenance and cleaning of restrooms.

To address some of these challenges, cities such as Seattle and Portland have approved new sanctioned encampments where toilets, showers, handwashing stations, food delivery, and medical services are centralized. Tents are raised on pallets and include cots inside, providing the privacy and comfort often lacking in congregate shelters, thereby allowing residents to continue to shelter together with the same people.

TABLE II-1 | RESPONSES FROM COMMUNITIES IN THE BAY AREA

	BROAD PRIMARY INTERVENTION	SHELTERED PREVENTION	UNSHelterED PREVENTION	IDENTIFIED COVID-19 CASES
CDPH/CDC GUIDELINES	Provide hotel rooms or housing as far as resources allow.	Bring sheltered into hotels. Decrease density. Increase cleaning. Provide masks and hand sanitizer. Screen guests. Space beds six feet apart.	Bring unsheltered into hotels. Do not clear tents unless individual housing units are available. Ensure nearby restrooms open 24 hours a day. Space tents out by six feet.	Provide hotels rooms or similar single-occupancy rooms for recovery.
BERKELEY, CA^{83, 89, 90}	Hotel rooms available for those over 60 years old, those over 50 years old with underlying conditions, those with contact with identified COVID-19 cases, and those symptomatic awaiting tests. Anticipates 10 FEMA trailers coming.	Has started to move at-risk individuals from shelters into hotels under Alameda County’s Operation Safer Ground. Shelters are still open with reduced capacity and not accepting new people. Shelters have become 24-hour shelters to limit the coming and going of individuals.	No written, official moratorium on sweeps and tows. Deployed 31 handwashing stations and six portable toilets.	Plans to provide single hotel rooms for those who test positive and need to quarantine but have no home or who live in single room occupancy housing with shared bathrooms for 14 days.
OAKLAND, CA^{86, 90, 91}	Hotel rooms available for those over 65 years old, those with underlying conditions, those with contact with identified COVID-19 cases, and those symptomatic awaiting tests. Has 66 FEMA trailers with none in operation.	Prioritizing hotel placement from shelters. Unclear if physical distancing guidelines are being implemented in shelters.	Passed a resolution to “acquire buildings, facilities, and supplies to prevent COVID-19 from spreading among high risk and unhoused communities.” Passed, but not yet enacted, a resolution requesting the City Administrator to halt tent removal.	Plans to provide single hotel rooms for those who test positive and need to quarantine but have no home or who live in single room occupancy housing with shared bathrooms for 14 days.
SAN FRANCISCO, CA⁹²⁻⁹⁴	Hotel rooms available for those over 60 years old, those with underlying conditions, those with contact with identified COVID-19 cases, and those symptomatic awaiting tests. Has 90 FEMA trailers with none in operation.	One-night reservations ended and shelters closed to new entrants. Have made masks and sanitizer more readily available. Increased but not intensive cleaning. Beds are spaced three feet apart in many shelters, but beds are no longer bunked and shelters are decreasing density as exits increase.	Deployed handwashing stations to meet UN guidelines. Stopped taking or removing tents, recognized in an official statement. Encouraging six feet distance between tents. Park rangers continue to enforce the anti-camping ban.	Plans to provide single hotel rooms for those who test positive and need to quarantine but have no home or who live in single room occupancy housing with shared bathrooms for 14 days.
SAN JOSE, CA^{95, 98}	Hotel rooms available for those over 65 years old, those with underlying conditions, those with contact with identified COVID-19 cases, those symptomatic awaiting tests, and families. Has 105 FEMA trailers allocated with none in operation. Fast-tracking a \$17 million plan to build up to 500 modular and prefabricated homes.	Using Parkside Hall and South Hall as temporary shelters for unhoused adults. Using Camden Community Center as a temporary shelter for unhoused families. Shelters are operating at a set capacity and closed to new entrants when full. Shelters are “in compliance with recommended social distancing.”Set up cots and isolation trailers at local fairgrounds. Warming centers have extended their service as have other shelter providers.	Enacted a moratorium on clearing homeless encampments. Installed 14 hygiene facilities with handwashing stations, hand sanitizer, portable toilets, clean water, and refuse pickup. Increased garbage removals from encampments. Opened two safe parking locations for those in cars or vehicles.	Has 172 hotel rooms available for families and homeless individuals who are vulnerable, test positive, or otherwise show symptoms of the virus.
NEXT STEPS	Make single occupancy housing or hotel rooms available for most individuals experiencing homelessness. Otherwise, expand access by age range or by medical conditions.	Bring individuals in large congregate shelters into hotels as soon as possible to prevent outbreaks. Increase physical distancing through temporary partitions or walls or, less ideally, curtains or cubicles. Maximize testing — at minimum, test all shelter residents after a positive case.	Increase access to 24-hour restrooms and handwashing stations. Increase portable latrines throughout the city at encampments. Distribute tents. Provide written and public statements halting tent confiscation; eviction from encampments; and towing, citing, or fining of vehicles that serve as shelters. Create organized safe spaces with centralized access to food, health resources, and sanitation, as an alternative to dispersed camping, similar to those seen in Seattle.	Extend stays beyond 14 days until there are adequate services to stabilize individuals with homeless services in the community.

PART III

Recommendations

Limitations of Existing Guidelines

Although the primary intent of our recommendations is to inform policy in hotspots, such as those in the San Francisco Bay Area and California as a whole, we are acutely aware that our country is experiencing multiple sequential pandemics. This means that the peak of cases may have passed in some areas while it is still ahead in others. Thus, interventions or outcomes for which the time may have passed in hot spots may be relevant elsewhere. Our experience in the Bay Area may therefore serve as both an example and a cautionary tale for communities at different phases of the pandemic.

There are limitations to guidelines from the CDC and the CDPH, which can be attributed largely to the rapid evolution and spreading of the virus as well as an exponential increase in knowledge about SARS-CoV-2 and COVID-19 on a daily basis.

The first limitation is that the recommendations were written at a time when it was reasonable to assume that the majority of the unsheltered population were uninfected. Thus, the goals were to sequester and care for the minority of those who were infected or sick in hotel rooms with the assumption that those left behind could be kept safe with shelter thinning and reconfiguration. **Because available, albeit sparse, data suggest that many shelter residents are infected, the focus needs to shift to large-scale coordinated care for those who are sick, close monitoring of those who are symptomatic, and provision of single-occupancy sites for those who are presumed uninfected to effectively shelter in place.** We currently know even less about infection of unsheltered homeless populations, but the most strategic preventative step would be to follow the same protocols.

Another limitation of the guidelines is the presumption that maintaining a distance of six feet when we are outside or in supermarkets could be translated to an assumption that keeping shelter beds six feet apart would be safe. Clearly, based on data presented in Part I of this document, **high-density congregate settings are not safe even if they follow current guidelines.** Residents of these shelters need the types of physical barriers provided by single-occupancy units to protect themselves from infection or to protect others from their presumed or test-confirmed infection.

Finally, when the initial guidelines were created, data had not yet accumulated regarding the speed and rate of infectious spread, particularly asymptomatic spread, of SARS-CoV-2. Some had hoped that screening and subsequent testing of symptomatic cases would protect shelters and or encampments. However, the shelter outbreaks in Boston and San Francisco both occurred after such screenings were in place. The speed of viral spread in the largest shelter in San Francisco illustrated that **it is unlikely that screening paired with targeted surveillance testing can be adequate to prevent an outbreak once there are**

cases in congregate shelters.

Although the guidelines address the need to halt all encampment sweeps, which many cities have adopted at least in principle, **additional measures are needed to further substantially mitigate the risk to individuals who are outside** should hotel rooms not be available or should some people be unable or decline them. To our knowledge, there are no data yet on rates of infection in encampments to guide us.

The current focus on single adults, although necessary given the demands of positive cases, **has obscured the needs of families experiencing homelessness, of unaccompanied minors, and of transitional age youth.** Together these populations make up at least 35% of the homeless population nationally over the course of a year. However, to limit viral spread and resulting mortality, they must receive proportionally equivalent attention and resources.

Below, we share our overall recommendations regarding testing for PEH, then provide overall recommendations for housing for PEH. We then provide specific additional guidelines by demographic subgroups. We then provide recommendations for individuals who decline housing and choose to remain in encampments or to remain sheltered in their cars, then provide recommendations regarding individuals with substance use disorders. Finally, we offer recommendations for staffing and recommendations for maximizing feasibility, acceptability, and effectiveness of recommendations.

