

# COVID-19 AND HOMELESSNESS IN NEW YORK CITY

## PANDEMIC PANDEMONIUM FOR NEW YORKERS WITHOUT HOMES

Homeless People Sleeping in Shelters  
Face Disproportionately High Mortality Rate

by Giselle Routhier and Shelly Nortz

## INTRODUCTION

New York City is now the epicenter of the COVID-19 crisis in the United States, and within our city the communities suffering the greatest harm are Black and Latinx New Yorkers – especially those who are homeless. Government responses at every level have been far too slow to contain the spread of the new coronavirus, leading to chaos for those sleeping in shelters, on the streets, and on the subways.

On January 24th of this year, Mayor de Blasio held his first public briefing on City preparedness for COVID-19, and Health Commissioner Barbot noted then that there were roughly 800 confirmed cases in the world, principally in China, and that 25 people had died. During the prior week, the number of single adults living in New York City shelters reached new all-time records on two nights. Four months later, the COVID-19 toll on homeless people in New York City alone has exceeded the early infections and mortality in China that had signaled the disaster about to strike the most vulnerable members of our community. The pandemic hit with such speed that we may never know the true magnitude of the losses, but we must ask ourselves now whether we might have saved more lives had officials been listening and acting in more effective and timely ways to protect us all from this deadly virus.

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Photo courtesy of Gareth Smit

This paper outlines the disproportionate impacts of the pandemic – including a very high mortality rate – for homeless New Yorkers, the vast majority of whom belong to communities of color, and chronicles government responses and missteps in the early months of the crisis. It closes with recommendations for urgent and near-term City and State actions needed to help sheltered and unsheltered homeless New Yorkers obtain safe shelter; to address the economic impact of the crisis on the ability of low-income individuals and families to obtain and retain housing; and to plan for the likelihood of future pandemics as they may affect how New York provides safe shelter to our homeless neighbors.

## THE IMPACT OF COVID-19 ON HOMELESS NEW YORKERS

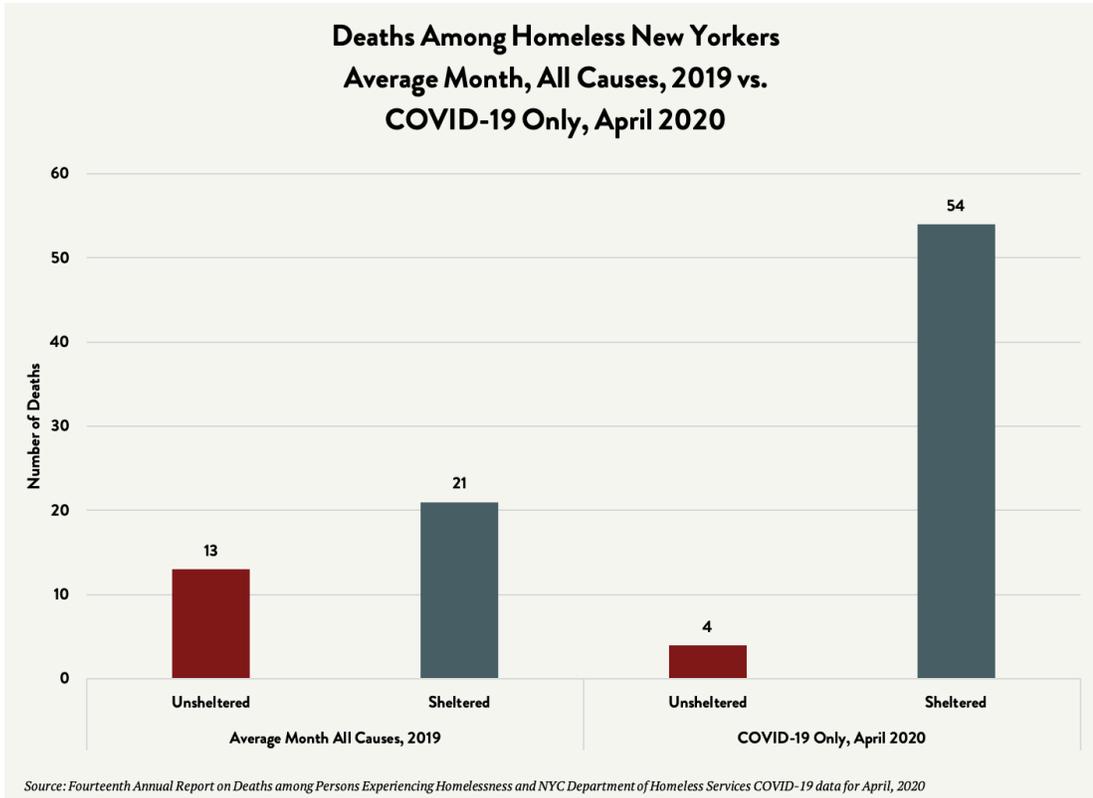
New York City was facing record homelessness prior to the coronavirus pandemic, and the virus has only further magnified the holes in the social safety net with its disproportionate impact on homeless New Yorkers. Since COVID-19 began spreading through New York City, the lack of access to safe private spaces for homeless people has exacerbated transmission, hospitalization, and deaths among this vulnerable group of individuals and families, with those living in congregate shelters finding themselves at particularly high risk.