Overall Testing Recommendations for PEH

The current test misses 10 to 30 percent of symptomatic infected people and a larger proportion of asymptomatic infected people depending on the overall prevalence of disease in a community. Thus, a single negative test does not conclusively rule out infection and does not indicate that an individual will not still be able to transmit the virus.^{99, 100}

The primary obstacle to testing PEH at this time is the lack of tests and supplies needed for testing and repeat testing, primarily swabs and PPE. There are also a variety of aims for testing, such as testing primarily for disease surveillance, individual medical assessment, or placement in housing. Ideally, testing would be administered to all PEH given their high structural risk and medical vulnerability relative to the sheltered population.

Universal testing, versus testing only people with symptoms, is necessary to inform policy and slow the spread of disease. Existing research suggests that identifying and isolating 90 percent of positive cases is an effective short-term solution to slowing the spread of disease.⁸ However, since the majority of coronavirus cases are either mild or asymptomatic, testing only symptomatic individuals will fail to detect the majority of cases and render isolation of 90 percent of cases impossible.¹⁰¹ **In the absence of universal testing, surveillance testing** of a purposive sample of a broad sample of PEH **is necessary to guide policy.** In other words, we should test a sample of individuals from a range of sites, hotels, shelters, in encampments and other sites, as a way to guide our response.

Selective testing of symptomatic individuals in shelters is problematic. For the reasons discussed above regarding missed positives, such a policy will inevitably lead to continued transmission. If one client is positive, there will likely already have been transmission by the

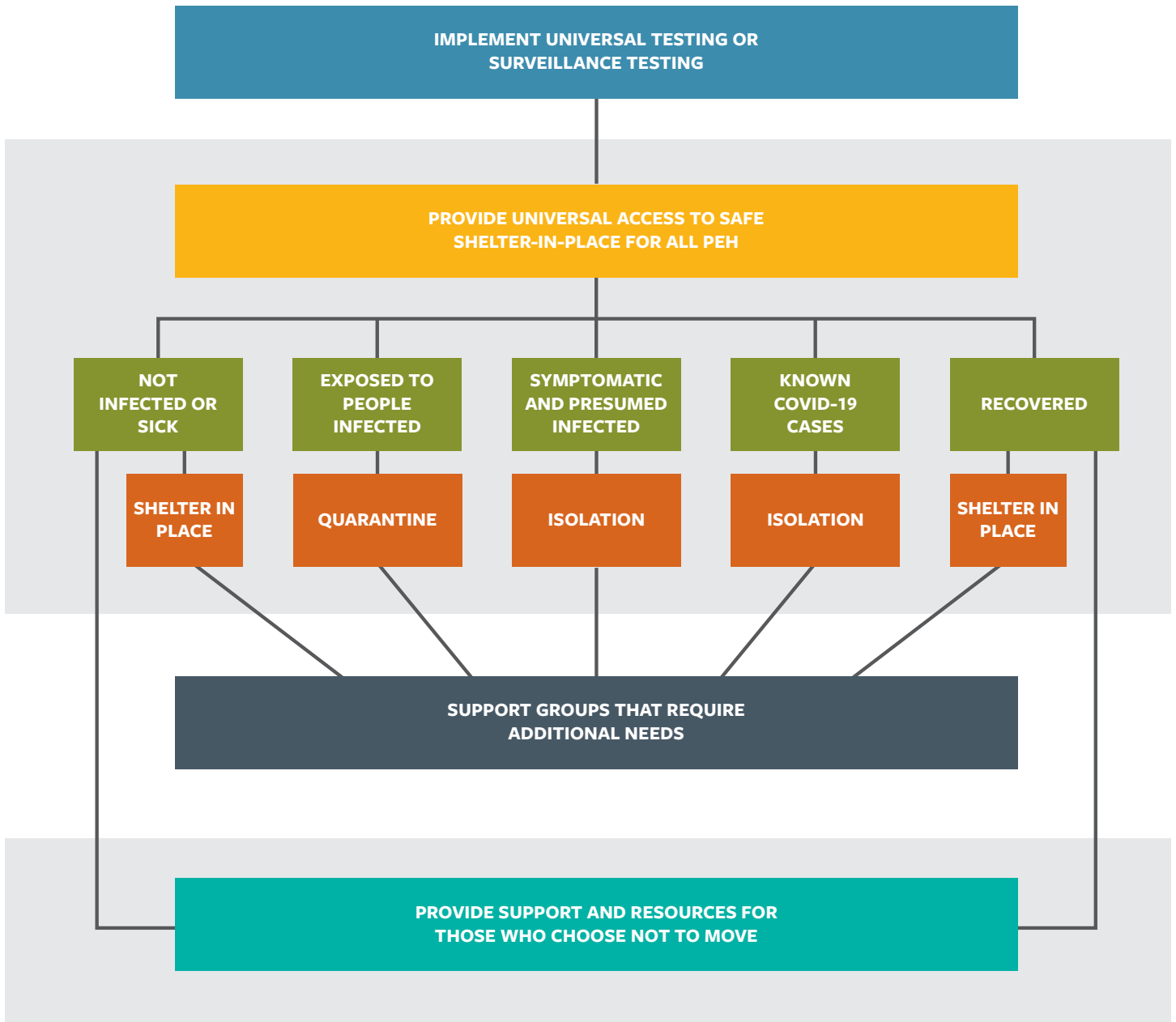


FIGURE III-1 | OUR RECOMMENDATIONS IN CONTEXT

The flowchart above provides a broad overview of how our recommendations relate to each other. The ordering of the recommendations reflect the order in which they appear in this report.

BOX III-1 | METHODS OF MONITORING DISEASE PREVALENCE AND SPREAD

Screening refers to low-cost, low-threshold monitoring for a disease that is designed to identify potential cases of a disease in order to selectively test a targeted population for diagnostic testing. In the case of COVID-19, most screening measures involve the assessment of body temperature coupled with questions regarding symptoms including cough and shortness of breath. Those with temperatures and symptoms consistent with possible infection would then receive diagnostic tests for COVID-19.

Surveillance testing involves the testing of a portion of a population in order to make inferences about incidence and prevalence of a disease in the population as a whole.

Universal testing involves the testing of an entire population. This may refer to universal testing of one specific population, such as testing everyone in a single congregate setting, SRO, or encampment, or testing of an entire population, such as testing all PEH in a city or municipality.

time results are reported. For this reason, affected shelters should be urgently prioritized for safer single-unit housing.

Universal testing should be conducted in encampments and with all clients who are outside, particularly if hotel rooms are not available or if they are unable or decline to move into single-occupancy housing. It is likely infection in one resident predicts infection in other residents. Again, if universal testing is not conducted, then surveillance testing should be performed to identify hot spots for medical attention and prioritization for safer housing.

All families, unaccompanied minors and YEH should be tested.

Testing should never be a prerequisite to access to housing where a client can appropriately shelter in place. If testing is not available, individuals should simply be housed first.

Surveillance data to guide policy are desperately needed. If at all possible, it is important to make the most of the data we do have, possibly through case investigations to gather information regarding positive cases to date and their risk factors, including housing status.

Overall Recommendations for Housing of PEH by Infection or Exposure Status

We recommend that all PEH be given access to housing and support so they can shelter in place, quarantine, or medically isolate safely. For most individuals this will require low-barrier hotel rooms or single-occupancy units. For others, this will require the resources and supports to safely shelter in place in their current housing. These recommendations align with CDPH's recommendations outlined in Part II, developed in partnership with Professor Margot Kushel of UCSF and the UCSF Benioff Homelessness and Housing Initiative. This document states that the "primary strategy for intensive infection

prevention efforts is providing single occupancy housing.” These guidelines are also represented in Table II-1.

In the context of the COVID-19 pandemic, PEH can be subdivided into five subgroups:

1. People who are not infected or sick.
2. People who have been exposed to people who are infected.
3. People who are symptomatic and presumed infected.
4. People who are known cases of COVID-19.
5. People who have recovered.

The first three groups should be sheltered in hotels or single-occupancy units.

Most people who are not infected or sick should be offered a hotel or single-occupancy unit with a private bathroom so that they can shelter in place in the same way the general population has been instructed. This will minimize their exposure to people who are infected, decrease their likelihood of being infected if exposed through individual access to hygiene, and increase the speed with which they are referred to care if they fall ill. These individuals should be provided face masks to wear if they leave their room. However, we have made more detailed recommendations for individuals by subgroup.

People who have been exposed to people who are infected should be quarantined in a hotel or single-occupancy unit, preferably in a separate hotel from other groups. These individuals should be provided face masks to wear when awake and/or if they leave their room.

Persons under investigation (PUI), people who are sick and presumed infected, should be isolated, preferably in a separate hotel from other groups or in a hospital if necessary. These people should have access to face masks.

The hotels and single-occupancy units for the first three groups should also provide for basic needs, including three meals per day delivered to each room, daily temperature checks and symptom screening, and ongoing supportive services.

Known COVID-19 positive individuals can be co-located in field hospitals or dedicated COVID-19 wards where they can be monitored for symptoms, receive on-site care, and be transferred should they need a higher level of care. This has been modeled in Boston, which was based on successful approaches of rapidly-mounted large field hospitals in China.^{100, 102, 103}

People who have recovered from COVID-19 who have two documented sequential negative tests can presumably live safely in a congregate setting. If new research arises that shows higher rates of re-infection than currently assumed, then this recommendation will need to be revisited. Given decreased access to basic needs in the community, cities should continue to provide PEH who have recovered from COVID-19 with housing, basic needs (including food), supportive services, and lengthen their housing until it is deemed safe for vulnerable populations to no longer to shelter in place.

TABLE III-1 | RECOMMENDATIONS BY INFECTION STATUS

	OVERALL RECOMMENDATIONS	ADDITIONAL CONSIDERATIONS
THOSE NOT INFECTED OR SICK	Shelter in place in hotel rooms or similar single-occupancy units with private bathrooms, preferably in a separate hotel from those who have been exposed or are showing symptoms.* Individuals should wear face masks if they leave their room. Specific recommendations apply to demographic subgroups as outlined.	Individuals who choose to stay in tents or cars should receive basic needs, masks, and outreach so they can shelter safely.
THOSE EXPOSED TO PEOPLE WHO ARE INFECTED	Quarantine in hotel rooms or similar single-occupancy units with private bathrooms, preferably in a separate hotel from other groups.* Individuals should wear face masks if they leave their room.	
THOSE WHO ARE SYMPTOMATIC AND PRESUMED INFECTED	Isolation in hotel rooms or similar single-occupancy units with private bathrooms, preferably in a separate hotel from other groups, or transfer to a hospital if necessary.* Individuals should wear face masks if they leave their room.	
THOSE WHO ARE KNOWN CASES	Isolation in a field hospital or COVID-19 ward where they can be monitored for symptoms and receive on-site care.	
THOSE WHO HAVE RECOVERED	Shelter in place in their current housing while having access to supports and resources for meeting basic needs.	Individuals can presumably live safely in congregate settings, but this recommendation may need to be revisited as new research arises.

* The hotels and single-occupancy units should also provide for basic needs, including three meals per a day delivered to each room, daily temperature checks and symptom screening, and ongoing supportive services.

Housing Guidelines by Demographic Group of PEH

SINGLE ADULTS IN HIGH-DENSITY SHELTERS

All single adults in high-density shelters should be placed in hotels, as per earlier guidelines, as quickly as possible.

Sheltering of non-medically vulnerable adults should not be conditional on sheltering those who are vulnerable.

Placements and staffing should match needs. Most PEH 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” PEH.

PEOPLE IN UNSAFE LIVING SITUATIONS/AT RISK OF HOMELESSNESS

This group includes people who are affected by domestic violence, or couch surfing, trading sex for a place to stay, or exiting jail or prison without housing.

These individuals should be provided with a hotel room or single-occupancy units in which to shelter in place, as per earlier guidelines.

FAMILIES

Families in shelters in which each family has their own separate room should be supported by careful cleaning and hygiene practices, frequent disinfecting in communal areas, and wearing masks in shared spaces.

Families who are not in appropriate family shelters should be placed into appropriate safe housing or hotel rooms with a private bathroom.

Children should be provided with schooling or childcare/family respite care to allow parents who have the ability to work to maintain their job and income. **Wi-Fi and computer access should be ensured** for school-aged children to participate in online classrooms.

Support services should be sustained to ensure uninterrupted access to healthy nutrition, and for linking to existing permanent housing waitlists.

Parental support, as well as mental health support, are critical given the increased rate of anxiety and stress and higher risk for trauma during shelter in place.

UNACCOMPANIED MINORS AND YOUTH

Although youth without underlying medical issues are not the highest-risk group medically, they need to be housed safely to prevent them and the larger community from the spread of infection. Like other youth more broadly, YEH are particularly vulnerable during this epidemic because they are at a point in their lives when they need to be engaged in the community to gain the skills for a successful transition to adulthood.

Unsheltered youth, who represent the majority of youth experiencing homelessness, may not be able to access a bed in a youth shelter in some cities. These youth **should be offered a hotel room/single-occupancy unit staffed with youth-appropriate staff. Minors (generally very few in number) should be housed separately from transitional-aged youth. Both groups should be sheltered separately from older adults**, preferably in separate buildings. Youth are well-known to avoid shelters for adults due to concerns for their personal safety. Should unsheltered youth decline housing and elect to stay outside, they should be provided with support through youth-friendly outreach with attention to physical distancing and provision of hygiene supplies and masks. Earlier recommendations for adults in encampments also apply to unsheltered youth.

Youth programs, including outreach/drop-ins/engagement centers/congregate housing/rapid re-housing can and should continue to serve all sub-groups of youth, while incorporating measures to decrease the numbers of contacts and decrease risks of transmission. This is extremely challenging for many youth programs that are small and fiscally vulnerable. To operate, they will need to take steps to increase physical distancing, implement frequent disinfection protocols, and provide ongoing education, supplies, and support to staff and youth for scrupulous personal hygiene.

Congregate youth shelters are small and often less dense than large congregate adult shelters and provide consistent housing and relationships to youth. With reduced capacity, stable census, and adherence to safety protocols, it is likely safer for youth to remain in housing with support and safety measures than to move them to a new setting where they will be working with staff who are not youth-friendly and may come into contact with adults. Such shelters need support to create spaces where youth who develop symptoms can quarantine or, preferably, given the option to have such youth move into a hotel for youth who are symptomatic and presumed infected. Safety protocols for those shelters to continue to operate include intensive, frequent disinfection and access to PPE for staff and clients. Some congregate shelters for youth provide individual rooms but have shared bathrooms or kitchens. Given the importance of continuity to help youth shelter in place and the scarcity of youth-trained staff, such sites should continue to operate by providing food deliveries to individual rooms, masks to wear outside of rooms, and frequent cleaning of shared bathrooms and of surfaces in shared spaces.

Particularly in times of crisis, minors and youth will continue to leave home because they are kicked out or need to run away from family violence or dysfunction. Thus **shelters for minors and youth need to continue to operate and are even more critical at this time.**

Families who are sheltering youth who are couch surfing should receive financial support to stabilize their housing and meet host families' increased costs, particularly for food and utilities.

Some YEH are medically vulnerable and so should receive housing as needed to allow them to shelter in place more safely.

Some YEH are parents and need to be prioritized for settings to support them and their children to keep themselves safe and meet basic needs. **In particular, pregnant women and children under one year of age should be considered medically vulnerable.**

Models that allow youth to shelter in place in **host homes or in kinship care**, with appropriate precautions to prevent viral spread, **should be considered.**

UNSTABLY HOUSED AND HOMELESS STUDENTS

Colleges and universities should keep dormitories, student housing, and food service available for students who would be at risk of homelessness if dormitories were to close.

Colleges and universities should expand on-campus housing to students and staff experiencing homelessness who were not previously living in campus housing.

Colleges and universities should work across their systems to provide shelter for students and staff at community colleges who are experiencing homelessness or facing housing instability, such as those living in vehicles or those who are currently unhoused.

Guidelines for People Who Choose to Remain in Encampments or Shelter in Their Cars

ENCAMPMENT RESIDENTS

Encampment residents should be given the option of moving to safe single-occupancy housing, although some individuals will choose not to or will not be able to. The following describes measures, supports, and resources to allow residents to be able to meet their basic needs while sheltering in their tents, so they can minimize contact with each other or with non-residents, thus minimizing their risk of being infected or infecting others.

Successful examples of encampment supports include the sanctioned encampments in Seattle, which provide security, food, showers, toilets, and on-site services, but in an outdoor setting where people are able to maintain isolation in tents or tiny homes.

To minimize contact or displacement, **policies to halt confiscation of tents and belongings need to be enacted, adhered to, and publicized** to residents.

Encampment residents should be encouraged to **space tents further apart. Garbage removal** services should be provided to free up space. **Additional public land should be made available on which to camp**, so residents can move off of sidewalks where they may come into contact with others. Residents without tents should be given tents.

Outreach to residents should include education regarding safety guidelines and the distribution of masks and hand sanitizer.

Meals should be provided to residents to minimize the need to travel or panhandle to obtain food.

Outreach-based symptom and temperature screenings should be conducted regularly (preferably daily) so new infections can be detected as soon as possible and sick individuals can be moved to hotel rooms or hospitals.

Additional applicable sanitation measures are described in this section.