Many unsheltered homeless individuals reasonably fear the spread of COVID-19 within the shelter system: As of May 31st, the Department of Homeless Services (DHS) reported 926 confirmed positive COVID-19 cases in approximately 179 shelter locations. As of that date, DHS had reported 86 deaths of homeless people due to COVID-19.

In the month of April alone, 58 homeless people died of COVID-19, the vast majority (54) among homeless people living in shelters. In comparison, during fiscal year 2019, an average

of 34 homeless people died each month, including 21 in shelters. Thus, the number of COVID-19-related deaths among homeless New Yorkers in shelters in April 2020 was 157 percent higher than the number of deaths from all causes during an average month in 2019. This is just a preliminary impression of the devastating impact of the virus for those living in shelters based on confirmed cases alone. As we gather more information, a fuller understanding of the disproportionate harm done to homeless New Yorkers will be seen in “excess mortality” data that will show how many more people died in this period than would have been expected, including people confirmed to have died of COVID-19, those presumed to have died of COVID-19 without being tested, and those who died due to a lack of access to appropriate medical care as the pandemic strained the city’s medical system.

Chart 1

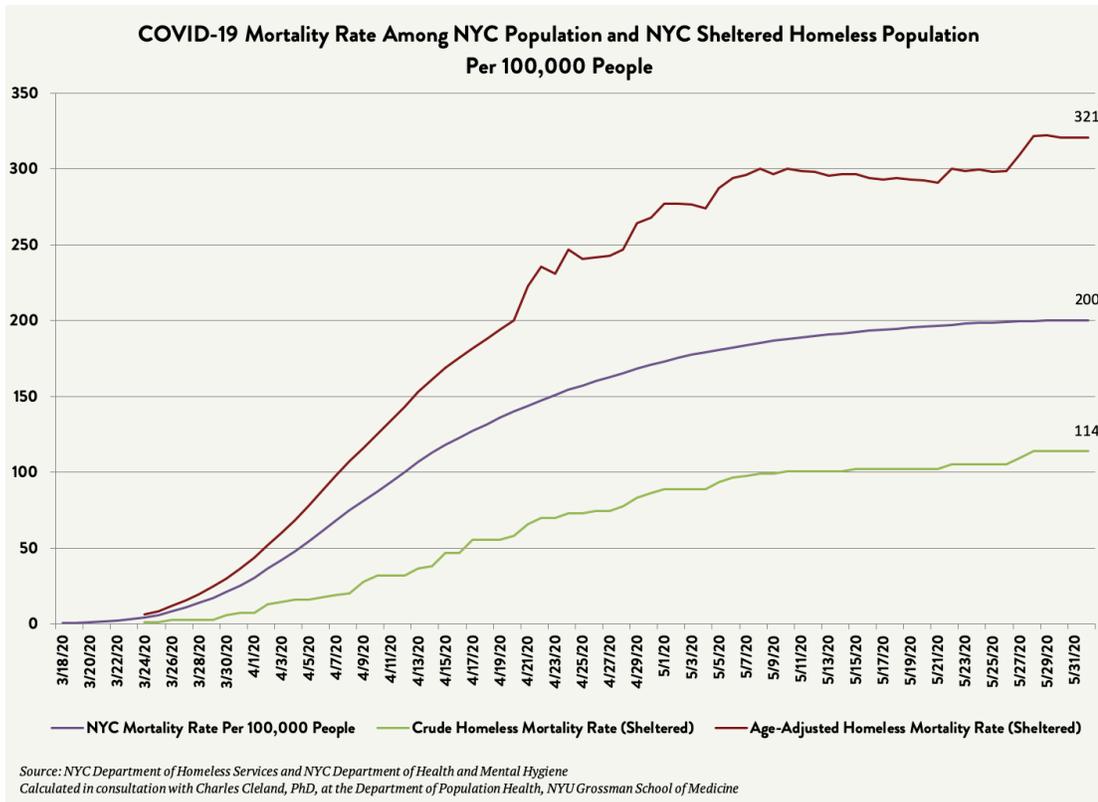


Because the sheltered homeless population skews much younger than the general New York City population, and COVID-19 is known to be particularly deadly among older adults, an age-adjusted analysis is helpful in comparing mortality rates for homeless New Yorkers with those for the NYC population generally. In consultation with Charles Cleland, PhD, a biostatistician at NYU, Coalition for the Homeless calculated the age-adjusted mortality rates among sheltered homeless New Yorkers to date.<sup>1</sup> As of June 1st, the overall New York City mortality rate due to COVID-19 was 200 deaths per 100,000 people. For sheltered homeless New Yorkers, it was 321 deaths per 100,000 people – or 61 percent higher than the New York City rate. This means that many more homeless people have died from COVID-19 than would have been expected if they were dying at the same rate as all NYC residents. The reported New York State mortality rate as of May 29th was 152 deaths per 100,000 people.<sup>2</sup>

1 Because age data are not available for unsheltered homeless New Yorkers, this calculation is not yet possible for that group.

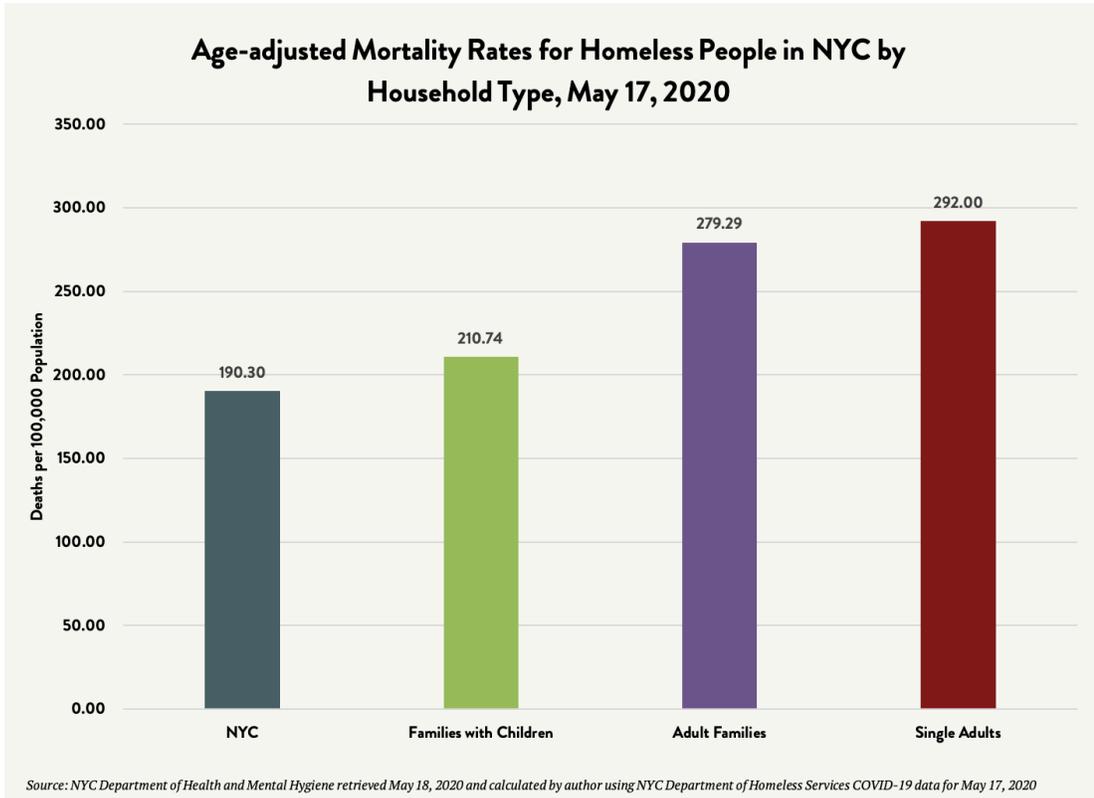
2 <https://www.statista.com/statistics/1109011/coronavirus-covid19-death-rates-us-by-state/>

Chart 2



The type of shelter setting and prevalence of risk factors among homeless people affect their exposure and vulnerability to COVID-19. The age-adjusted mortality rate for those staying in shelters varies by sub-population and is highest among those living in congregate shelters (most single adults) and those with higher rates of disability and risk factors (adult families and single adults). Regardless of household composition or shelter setting, the age-adjusted mortality rate for all homeless New Yorkers exceeds that of the New York City population in general: The rate for families with children is 11 percent higher, for adult families without minor children it is 47 percent higher, and for single adults the rate is 53 percent higher based on our calculations using Department of Homeless Services data for May 17th.

Chart 3



The mortality rate for those living in shelters may well be even higher because it was calculated without the inclusion of probable deaths due to the lack of complete public reporting, although there is ample anecdotal and documentary evidence of probable excess mortality among those staying in shelters and those who are unsheltered, just as there is for the general population.

COVID-19 infections, hospitalizations, and deaths among unsheltered homeless New Yorkers may take several months to measure due to delays and incomplete reporting, as well as the understandable hesitance of many unsheltered New Yorkers to visit drop-in centers, shelters, and emergency rooms in the midst of the pandemic. However, the excess mortality rate for unsheltered homeless individuals will likely be found to be high as well because they suffer high rates of serious underlying health conditions, are less likely to have been tested for COVID-19, and may face a similar, if not greater, COVID-19 mortality risk compared with sheltered adults.



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# THE IMPACT OF COVID-19 ON PEOPLE OF COLOR

Black and Hispanic/Latinx New Yorkers are disproportionately affected by homelessness, and these communities are also disproportionately affected by COVID-19. Approximately 57 percent of heads of household sleeping in shelters are Black, 32 percent are Hispanic/Latinx, 7 percent are White, less than 1 percent are Asian-American or Native American, and 3 percent are of unknown race/ethnicity.