PEOPLE LIVING IN CARS

People living in cars should have the opportunity to move into housing. Should they decline or not be able to move, they need to be provided with support to safely shelter in place.

Safe parking areas need to be provided so cars can be parked far apart.

Ticketing and towing of cars needs to be suspended.

Outreach, meals, and symptom and temperature checks should be provided, as for encampment residents.

Additional applicable sanitation measures are described in this section.

SANITATION

In public spaces, **local governments should strive to meet and exceed minimum UN sanitation standards.**¹⁰⁴

Estimate the size and geographic distribution of the population of PEH.

Establish at least one restroom per 20 individuals that is no further than 50 meters from the people it is intended to serve.

Restrooms must be kept open 24 hours a day.

As for the SF Pit Stop Program, **restrooms should ideally be staffed by attendants** who ensure that restrooms remain clean, functional, and stocked with soap, toilet paper, paper towels, and hand sanitizer. The presence of attendants will help ensure that these facilities are not utilized for purposes other than hygiene and sanitation and may provide a sense of security for individuals who may be concerned about being followed into the restroom and trapped by a stranger, particularly at night. Attendants should be unarmed, be instructed not to screen out any individuals from use of the restroom, perform safety checks when the restroom is occupied by knocking on the door after five minutes to ensure that an overdose has not occurred, and be members of the communities that they will be serving, if possible.

We acknowledge that staffing with attendants may be prohibitively expensive and that provision of an adequate number of restrooms is the most important consideration in this emergency situation. If it is not possible to staff restrooms with attendants, then **unstaffed facilities should be checked, restocked, and disinfected at least three times per day.**

Provision of showers, clean water, and soap should also meet or exceed minimum UN standards, with at least one shower per 50 persons and 15 liters of potable water per person per day (allowing for laundry), and 450 grams of soap per person per month.¹⁰⁵ Provision of laundry services may be considered as a partial substitute for the distribution of water and soap intended for clothes washing purposes. Policies should be informed by coordination with outreach groups.

Recommendations for People With Substance Use Disorders

A harm reduction approach and continued accessibility of substance use treatment are critical to the safety and health of people with substance use disorders. The American Society of Addiction Medicine,¹⁰⁶ US Drug Enforcement Agency,¹⁰⁷ Substance Use and Mental Health Services Administration,¹⁰⁸ and California Bridge¹⁰⁹ have all provided guidance on harm reduction steps necessary for people who use drugs during the pandemic.

We also endorse the detailed April 6, 2020 recommendations provided by the San Francisco Department of Public Health entitled “Interim Guidance for Providers: Addressing Needs of People Who Use Alcohol, Tobacco, or Other Drugs Who are Sheltering in Place or Require Isolation or Quarantine Related to COVID-19.”⁹³ A summary of their guidance is given here and applies to both sheltered and unsheltered people.

Provide harm reduction guidance to all people who use substances.

- Provide information pamphlets on safe drug use.
- Prescribe or provide naloxone, syringes, and other safe consumption supplies.
- Recommend fentanyl test strips for all individuals using non-prescribed drugs.
- For those who may need to use substances alone, recommend they contact Never Use Alone at (800)-484-3731 for telephone support during use.
- Recommend alternatives to smoking of drugs, and how to minimize or clean shared equipment.

Ensure access to addiction medicine services.

- Assess for risk of life-threatening withdrawal and prescribe or provide supportive medication.
- Extend medications for opioid use disorder (MOUD) prescriptions to the maximum duration.
- Ensure medications are received.
- Stay connected to prevent worsening of mental health during social isolation.

In addition to these recommendations, contingency protocols must be put in place for those individuals who decline medical management of their substance use while in isolation and quarantine. The alternative options, such as forced withdrawal or forced medical management, are not acceptable. These protocols must assume approaches that reduce harm as it pertains to COVID-19 transmission, while not violating the principles of autonomy and beneficence. Some examples of potential options for this include keeping alcohol on site or creating protocols for people to go outside to obtain substances in ways that are

supervised and maintain social distancing measures with minimal contact with potential vectors.

Staffing Recommendations

Measures must be taken to protect staff, promote staff effectiveness, and meet increased needs for staffing.

PROTECTING STAFF AND PROMOTING STAFF EFFECTIVENESS

Support 100 percent compliance with mask utilization with provision of an ample supply of appropriate masks.

Provide an ample supply of appropriate PPE, including gloves and face shields, clear guidelines for utilization appropriate to learner needs, and repeated sharing of information.

Encourage physical distancing to the maximum extent possible between staff or between staff and clients. Strongly discourage any physical contact at all except in case of emergency and with appropriate protective gear.

Take staff temperatures and screen staff for symptoms daily. Send staff home to quarantine immediately should symptoms arise. Encourage self-monitoring for fever or symptoms. Provide thermometers for home use if possible.

Provide sick leave to staff who become ill or staff who are not able to work due to medical vulnerability.

Provide hazard pay to staff who continue to work. Given that staff often have to travel long distances in a car to work, provide free parking nearby and provide permits to suspend ticketing or towing of staff vehicles.

Provide access to emotional support and counseling to staff who need it. Provide on-demand testing for staff who are symptomatic or asymptomatic who come into direct contact without adequate PPE with a client diagnosed with or suspected to have COVID-19. Also, provide on-demand testing if a provider is within six feet of the diagnosed or suspected client for more than a few minutes during their illness or for two days beforehand. Given the likely large, but as yet undefined, extent of asymptomatic and pre-symptomatic transmission, staff should ideally have access to on-demand testing based on their occupational risk.

MEETING INCREASED DEMAND FOR STAFFING

Staffing should not be an impediment to quickly housing PEH. Lower-need clients can be transitioned as systems are developed to support high-need clients.

Supporting PEH to transition into hotels or single-occupancy units will be most effective if the process is supported by trusted service providers and critical onsite supports. Multilingual staff should be available as needed.

Create hotels with different levels of staffing.

“Low-need hotels” would be able to require only the staff of a typical hotel service, plus food delivery with access to regular outreach services. The majority of unstably housed and homeless individuals will be able to reside in such hotels.

“High-need hotels” would focus on those clients with especially high physical, mental health, or substance use needs. A minority of clients will need this high level of support, preferably from experienced staff with whom they have an ongoing relationship.

Volunteers can be leveraged for supportive, lower-risk tasks, such as providing meals to residents in hotels or single-occupancy units designated for those who have not been confirmed with COVID-19 or without confirmed exposure.

Experience in several shelters, such as Hospitality House in San Francisco, suggests that **the most efficient and effective process may be to transition all consenting residents of a congregate shelter into a hotel at the same time**, leveraging existing shelter staff’s training and personal relationships with shelter residents. This reduces overall staffing needs because the shelter can close after it is transitioned all at once.

Given the likelihood that clients have had past experiences with law enforcement, incarceration, or institutionalization in mental/behavioral health settings, **all hotel staff and security guards should receive trauma-responsive training in advance on how to avoid conflict**. While security is important, hotels should avoid unnecessary and excessive surveillance such as pat-downs, property searches, and additional restrictions of entry and exit beyond those applied to the general population.

Consider hiring and training clients who are transitioning out of homelessness and may have lost their jobs as new support staff.

Maximizing Feasibility, Acceptability, and Effectiveness of Recommendations

We will maximize feasibility, acceptability, and effectiveness of these guidelines if we prioritize communication, respect, and individual autonomy in decisions about where people are going to shelter. It is recommended to tap into existing structures, such as advisory boards, to **ensure the inclusion of clients’ voices** in the drafting and implementation of policy that affect their daily lives.

The following recommendations are informed by best practices and evidence to maximize success in implementing guidelines:

- **Ensure safety for diverse clients, including LGBTQ clients.**
- **Establish and advertise a hotline for PEH and people at risk of homelessness** to access COVID-19 related services, care, and housing and to provide information about the hotel entry process.
- **Ensure that all written materials accommodate a variety of languages, are tailored to low literacy levels, and use non-technical language.**

- Allow PEH to bring their belongings with them to the greatest possible extent. **Provide safe, trustworthy storage for the belongings** of those entering hospitals, hotels, single-occupancy units, or field hospitals that cannot accommodate their belongings. This will encourage clients to access sites which may not be able to accommodate a client's property by providing safe and secure storage.
- **Provide clear support for navigating the intake procedures.**
- **Provide transportation, for people and their belongings**, between referral sources and hotel accommodations, without requiring burdensome wait times.
- **Accommodate partners** who choose to reside in one room together.
- **Accommodate pets** to the maximum extent possible for medical reasons. Arrange for **safe foster care for pets** who cannot stay with their owners during isolation periods or hospitalization.
- **Suspend all current laws criminalizing individuals for their homelessness**, such as ordinances that prohibit panhandling or lying in public spaces. Replace these efforts with the increased provision of basic needs without the threat of punishment (threatening to confiscate belongings, refusing to admit partners or pets into hotels).



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APPENDICES

Appendix A

Bay Area Responses to Addressing the Needs of PEH

In this appendix, we provide detailed descriptions of community responses across the Bay Area. This information is up-to-date at the time this report is released. Although we realize that this is a quickly evolving situation, we hope these case studies provide much-needed context during the COVID-19 pandemic.

SAN FRANCISCO, CA

POINT IN TIME: As of the San Francisco 2019 Point-in-Time Count, there are 8,035 PEH in San Francisco, of whom 5,180 (64 percent) are unsheltered.¹ The city’s supplemental count included an additional 1,773 individuals staying in jails, hospitals, or residential facilities who would otherwise be homeless and families living in single room occupancy (SRO) units.

HOTELS & TEMPORARY HOUSING EFFORTS: Currently, San Francisco is making hotel rooms available for those who have tested positive for COVID-19, are symptomatic and awaiting tests, or have been in contact with individuals who have tested positive (mainly in the case of shelter outbreaks), and are 60 years old or with underlying health conditions. The city is currently developing referral processes to move vulnerable individuals into hotels from sheltered and unsheltered settings. As of April 16, less than 800 PEH had been placed into hotels. The city projects it will need 7,000 hotel rooms for COVID-19 patients in need of quarantine and an additional 19,000 SRO accommodations for vulnerable individuals currently unhoused and residents who may become infected over the course of the pandemic.

On April 14, all 11 members of the San Francisco Board of Supervisors voted to pass an emergency ordinance — “Limiting COVID-19 Impacts through Safe Shelter Options.”² The ordinance calls for the city to secure 8,250 private rooms by April 26, 2020, including 7,000 rooms for PEH in San Francisco. In contrast to the administration’s current policy approach, the legislation charges the city to move 7,000 unhoused individuals, regardless of age or underlying health conditions, into hotels before they become COVID-19 patients as a preventative measure to reduce and slow viral spread. More than 100 medical professionals published an open letter supporting this plan on March 24.³ The Mayor has yet to sign or implement this legislation.

San Francisco is no longer accepting any new shelter guests. This includes both one-night

¹ <http://hsh.sfgov.org/wp-content/uploads/FINAL-PIT-Report-2019-San-Francisco.pdf>

² <https://sfgov.legistar.com/View.ashx?M=F&ID=8248420&GUID=EDABF2AA-EC0D-4AA6-A529-FA2B9DF67998>

³ <https://www.sfxaminer.com/opinion/opinion-medical-experts-advocate-for-more-hotels-for-the-unhoused-and-quickly/>

reservations and 90-day reservations. When shelters stopped accepting guests, there were still over 700 people on the waitlist. Those who have left congregate shelters to shelter in place in hotel rooms or when admitted into hospitals are not being readmitted into shelters. Although this policy follows CDC and CDPH guidelines, it has put hundreds of people out on the street. Staff are screening current shelter guests, but temperature checks are not in place in all shelters, as of April 14. Those who are screened and displaying symptoms are placed into hotels and given a COVID-19 test. Physical distancing is not possible in many shelters with some beds still spaced three feet apart. Masks and hand sanitizer are more available now than at the start of the pandemic.

PEH in San Francisco have tested positive across three shelters as of April 16. In two of the shelters, the person testing positive was quarantined and those in the shelter with closest contacts were placed into hotels. Those who met the criteria of being at high risk to COVID-19 in these shelters were also immediately moved into hotels. Those who were not in close proximity to a person who tested positive remained in the shelter. These shelters were not put on 24/7 quarantined lockdown and people continue to enter and exit the shelter.

However, at MSC South, the city's largest shelter, after two initial guests tested positive and subsequent tests returned positive for people with whom they were in contact, public health officials initiated shelter-wide testing. On Saturday, April 4, two shelter guests tested positive. On Monday, April 6, those who were identified as vulnerable or were in close contact with those who tested positive were moved into hotels. On Wednesday, April 8, 144 people were tested and only five people tested positive. On Friday, April 10, the same 144 were tested again and 70 tested positive. On Friday, all those who tested negative were moved into hotel rooms. On Saturday, April 11, the remaining positive cases were moved into hotel rooms. Over subsequent days further testing took place and 92 shelter guests and 10 staff tested positive. The vast majority of positive cases were asymptomatic. From this experience, we can see how quickly COVID-19 can spread in a congregate shelter and the need for rapid isolation of all shelter guests after a positive case appears. It also demonstrates the limits of any meaningful use of diagnostic testing to prevent outbreaks in a congregate shelter setting.

In public spaces, San Francisco has deployed handwashing stations and is increasing this number to meet UN sanitation and hygiene standards. Accessible bathrooms are still lacking across the city. The Mayor's office has posted a public announcement on its website that it is no longer confiscating tents.⁴ There has been no public outreach or communications effort to let unhoused people know this is the case, or any effort to provide those unsheltered with provisions of protection and care, such as tents, food, medical assistance, etc. Parks remain off-limits, including areas that have been closed to recreation, such as sports fields and courts, which would allow people to camp off of sidewalks and outside of residential neighborhoods.

ALAMEDA COUNTY, CA

POINT IN TIME: As of the Alameda County 2019 Point-in-Time Count, there are an estimated 8,022 PEH in Alameda County, of which 6,312 (79 percent) are unsheltered.⁵ Although Blacks/African-Americans constitute 11 percent of the total Alameda County

⁴ <https://sf.gov/information/covid-19-and-people-experiencing-homelessness>

⁵ https://everyonehome.org/wp-content/uploads/2019/07/2019_HIRDReport_Alameda_FinalDraft_8.15.19.pdf

population, they are represented in 47 percent of the County’s homeless population.

HOTELS & TEMPORARY HOUSING EFFORTS: Alameda County has contracted with two hotels in Oakland⁶ for a total of 393 rooms⁷ for unhoused individuals in need of quarantine or isolation. Referrals may be made from clinics, hospitals, shelters, Santa Rita Jail, or an approved list of outreach teams.⁸ No walk-ins are accepted at the hotels.

Operation Comfort: One hotel is available for people that test positive, are symptomatic, or have been exposed to COVID-19. Individuals in this category must be screened by a medical triage clinician who then arranges for transportation to the site. These individuals will be discharged to their “previous living situation” at the end of their isolation or quarantine. According to an April 16 memo from the City of Oakland Mayor, Operation Comfort has accepted 57 individuals.⁹

Operation Safer Ground: A second hotel is available for high-risk individuals who are over the age of 65 or meet high-risk medical criteria. Originally, outreach and prioritization was conducted through the County’s Homeless Management Information System (HMIS). However, the County is now moving toward transitioning high-risk residents of congregate shelters into hotels in order to reduce shelter capacity, a process dubbed Operation Dynamo; there is no publicly available information about this process. According to an April 16 memo from the City of Oakland Mayor, Operation Safer Ground has accepted 154 individuals.¹⁰

There is not a transition process between Operation Comfort and Operation Safer Ground hotels for residents that end their isolation/quarantine and would otherwise be unsheltered upon discharge. There are currently no hotel accommodations or supportive housing specifically for people with severe mental illness. Hotel residents confirmed that they only receive 60 minutes of outdoor time per day across three 20-minute supervised outings, outings which could be revoked in the instance when press were on site.

Alameda County received 15 trailers from the state in January 2020 and gave them all to Oakland; all 15 are planned for a 30-bed youth program for Oakland, Berkeley, and the County. Alameda County received an additional 91 former FEMA trailers for the coronavirus pandemic, of which the City of Oakland received 66. All trailers are double occupancy. No trailers are currently in use.¹¹

There is currently no street outreach being conducted to transition unsheltered PEH from the streets/encampments into hotel or individual housing units. The Oakland City Council President has called upon the Mayor and Alameda County to move all PEH into hotels immediately.¹²

⁶ <http://www.acphd.org/media/565613/covid-19-hotel-efforts-4.6.2020.pdf>

⁷ <http://www.acphd.org/media/569028/project-roomkey-faq.pdf>

⁸ <http://www.acphd.org/media/566095/project-roomkey.pdf>

⁹ <https://cao-94612.s3.amazonaws.com/documents/4.16.20-COVID-19-Homeless-Response-Update-Council-Info-Memo.pdf>

¹⁰ <https://cao-94612.s3.amazonaws.com/documents/4.16.20-COVID-19-Homeless-Response-Update-Council-Info-Memo.pdf>

¹¹ <https://www.mercurynews.com/2020/04/02/oakland-gets-91-trailers-to-house-homeless-during-coronavirus-outbreak/>

¹² https://www.kron4.com/health/coronavirus/oakland-council-president-calls-for-homeless-residents-to-be-immediately-placed-in-hotels/?fbclid=IwAR0rkqRsv2-hOp6IR0DrOljob_KtHhL9d-n0ajedWDD4L87_cC3syQq9uSI

On Saturday April 11, Alameda County tested 53 shelter guests after news broke about an outbreak in San Francisco's largest shelter, MSC South. All 53 tests from Alameda County's shelter guests returned negative. However, in contrast to San Francisco's re-testing over subsequent days, the City of Oakland has not re-tested any of the original 53 shelter guests.