Research conducted by Pew during the second week of April revealed that Black adults nationwide were more than twice as likely to know someone who had been hospitalized or died as a result of COVID-19 (27 percent) compared with just 13 percent each among White and Latinx adults.<sup>3</sup>

An early April *Washington Post* analysis of Johns Hopkins data found that in predominantly Black counties across the nation, infection rates were three times those in predominantly White counties, and that the mortality rates in counties with predominantly Black populations were six times the rates in predominantly White counties.<sup>4</sup>

The racial disparities underlying the impact of COVID-19 were examined in a recent letter by three physicians to the *Journal of the American Medical Association*, in which they discussed the social determinants of health that place minority communities at greater risk from the pathogen, including:

struggling in poverty with limited job and social mobility; working frontline jobs with lack of adequate personal protective equipment (eg, public transportation, pharmacy, grocery, and warehouse distribution workers); living in crowded apartments where social distancing is impossible; shopping in food deserts or swamps without access to healthful foods; being underinsured and using self-rationing of health care as a strategy; relying on public transportation on crowded buses and subways...<sup>5</sup>

The age-adjusted COVID-19 mortality rate per 100,000 population calculated by the NYC Department of Health and Mental Hygiene (DOHMH) as of June 1st for total deaths (confirmed and probable COVID-19 deaths) was 218.11 among Black New Yorkers, 230.02 for Hispanics/Latinx, 108.79 for Whites, and 102.51 for Asians. All of these rates are exceeded by the June 1st age-adjusted mortality rate for homeless people sleeping in NYC shelters, which was 321 per 100,000. It is clear that homeless New Yorkers are suffering the compound effects of institutionalized racism, extreme poverty, and completely inadequate protection from the new coronavirus.<sup>6</sup>

Not only is the virus itself disproportionately harmful to Black and Latinx people in the U.S., but the economic harm is also much worse for these communities. A recent Kaiser Family Foundation survey

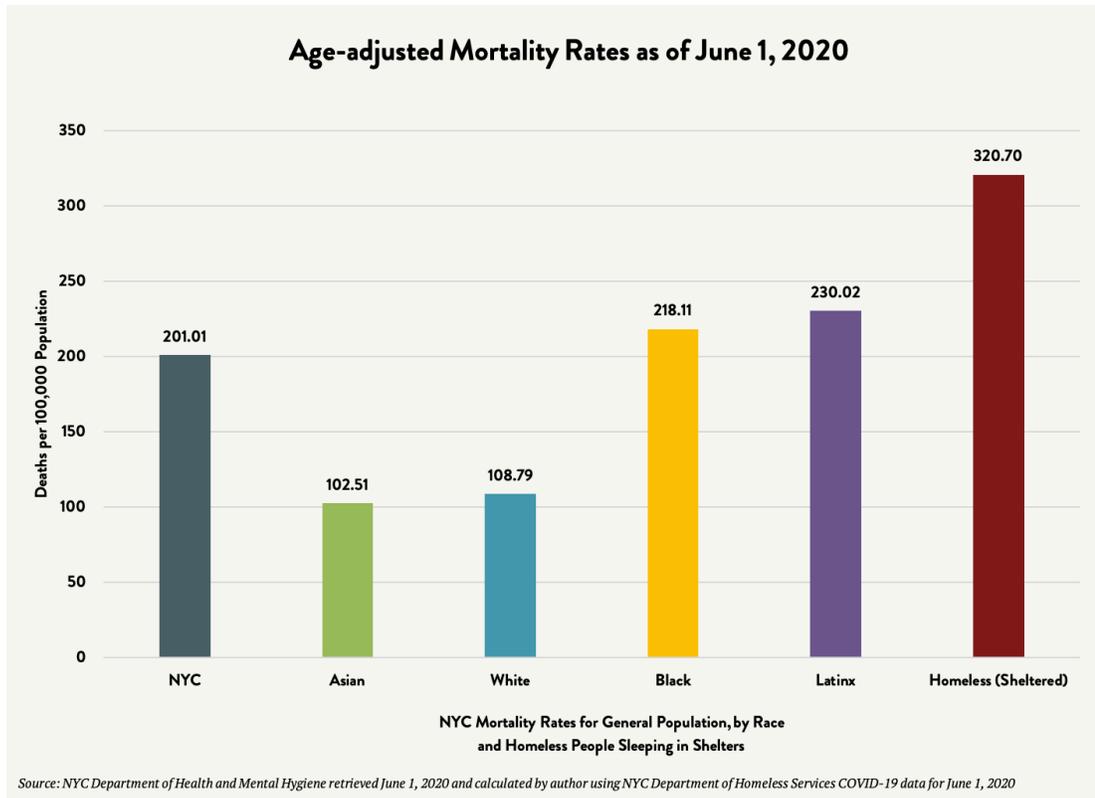
3 [https://www.people-press.org/2020/04/14/health-concerns-from-covid-19-much-higher-among-hispanics-and-blacks-than-whites/pp\\_2020-04-14\\_covid-health-impact\\_0-02-2/](https://www.people-press.org/2020/04/14/health-concerns-from-covid-19-much-higher-among-hispanics-and-blacks-than-whites/pp_2020-04-14_covid-health-impact_0-02-2/)

4 <https://www.washingtonpost.com/nation/2020/04/07/coronavirus-is-infected-killing-black-americans-an-alarmingly-high-rate-post-analysis-shows/?arc404=true>

5 <https://jamanetwork.com/journals/jama/fullarticle/2764788>

6 The *crude* (not age-adjusted) COVID-19 mortality rate per 100,000 population calculated by APM Research Lab for New York State based on Health Department data as of May 26th for total deaths (confirmed and probable COVID-19 deaths) was 251.1 among Black New Yorkers, 187.1 for Hispanics/Latinx, 80.9 for Whites, and 117.7 for Asians. As APM reported nationally, "The latest overall COVID-19 mortality rate for Black Americans is 2.4 times as high as the rate for Whites and 2.2 times as high as the rate for Asians and Latinos." <https://www.apmresearchlab.org/covid/deaths-by-race>. Note from source: "Data have been presented in 'crude' percentages and rates, meaning no adjustment has been made to standardize varying age distributions in the populations. Because the White population is older on balance in nearly all locations, age-standardizing would likely serve to widen disparities between White and other populations. Age standardizing is not possible at this time."

Chart 4



found that 48 percent of Black adults and 46 percent of Latinx people say they are having trouble paying their bills, compared with just 23 percent of White non-Hispanic adults.<sup>7</sup>

A recent survey found that more than half of adults (54 percent) expressed concern about not being able to keep their housing without additional assistance, including 72 percent of Blacks and 76 percent of Latinx adults.<sup>8</sup>

A CUNY Graduate School of Public Health and Health Policy survey conducted in the third week of April found the job loss rate among Latinx New Yorkers to be 44 percent, compared with 32 percent among Whites. The survey also showed that job losses among Asians had jumped from 25 percent to 40 percent compared with the month prior, and among Blacks the losses had more than doubled from 17 percent to 35 percent.<sup>9</sup>

<sup>7</sup> <https://www.axios.com/coronavirus-economy-jobs-unemployment-racial-disparities-29e3c6c4-bb43-4eaf-bf90-04697ca66b2d.html>

<sup>8</sup> <https://www.opportunityhome.org/poll-the-public-highly-concerned-about-housing-instability-during-covid-19-expects-major-action-from-congress/>

<sup>9</sup> <https://sph.cuny.edu/research/covid-19-tracking-survey/week-6/>

## HOMELESS NEW YORKERS ARE PARTICULARLY VULNERABLE TO COVID-19

The statistics above highlight the risks of being homeless amidst a deadly pandemic. For homeless New Yorkers in congregate shelters, the ability to adequately socially distance is impossible: 19,000 single adults are currently sheltered in approximately 150 locations across the city, with the vast majority of these locations providing shared dormitories, bathrooms, and dining areas. In addition to space limitations, homeless adults in congregate shelters:

- May not be able to wash their hands as frequently as needed due to lack of soap, shared bathrooms, and inoperable fixtures.
- Are not adequately screened upon entry to shelters.
- Live in environments where the necessary levels of cleaning and sanitation may not be effectively implemented, especially in light of the large number of individuals using the facilities and lack of adequate maintenance personnel to keep up with disinfection guidelines.
- May face shortages of core shelter staff to provide food and social services.

Unsheltered homeless New Yorkers face a different and more daunting set of challenges meeting their basic needs. Homeless people on the streets or staying in the transit system:

- Face a critical lack of access to food, water, bathrooms, showers, and laundry as well as places to warm themselves, access the internet, store their belongings, and charge electronic devices and electric equipment such as wheelchairs.
- Do not have access to basic supplies including hand sanitizer, wipes, clothing, socks, toiletries, and blankets.
- Experience highly intensified levels of stress and isolation on the streets that exacerbate symptoms of serious mental illnesses as well as chronic and acute physical health conditions.

Moreover, a significant percentage of homeless New Yorkers are considered at high-risk, including seniors as well as adults and children with underlying health conditions such as diabetes, hypertension, obesity, respiratory conditions, heart ailments, cancer, kidney or liver disease, and compromised immunity.<sup>10</sup> In a survey conducted by the Department of Homeless Services in 2017, the agency estimated that 67 percent of all single adults sleeping in the shelter system have some type of disability that may require a reasonable accommodation to ensure they have meaningful access to shelters and shelter-related services. Significantly, 27 percent reported a condition requiring air conditioning and 34 percent reported a condition requiring specific appliances or medical equipment. These underlying health conditions and disabilities likely place homeless New Yorkers at particular risk for complications should they contract COVID-19.

10 O'Connell, J. (2005). Premature Mortality in Homeless Populations: A Review of the Literature. National Health Care for the Homeless Council via: <http://sbdwww.org/wp-content/uploads/2011/04/PrematureMortalityFinal.pdf> and The Hard, Cold Facts About the Deaths of Homeless People via: <https://nhchc.org/wp-content/uploads/2019/08/HardColdFacts.pdf> See also: <https://www1.nyc.gov/site/doh/covid/covid-19-prevention-and-care.page>

## DELAYED AND INADEQUATE GOVERNMENT RESPONSE

Although officials and the public learn new information about COVID-19 each day, it has long been clear that the virus spreads rapidly within congregate living environments like shelters. The following chronology reveals how chaotic the early response was in New York City, and highlights the impact on homeless people and those serving them.

By February 2nd, the first suspected COVID-19 cases had been identified in New York City among recent travelers to affected regions, and health officials were following the expected protocols for isolating, testing, and treating patients as well as tracing their contacts to monitor the spread of the virus. None actually tested positive at that time.

As of February 24th, there still were no confirmed cases in New York City, and the Mayor announced that there were 1,200 hospital beds available for those who may require hospital isolation while awaiting test results or after having tested positive. Three individuals who no longer needed hospitalization had been quarantined in a hotel, and officials reported having quarantine capacity. However, by this time, health officials were already looking at models that projected 100,000 New York City infections by mid-April – a projection that ultimately fell short by more than 34,000.