OAKLAND, ALAMEDA COUNTY, CA

POINT IN TIME: As of the Oakland 2019 Point-in-Time Count, there are 4,071 PEH in Oakland, of which 3,210 (79 percent) are unsheltered.¹³ Although Blacks/African-Americans constitute 24 percent of the total City of Oakland population, they are represented in 70 percent of the City's homeless population.

HOTELS & TEMPORARY HOUSING EFFORTS: Hotel efforts in Oakland are through Alameda County's Operation Comfort and Operation Safer Ground.

Of the 91 FEMA trailers in Alameda County, the City of Oakland received 66 trailers. No trailers are currently in operation, though the city anticipates opening the trailers in early May with the provision of staffing, 3 meals/day, and laundry; the trailers will not provide electricity. The city has not identified an ongoing funding source to keep the program running beyond the pandemic and has insinuated that trailer guests will be discharged back to the streets.¹⁴

ENCAMPMENTS: There are estimated to be anywhere from 90 to 200 encampments in Oakland.¹⁵ According to an April 16 memo, the City has claimed it is servicing 40 encampments with port-a-potties, wash stations, and garbage removals, but recognizes that reports are indicating that these are not being serviced regularly or predictably.¹⁶ Additionally, the two providers of handwashing stations are reportedly out of stations so no additional handwashing stations are being disbursed to the remaining encampments and the city is not currently making upgrades to any encampments.

The City of Oakland has adopted CDC guidelines for encampments and passed a moratorium on encampment evictions unless "individual housing units or alternative shelter is provided."¹⁷ This resolution has not yet been implemented by the City Administrator. Oakland is moving forwards with acquiring housing options for unhoused communities and seeking reimbursement from FEMA.

Residents sheltering in vehicles have reported several instances of towing, ticketing, citations, and arrests on the basis of outstanding warrants, probation, or parole. Public spaces and parks appear to still be off-limits, including areas that have been closed to recreation, such as sports fields and courts that could allow people to camp off of sidewalks and outside of residential neighborhoods.

¹³ https://everyonehome.org/wp-content/uploads/2019/12/2019HIRDReport_Oakland_2019-Final.pdf

¹⁴ <https://cao-94612.s3.amazonaws.com/documents/4.16.20-COVID-19-Homeless-Response-Update-Council-Info-Memo.pdf>

¹⁵ <https://www.antievictionmap.com/oakland-homeless-encampments-1>

¹⁶ <https://cao-94612.s3.amazonaws.com/documents/4.16.20-COVID-19-Homeless-Response-Update-Council-Info-Memo.pdf>

¹⁷ <http://oakland.legistar.com/gateway.aspx?M=F&ID=2a44f6a5-991b-4577-b494-6b268c31637d.pdf>

BERKELEY, ALAMEDA COUNTY, CA

POINT IN TIME: As of the Berkeley 2019 Point-in-Time Count, there are 1,108 PEH in Berkeley, of which 813 (73 percent) are unsheltered.¹⁸ Although individuals identifying as Black/African American constitute about 9 percent of the city's population, Black/African American individuals were overrepresented in the population of PEH, at 57 percent.

HOTELS & TEMPORARY HOUSING EFFORTS: Hotel efforts in Berkeley are through Alameda County's Operation Comfort and Operation Safer Ground.

Of the 91 FEMA trailers in Alameda County, the City of Berkeley received 10 trailers. As of April 15, fewer than 10 symptomatic people were transitioned to hotels under Operation Comfort, and at least 22 people at-risk individuals in shelters have been moved to hotels under Operation Safer Ground.¹⁹

Separately from Alameda County's efforts, the City of Berkeley has acquired a four-bedroom house and eight RVs but still must coordinate how to obtain water and electricity and secure transportation for residents. As of April 3, the Emergency Operations Center (EOC) also reported intent to submit a grant application for 30 pallet shelters.

Shelters in Berkeley are still open but have reduced capacity and have become 24-hour shelters to discourage people from going outside.²⁰ These new changes were enforced to limit the spread of the virus for shelter guests, but have also caused an overall reduction in day-time drop in services for unsheltered PEH, reducing access to services like showers and laundry. As of April 8, Berkeley has not ordered any additional tents through FEMA funds.

ENCAMPMENTS: The City of Berkeley has not yet enacted a moratorium on sweeps and tows. In all of the encampments and on-street sites, there has been a dire need for food, drinking water, handwashing stations, garbage collection, and portable toilets.²¹ As of April 15, Berkeley established a partnership with the Berkeley Food Network to distribute groceries, installed a total of 31 handwashing stations and six portable toilets per the Berkeley map,²² and expanded shower programs at two locations.²³ Additionally, the Telegraph Business Improvement District agreed to add some portable toilets and regularly clean public bathrooms near Telegraph Avenue. However, outreach volunteers have noted how many toilets were in poorly accessible locations and some public bathrooms were not cleaned or stocked for several weeks. There have also been reports of police harassing individuals to leave public bathrooms. Furthermore, volunteers have noted that both sick and healthy residents in the encampments use the same handwashing stations and portable toilets because of the limited availability. To prevent the potential spread of disease among the residents, there is an urgent need to place more handwashing stations and portable toilets in accessible areas at each of the encampments.

In the meantime, volunteer outreach workers from the Berkeley Outreach Coalition and

¹⁸ https://everyonehome.org/wp-content/uploads/2019/09/2019HIRDReport_Berkeley_2019-Final.pdf

¹⁹ <https://www.berkeleyside.com/2020/04/14/berkeley-starts-moving-fragile-homeless-individuals-to-hotel-in-oak-land>

²⁰ <https://www.berkeleyside.com/2020/03/19/homeless-people-in-berkeley-to-see-big-changes-in-how-they-sleep-get-food-get-showers>

²¹ <https://www.dailycal.org/2020/04/10/berkeley-homeless-community-struggles-amid-covid-19-city-responds/>

²² <https://berkeley.maps.arcgis.com/apps/View/index.html?appid=715bb83772db4b85b64c44fc5dbce21f>

²³ <https://www.cityofberkeley.info/covid19-service-notice/>

other entities have been addressing the acute needs of PEH, such as by installing and servicing DIY handwashing stations, cleaning the public bathrooms, providing 300 grocery bags weekly, and distributing supplies (tents, medical kits, water, and harm reduction supplies).²⁴ The City of Berkeley is trying to coordinate all of these efforts to ensure that there is no overlap or gap in care.

SAN JOSE, CA

POINT IN TIME: As of the San Jose 2019 Point-in-Time Count, there are an estimated 6,097 PEH in San Jose, of which 5,117 (84 percent) are unsheltered.²⁵

HOTELS & TEMPORARY HOUSING EFFORTS: The City of San Jose is using community spaces, such as Park Hall and South Hall, as temporary shelters. As of March 26, 172 motel/hotel rooms in San Jose and nearby cities have been secured for isolation and quarantine.²⁶ Additionally, a little more than 100 trailers provided by the state have been used as temporary homeless shelters.²⁷

The local fairgrounds have been opened to provide space for cots and those who present symptoms are isolated in trailers.²⁸ Warming centers that typically close by the end of April have extended their service, as have other shelter providers. San Jose has also fast tracked a \$17 million plan to build up to 500 modular and prefabricated homes for PEH.²⁹

ENCAMPMENTS: The City of San Jose has adopted CDC guidelines for encampments and has temporarily suspended abatements by local authority.³⁰ San Jose has contracted to get sanitation workers to remove garbage from local homeless encampments so that sites are sanitary and clean.

The city has opened two safe parking locations for PEH who are unsheltered and living in a vehicle. Local businesses and organizations that own or have access to parking lots are being requested to donate some of this space temporarily as well.