On February 25th, the United States Centers for Disease Control and Prevention (CDC) warned of impending community spread and the need for pandemic preparedness in the United States, saying: “Disruption to everyday life might be severe.” Former New York City Health Commissioner Tom Frieden was blunt, warning that an unprecedented COVID-19 pandemic lay ahead, requiring urgent action to limit the impact, and that “thousands of undetected and infectious patients have been and continue to travel around the world,” in part because up to half of those infected with the virus are asymptomatic.<sup>11</sup> The next day, officials reported that the three patients in a New York City quarantine hotel had been released with no positive test results to date.

On February 28th, officials at the CDC issued updated guidance to address community spread of the pandemic after the first evidence of infection unrelated to travel.

On March 1st, the first COVID-19 infection diagnosed in a recent traveler located in New York City was announced, and it is now known that at that time there were likely already 10,700 infections in New York City according to researchers at Northeastern University.<sup>12</sup>

<sup>11</sup> <https://www.cnn.com/2020/02/25/health/coronavirus-pandemic-frieden/index.html>

<sup>12</sup> <https://www.dailymail.co.uk/news/article-8255139/Cuomo-says-coronavirus-arrived-New-York-Europe-2-2million-arrived-flights.html>; See also: <https://gothamist.com/news/officially-nyc-had-one-covid-19-case-new-research-suggests-it-was-actually-10000>; and <https://www.nytimes.com/2020/04/23/us/coronavirus-early-outbreaks-cities.html?action=click&module=Spotlight&pgtype=Homepage>

On March 2nd, the Mayor announced the launch of an early COVID-19 detection system (through which people with symptoms would be tested for the flu and other known pathogens as well as COVID-19), and he finally warned that community spread was likely.

On March 4th, the Department of Homeless Services shared detailed guidance from DOHMH with shelter providers directing planning and protocols to be followed in the period of limited spread of the virus, and other protocols to follow should transmission of the virus become widespread, including recommendations to screen residents and isolate them onsite. DHS simultaneously directed shelters to screen residents for symptoms and recent travel to affected countries, isolate the people with symptoms onsite, arrange clinical evaluation onsite if available, and if not, summon 911 to transport those screening positive for both questions to a hospital.<sup>13</sup>

On March 5th, evidence of community spread in New York City to two individuals who had not traveled abroad was made public, and two days later, mandatory quarantine of 18 individuals had been ordered, while 2,255 people were in voluntary self-quarantine. Mandatory quarantine was enforceable by police officers for those failing to follow the isolation requirements, and included daily calls as well as unannounced visits twice per week. Those in self-quarantine received robo-calls and text reminders about follow-up care. The number of confirmed cases was doubling every day or two, although it initially appeared to be slower (doubling every five or six days) due to lags in test results and reporting.

On March 6th, the Mayor's Office issued the following guidance to health and human services providers:

The CDC recommends that persons in the high-risk category who are asymptomatic be **quarantined for a period of 14 days**.

The CDC recommends that persons in the medium-risk category who are asymptomatic voluntarily self-monitor by remaining home or in a comparable setting, **avoiding congregate settings**, and limiting public activities.<sup>14</sup>

Simultaneously, the Governor mandated quarantine for all who had been exposed and those having traveled to the affected countries.<sup>15</sup>

But there was a problem: The virus had already spread widely within the community, and the notion of a traditional test, treat, quarantine, and trace strategy was no longer viable. Health officials arranged a briefing for City Hall on the models showing the likelihood of 100,000 infections by mid-April, hopeful that the policy could be shifted to mitigation, but that was not to be.<sup>16</sup>

Next, a group of public health experts sounded the alarm in a March 9th letter to the Mayor, declaring that COVID-19 had become a public health emergency, and warning that the City's policy should immediately shift from containment to mitigation in order to save lives.<sup>17</sup> They wrote: "The ability to 'home/self-isolate or quarantine' doesn't work for the hundreds of thousands of New Yorkers who are unstably housed – what is the plan for them?"

And yet the schools were still open, despite the advice of those inside and outside government,

<sup>13</sup> This guidance was supplied to Coalition for the Homeless by the Department of Homeless Services on March 16, 2020.

<sup>14</sup> <https://www1.nyc.gov/assets/mocs/downloads/pdf/Non%20profit%20provider%20corona%20FAQ%20as%20of%203%206%202020.pdf>

<sup>15</sup> [https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/Interim\\_Containment\\_Guidance\\_COVID-19.pdf](https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/Interim_Containment_Guidance_COVID-19.pdf)

<sup>16</sup> <https://www.propublica.org/article/two-coasts-one-virus-how-new-york-suffered-nearly-10-times-the-number-of-deaths-as-california>

<sup>17</sup> [https://www.treatmentactiongroup.org/wp-content/uploads/2020/03/community\\_letter\\_covid\\_19\\_nyc-.pdf](https://www.treatmentactiongroup.org/wp-content/uploads/2020/03/community_letter_covid_19_nyc-.pdf)

and the virus was spreading like wildfire.

The first confirmed COVID-19 infection of a homeless person came to Coalition for the Homeless' attention the week of March 9th, when the person's eight dorm-mates were placed in a separate quarantine facility for 14 days. News of this first case became public the following week on March 17th, although reports to news outlets about infections, hospitalizations, and deaths among homeless people were not routinely shared until two weeks later.

On March 10th, the Mayor reported there were 36 confirmed cases in New York City, with 30 people in mandatory quarantine (at least one-quarter of whom were apparently homeless) and 1,980 in voluntary isolation.

But almost as soon as it had begun, by the end of that week the quarantine policy had been quietly abandoned by DOHMH on March 13th. DOHMH issued new policy guidance two days later, shifting the City's public health approach from containment to mitigation. Suddenly gone from the public health response was the tried-and-true strategy for preventing the spread of this pathogen. The testing had revealed a troubling reality: Virtually everyone with flu-like illness was presumed to have COVID-19, because the tests for all of the pathogens that cause similar illnesses were coming back negative.

On March 15th, a Sunday, Governor Cuomo closed the schools. The same day, DOHMH issued 12 pages of new policy guidance for congregate settings outlining a pandemic mitigation approach that sought to help providers, shelters among them, cope with what was then termed "widespread community transmission in NYC." The guidance differed dramatically from that previously provided to shelter operators on March 4th. Specifically, it advised relocation of shelter residents and other homeless people to isolation locations for the management of COVID-like illness (CLI), and declared:

The most at-risk homeless population will be those who live on NYC streets and decline to live in NYC shelters. NYC agencies and partner organizations need to implement a plan that can identify CLI in this population and transport affected individuals to a dedicated facility, where they can be housed and supported for the full course of their illness as recommended by the NYC Health Department.

This guidance has yet to be effectively implemented. As the City continues to try to cajole those sleeping outside and on the subways to enter traditional congregate shelters and safe haven facilities (many of which also have shared bathrooms and dining) where COVID-19 has become ubiquitous, there is little evidence that unsheltered people with CLI have been properly identified and appropriately isolated.

The Department of Homeless Services did not change its protocols for sending people with CLI to hospitals in response to these new requirements, and instead issued new guidance on March 16th that continued to advise shelter operators, medical providers, and outreach workers to send homeless people to emergency departments for testing and assessment prior to quarantine, except when a medical provider had the ability to offer testing outside an emergency room.

On March 16th, the Mayor announced that there would be 250 rooms available in isolation hotels, but with little context or transparency.

On March 17th, Coalition for the Homeless and Housing Works wrote to the City urging that the Department of Homeless Services policies be aligned with those of DOHMH:<sup>18</sup>

Currently, the DHS guidance instructs that a homeless person with flu-like symptoms be

<sup>18</sup> [https://www.coalitionforthehomeless.org/wp-content/uploads/2020/04/HomelessPersonsandCOVID-19Letter\\_03-17-20.pdf](https://www.coalitionforthehomeless.org/wp-content/uploads/2020/04/HomelessPersonsandCOVID-19Letter_03-17-20.pdf)

transported by EMS to a Health and Hospitals Emergency Room to be tested for COVID-19. Under DOHMH guidelines, one should not be tested for COVID-19 unless needing a hospital admission, and persons with non-acute symptoms should not be going to emergency rooms, much less using valuable EMS capacity. Rather, they should be transported, masked, to a medical shelter where they can be monitored, treated for fever and other symptoms, and provided bed rest, food, and fluids. Only if they show more acute symptoms should they be transported to the emergency room for possible admission.

At the crux of this is failure of the Department of Homeless Services to set up adequate medical beds, notwithstanding weeks of advance notice, to be able to shelter and care for every homeless New Yorker who develops COVID-19. If even 10% of homeless adults develop COVID-19, DHS must be ready with several thousand medical beds that are physically separate from other shelter beds.

Further, homeless people staying on the streets or in transit facilities lack access to toilets, food (many soup kitchens are closing), hand sanitizer, clothing, and toiletries. All homeless people need appropriate screening, and when symptomatic for COVID-19, access to safe transport to hotel rooms, a separate safe haven for those with symptoms, or medical shelters that are physically separate from other shelters.



Photo courtesy of Olivia Berke

That evening, we learned there were 20 isolation beds available for homeless individuals with symptoms who were not in need of hospitalization (the quarantine facility previously in use for the dorm-mates of a shelter resident who had tested positive was now temporarily an isolation facility). We were also advised that the guidance to transport people to emergency rooms had come from Health + Hospitals, not DOHMH.

The following day, March 18th, we began to receive complaints from physicians that emergency rooms were filling up with homeless people who were not in need of hospitalization, some with no symptoms at all, and that DHS was not answering the phone through which hospitals had been advised to arrange discharge to isolation locations for homeless individuals. That night, we were advised that DHS officials had not been made aware of the DOHMH policy changes issued on March 15th until that afternoon, and we received assurances that the DHS guidance would be revised to re-route people with mild symptoms to isolation hotels rather than emergency rooms. The revised guidance was not issued until March 23rd, more than a week after the policy had changed, and 10 days after the decision to end the use of quarantine.