²⁴ <https://www.latimes.com/california/story/2020-04-03/coronavirus-bay-area-activists-aid-homeless-people>

²⁵ <https://www.sanjoseca.gov/home/showdocument?id=38890>

²⁶ <https://www.sanjoseca.gov/news-stories/news/how-we-help#homeless>

²⁷ <https://www.mercurynews.com/2020/03/24/coronavirus-san-jose-prepares-109-trailers-to-house-homeless-individuals/>

²⁸ <https://abc7news.com/santa-clara-county-fairgrounds-fairground-shelter-homeless/6061271/>

²⁹ <https://www.mercurynews.com/2020/04/08/despite-budget-shortfall-san-jose-is-spending-17-million-to-build-tiny-homes-for-homeless/>

³⁰ <https://www.sanjoseca.gov/your-government/departments-offices/housing/homelessness-response/covid-19-resources>

APPENDICES

Appendix B

Other Community Responses to Addressing the Needs of PEH

In this appendix, we provide detailed descriptions of community responses across the United States outside of the Bay Area. This information is up-to-date at the time this report is released. Although we realize that this is a quickly evolving situation, we hope these case studies provide much-needed context during the COVID-19 pandemic.

PORTLAND, OR

POINT IN TIME: As of the Portland/Gresham/Multnomah County, Oregon 2019 Point-in-Time Count, there are an estimated 4,015 PEH, of which 2,037 (51 percent) are unsheltered.³¹

HOTELS & TEMPORARY HOUSING EFFORTS: Seasonal shelters have extended their operating season. The city has slowed or stopped its shelter intake to decrease shelter density. Within shelters, beds are being placed six feet apart either head-to-toe or toe-to-toe, and a staggered schedule has been implemented to limit interaction among residents.³²

Multnomah County has set guidelines to refer shelter residents to a medical motel if they are presenting with an illness, a new/worsening cough, or a temperature above 100.4°F.³³ Those who test positive for the disease are asked to provide a list of people with whom they may have been in close contact, and shelter staff then try to contact those people in order to inform them of their own risk.³⁴ Someone requesting shelter may be excluded if they present coughing and refuse to wear a face covering, but the county has advised that these people should be referred out to a medical motel rather than asked to simply leave.³⁵

ENCAMPMENTS: The City of Portland has adopted CDC guidelines for encampments and passed a moratorium on encampment evictions. The city has set up fewer than 20 portable toilets and hygiene stations for PEH to use and 54 bathrooms in public parks are regularly restocked and sanitized by the city.³⁶

³¹ https://static1.squarespace.com/static/566631e8c21b864679fff4de/t/5d434f685800cf0001847e20/1564692373569/2019+PIT+Report_FINAL.pdf

³² <https://multco.us/joint-office-homeless-services/covid-19-and-homelessness-multnomah-county>

³³ <https://multco.us/novel-coronavirus-covid-19/covid-19-guidance-shelter-settings>

³⁴ <https://multco.us/novel-coronavirus-covid-19/news/first-multnomah-county-resident-tests-positive-covid-19>

³⁵ <https://www.opb.org/news/article/portland-coronavirus-homelessness-covid-19-prevention-shelters/>

³⁶ <https://www.oregonlive.com/coronavirus/2020/03/portland-park-bathrooms-will-open-to-homeless-community-as-part-of-updated-camp-cleaning-guidelines.html>

Portland has also opened three outdoor homeless camps to slow the spread of the virus.³⁷ One site will give priority to LGBTQ people and one will give priority to people of color. Anyone who wants the services specific to those sites will also be allowed to camp there. The third site will be for everyone, with an emphasis on older people. Each location will have 45 tents on platforms with cots inside and can accommodate individuals or couples. The city will provide sleeping bags and tents to ensure they are clean and hygienic. Residents will be able to store their belongings, including their own tents and sleeping bags, while staying at the camp.

SEATTLE, WA

POINT IN TIME: As of the Seattle/King County 2019 Point-in-Time Count, there are an estimated 11,199 PEH, of which 5,228 (47 percent) are unsheltered.³⁸

HOTELS & TEMPORARY HOUSING EFFORTS: Seattle has also worked with King's County to start moving PEH that are presumed to be healthy out of shelters and into hotels³⁹ to alleviate high-density shelters, and has opened up motel rooms, modulars, and medical centers⁴⁰ for individuals who have tested positive for COVID-19 to quarantine. New spaces have been provided to shelters to ensure beds are at least six feet apart. The county has offered shelters onsite assessment and infection control guidance. The county has also opened up new units to house previously unsheltered individuals.

Seattle has also experienced a series of outbreaks in its shelters. As of April 8, 27 PEH had tested positive across 12 homeless shelters, including a newly opened shelter designed specifically to meet CDC guidelines.⁴¹ Some of these shelters implemented 14-day lockdowns after guests tested positive.

ENCAMPMENTS: The City of Seattle has adopted CDC guidelines for encampments and passed a written moratorium on encampment evictions.⁴² Seattle has increased litter and trash collection services at encampments and added hygiene and ongoing maintenance, including toilets, handwashing stations, daily sharps disposal, and daily waste removal. The city has set up portable toilets, hand-washing stations, and four hygiene trailers around the city for people who do not have easy access to hand-washing. The hygiene trailers are staffed by public utilities and outreach teams and are equipped with showers, toilets, handwashing stations, and garbage and needle disposal. Seattle has also opted to keep park bathrooms open despite park closure and has opened up community spaces to decrease capacity at shelters and promote social distancing.⁴³

Finally, Seattle has had a long history of allowing sanctioned encampments in its city. Prior to the pandemic, the city already had more than eight sanctioned encampments and had passed an ordinance to allow organized camps on 40 other sites. The city is now considering

³⁷ <https://www.oregonlive.com/coronavirus/2020/04/portland-opens-three-outdoor-homeless-camps-to-try-to-contain-spread-of-coronavirus.html>

³⁸ <http://allhomekc.org/wp-content/uploads/2019/09/KING-9.5-v2.pdf>

³⁹ <https://www.kingcounty.gov/depts/health/news/2020/April/2-covid.aspx>

⁴⁰ <https://www.kingcounty.gov/elected/executive/constantine/news/release/2020/March/25-kingcounty-seattle-covid-19-shelter.aspx>

⁴¹ <https://www.seattletimes.com/seattle-news/homeless/27-people-test-positive-for-coronavirus-in-king-county-homeless-shelters-public-health-officials-say/>

⁴² <https://homelessness.seattle.gov/covid-19-response-update-on-city-efforts-to-expand-shelter-hygiene-and-outreach-to-individuals-experiencing-homelessness/>

⁴³ <https://komonews.com/news/coronavirus/seattle-takes-steps-to-keep-homeless-safe-from-coronavirus>

fast-tracking some of those sites.

LOS ANGELES COUNTY, CA

POINT IN TIME: As of the Los Angeles Homeless Services Authority's 2019 Point-in-Time Count, there are an estimated 49,521 PEH in the Los Angeles Continuum of Care, of which 40,293 (81 percent) are unsheltered.⁴⁴

HOTELS & TEMPORARY HOUSING EFFORTS: Los Angeles County has set up emergency temporary shelters in city recreation center, including nine YMCA facilities open to PEH to use for showers, restrooms, and locker rooms.⁴⁵

Reports as of April 13, 2020 document that 23 homeless people in Los Angeles County, including four staying in shelters, had tested positive for the virus.⁴⁶ One shelter staff who contracted COVID-19 has died.⁴⁷ The floor of the shelter he was working on was put on a 14-day lockdown after he tested positive.

Additionally, Los Angeles County officials have continued to transition the medically vulnerable and elderly PEH into hotels.⁴⁸ As of April 15th, the county has contracts for beds with more 25 hotels for a combined total of 2,500 beds. The goal is to open 15,000 hotel rooms for people who are COVID-19-positive, in contact with COVID-19, awaiting tests, over the age of 65, or with underlying health conditions.⁴⁹

ENCAMPMENTS: Los Angeles County has provided 300 hand-washing stations, 120 portable bathrooms,⁵⁰ and several mobile shower services at some large encampment sites,⁵¹ such as Skid Row, which is home to nearly 10,000 PEH. As of April 15, Los Angeles County officials have increased refilling sanitation stations and are trying to make testing more available after six people tested positive.⁵² As of April 17, 300 trailers have been mobilized to serve residents without homes who are 65 and older or have pre-existing health conditions.⁵³

The Los Angeles Fire Department is also setting up a high capacity pop-up testing clinic in Skid Row, which will also include transportation to isolation and quarantine beds for people who test positive, to be implemented in the week of April 20, 2020.⁵⁴

The US Department of Veterans Affairs set up a temporary tent city for veterans

⁴⁴ <https://www.lahsa.org/homeless-count/>

⁴⁵ <https://patch.com/california/echopark/ymca-provide-hygiene-facilities-las-homeless-coronavirus>

⁴⁶ <https://www.latimes.com/homeless-housing/story/2020-04-14/coronavirus-homeless-safe-campground-veteran-affairs-los-angeles-campus>

⁴⁷ <https://abc7news.com/coronavirus-in-los-angeles-update-la-county-patient/6099247/>

⁴⁸ <https://patch.com/california/los-angeles/la-county-cities-block-coronavirus-homeless-housing-plan>

⁴⁹ <https://www.latimes.com/homeless-housing/story/2020-04-18/coronavirus-homeless-hotel-room-lahsa-project-roomkey>

⁵⁰ <https://losangeles.cbslocal.com/2020/03/18/coronavirus-covid-homeless-california-governor/>

⁵¹ <https://www.latimes.com/homeless-housing/story/2020-03-27/coronavirus-homeless-shelters-california-cities-confusion>

⁵² <https://www.latimes.com/homeless-housing/story/2020-04-16/coronavirus-skid-row-union-rescue-mission-outbreak>

⁵³ <https://www.nbcnews.com/news/us-news/california-fast-tracks-plans-house-homeless-residents-amid-covid-19-n1179656>

⁵⁴ <https://www.nbcnews.com/news/us-news/los-angeles-deploys-street-teams-help-homeless-during-covid-19-n1186746>

experiencing homelessness, the first time the Department has operated an encampment in four decades.⁵⁵ The goal is to support veterans experiencing homelessness to adequately shelter in place and practice social distancing. The initial tent city will house 25 PEH but plans to expand to 50 as needed.

NEW YORK CITY, NY

POINT IN TIME: As of the New York City Continuum of Care 2019 Point-in-Time Count, there are an estimated 78,604 PEH in the CoC, of which 3,622 (5 percent) are unsheltered.

HOTELS & TEMPORARY HOUSING EFFORTS: In recent weeks shelters have become hotbeds for COVID transmission, given shelter crowding and the absence of protective measures.⁵⁶ As of April 17, at least “537 homeless people in the city had tested positive for COVID-19 — many of whom live in the city’s vast shelter system— and 33 have died.”⁵⁷

Despite the increasing number of cases among PEH, New York City has continued to conduct sweeps of PEH, contrary to CDC guidelines. At the same time, the city did not implement budget revisions that would prevent unnecessary evictions and provide additional financial support to renters or others at risk of homelessness.⁵⁸ As of April 13, New York had housed over 4,000 individuals in hotel rooms, with another 2,000 to be housed in the subsequent week. Advocates argued that another 30,000 of the 100,000 empty hotel rooms in New York City are needed to protect residents experiencing homelessness.

BOSTON, MA

POINT IN TIME: As of the Boston Continuum of Care 2019 Point-in-Time Count, there are an estimated 6,242 PEH in the CoC, of which 121 (2 percent) are unsheltered.⁵⁹

HOTELS & TEMPORARY HOUSING EFFORTS: After discovering a cluster of COVID-19 cases at a shelter in Boston, Boston’s Healthcare For the Homeless tested all 397 shelter residents and found that 146 people, or 36 percent of all residents, had been infected.⁶⁰ The President of Boston’s Healthcare for the Homeless, Jim O’Connell, said, “This caught us unprepared, but the even more surprising finding is we screened all of them, and none had a fever, and very few had other symptoms.”⁶¹ Like San Francisco’s outbreak and subsequent testing, this outbreak in Boston shows just how widespread infection of COVID-19 is in congregate shelters and that it can circulate undetected.

Universities in the area have begun to open their recently cleared student dorms to house shelter staff and some are beginning to reserve beds for patients, including PEH, actively recovering from COVID-19. The healthcare system is moving quickly to create temporary

⁵⁵ <https://www.latimes.com/homeless-housing/story/2020-04-16/coronavirus-skid-row-union-rescue-mission-outbreak>

⁵⁶ <https://theintercept.com/2020/04/01/coronavirus-new-york-city-homeless-shelters/>

⁵⁷ https://www.vice.com/en_us/article/jge7ap/hundreds-of-nyc-doctors-and-nurses-are-begging-the-city-to-act-fast-to-keep-homeless-patients-safe

⁵⁸ <https://www.gothamgazette.com/state/9286-major-policies-not-included-in-new-state-budget-cuomo>

⁵⁹ https://files.hudexchange.info/reports/published/CoC_PopSub_CoC_MA-500-2019_MA_2019.pdf

⁶⁰ <https://www.wbur.org/commonhealth/2020/04/15/boston-homeless-population-coronavirus-asymptomatic-universal-testing>

⁶¹ <https://www.cnn.com/2020/04/17/us/boston-homeless-coronavirus-outbreak/index.html>

field hospitals. For example, the Boston Convention Center will hold 1,000 beds to be used for isolation and treatment, and 500 of these beds are being reserved specifically for PEH. As of April 7, a spokesperson for the city stated that they had enough isolation spaces for PEH that tested positive for COVID-19, but this may no longer be the case.⁶²

CHICAGO, IL

POINT IN TIME: As of the City of Chicago 2019 Point-in-Time Count, there are an estimated 5,290 PEH, of which 1,260 (24 percent) are unsheltered.⁶³

HOTELS & TEMPORARY HOUSING EFFORTS: Currently, Chicago is working to expand resources available to PEH by reducing crowding in its homeless shelters, renting hotel rooms, and distributing WASH facilities to encampments. The City announced on March 23 that approximately 900 beds at five different locations would be made available to congregate shelters to ease overcrowding.⁶⁴ As of April 13, 699 of the 900 beds were still available.⁶⁵ The Chicago Department of Public Health has released guidance for homeless shelters to implement preventative measures, such as screening for COVID-19, providing hand sanitizer, and spacing beds six feet apart.⁶⁶

On March 25, Mayor Lori Lightfoot announced a partnership with five hotels to ease hospital demand.⁶⁷ Hotel rooms are being provided for people who have been exposed to COVID-19 and are unable to isolate at home as well as for those diagnosed with COVID-19 but presenting with mild symptoms and not requiring hospitalization. However, on April 13, the city announced a partnership with several organizations to open a 100-bed isolation facility in an existing homeless shelter for COVID-19 patients without a permanent home.⁶⁸ It is unclear whether hotel rooms will still be utilized for PEH who test positive for COVID-19. The Chicago Coalition for the Homeless estimates that over 2,800 units of isolation housing is needed to provide shelter for those most at risk, particularly unsheltered individuals and individuals who are vulnerable due to age or underlying health conditions.⁶⁹

ENCAMPMENTS: Hand-washing stations are beginning to be provided to homeless encampments across Chicago,⁷⁰ and the city's Homeless Outreach Program has also given out hygiene kits, hand sanitizer, and wipes.⁷¹ According to one news report on April 8, the City of Chicago had confirmed one case of COVID-19 in a homeless shelter.⁷² By April 14, the same shelter had 12 confirmed cases.⁶⁵ The shelter remains operational.

⁶² <https://www.wgbh.org/news/local-news/2020/04/07/one-in-three-among-boston-homeless-have-tested-positive-for-coronavirus-city-officials-say>

⁶³ https://www.chicago.gov/content/dam/city/depts/fss/supp_info/Homeless/2019PITReportFinal110819.pdf

⁶⁴ <https://www.chicagotribune.com/coronavirus/ct-coronavirus-chicago-homeless-more-beds-20200323-cvqbcs-jws5athi6aqjkvcz3hqy-story.html>

⁶⁵ <https://www.chicagotribune.com/coronavirus/ct-confirmed-coronavirus-cases-chicago-homeless-shelter-20200414-2nppetd3anhgtk4wgsuohxfq4-story.html>

⁶⁶ <https://www.chicago.gov/content/dam/city/depts/cdph/HealthProtectionandResponse/COVID-19%20Guidance%20for%20Homeless%20Shelters%20Final%2003.20.2020.pdf>

⁶⁷ <https://chicago.cbslocal.com/2020/03/23/5-chicago-hotels-to-house-the-homeless-with-covid-19/>

⁶⁸ <https://chicago.cbslocal.com/2020/04/13/chicago-mayor-lightfoot-expanded-housing-services-for-homeless-during-covid-19-crisis/>

⁶⁹ <https://www.chicagohomeless.org/as-city-of-chicago-ramps-up-its-response-to-covid-19-homeless-advocates-stress-the-need-to-expand-on-solutions/>

⁷⁰ <https://chicago.cbslocal.com/2020/04/01/chicago-homeless-population-living-in-encampments-at-risk-for-covid-19/>

⁷¹ <https://chicago.curbed.com/2020/3/24/21191896/chicago-coronavirus-homeless-protections>

⁷² <https://wgntv.com/news/coronavirus/chicago-to-allocate-more-resources-to-help-the-homeless-during-covid-19/>