On March 17th, the Mayor also alluded to the need to begin “sheltering in place,” only to have that concept shot down by Governor Cuomo, who claimed local officials had no authority to order a quarantine – which of course they do, and had been doing for weeks. But on March 19th, when the tally of confirmed COVID-19 cases was doubling every three to four days, the Governor himself started to close down non-essential businesses and government with an order taking effect on March 22nd. Regrettably, the mitigation orders of the Mayor and Governor came too late for all of us, and particularly homeless New Yorkers.

On March 25th, the NYC Commissioner of Health and Mental Hygiene issued an official public health order stating that providing shelter to “individuals in congregate settings will further the spread of [COVID-19], endangering populations that are particularly susceptible to COVID-19 infection.” In this order, the Commissioner directed City agencies responsible for providing shelter to “locate, secure, operate, and make available non-congregate sheltering to any person needing to be isolated or quarantined in order to prevent the spread of COVID-19.”

Coalition for the Homeless started documenting problems as they were reported to us by homeless people, advocates, physicians, and others. Homeless people told us about:

- Living in shelters with dorm-mates who had tested positive for COVID-19 but remained in shelter dormitories, or in cordoned-off areas of congregate shelters.
- Being advised to return to a congregate dormitory or to practice social distancing on the street following testing for COVID-19 in an emergency room and learning of their positive test result days later.
- Being sent with positive symptoms not including fever to their assigned congregate shelter from an emergency department with a note to the shelter provider advising the need for isolation.
- The creation of quarantine rooms in two congregate shelters.
- Four LGBTQ COVID-19-positive patients in one emergency department waiting over the weekend for eligibility determinations for DHS isolation placements based on prior DHS history.

Physicians and advocates reported dozens of problems, among them:

- A patient who was COVID-19 positive and had been living with five other people in a studio, unable to quarantine at home, but ineligible for a DHS isolation bed because, although now temporarily homeless, they had not received DHS services in the past 12 months.
- On one day alone, five homeless patients waiting in one emergency department, all with mild COVID-19 symptoms, were denied isolation placements due to not having had received DHS services in the past 12 months.
- Homeless patients with mild pneumonia or mild COVID-19 symptoms who were admitted to hospitals unnecessarily because they were ineligible for isolation sites due to a lack of recorded DHS history, or were “not sick enough,” notwithstanding their lack of access to a safe place in which to self-quarantine.
- An outreach client escorted to shelter intake at 30th Street was diverted to an emergency department for testing prior to shelter admission, despite having no symptoms.
- A young, healthy patient with mild symptoms requiring isolation was the subject of 30 emails over a period of 12 hours between the emergency department and DHS due to reported “inconsistencies” in the person’s history before finally receiving approval of the isolation placement.
- Hours-long or overnight delayed responses to calls placed by hospitals to the DHS isolation placement hotline, resulting in numerous unnecessary inpatient admissions for homeless people who were later denied an isolation placement.
- A patient mildly ill with COVID-19 symptoms denied an isolation bed on the basis of their need to receive medication while isolated.
- Three homeless patients with mild symptoms served in the emergency department all day while calls to the DHS hotline were met with a busy signal.
- Delays in discharging patients to isolation because car companies declined to transport them.

- A patient referred to an emergency department with possible COVID-19 symptoms readmitted to congregate shelter facility serving 800 men to retrieve belongings en route to an isolation facility.
- A hospital serving a patient with mild COVID-19-like symptoms advised by the DHS isolation hotline and the patient's assigned shelter to return to the congregate shelter rather than an isolation shelter.
- A hospital advised that no access to isolation was possible for a patient with mild COVID-19-like symptoms for whom no test would be performed due to new testing limits.
- Failure to follow protocols to avoid sending sheltered homeless patients with mild symptoms to emergency departments.

On March 26th, The Legal Aid Society, which represents Coalition for the Homeless along with all of the homeless plaintiffs in the *Callahan* "right to shelter" case, wrote a letter to the City chronicling the chaotic situation in shelters and emergency rooms as those on the frontlines tried to figure out what to do for those homeless people who were sick, but not in need of admission to or retention in a hospital, among other things. They noted then that: "As of March 25th, there were 44 confirmed cases of COVID-19 among homeless people staying in 30 city shelters," and that City policies restricting eligibility for isolation hotels were resulting in *Callahan* class members who were sick with COVID-19 or recovering from it, exposed to others with it, or at risk of becoming ill with it, being denied placements to which they were entitled, including:

- people temporarily unable to return to their previous addresses due to the risk that other household members would become infected, whether they were previously doubled-up or part of the household;
- youth 18 or older previously served in the Runaway and Homeless Youth shelters;
- single adults who most recently were members but not heads of households staying in DHS family shelters who were required to leave due to alleged domestic violence circumstances;
- individuals who had recently lost their informal housing arrangements (such as rooms) as a result of pandemic-related job loss; and
- individuals who were hospitalized, in jail, or in other institutional settings who were newly homeless and who had not received DHS services in the past 12 months.

Legal Aid sought a commitment to address these and other problems, writing: "In the face of the unprecedented challenges posed by the COVID-19 pandemic in New York City, it is now clear that the only way for the City to meet its obligations under *Callahan v. Carey* and its basic responsibilities to protect the health and safety of New Yorkers is to immediately provide hotel placements to everyone who needs one."

Despite this and similar correspondence, and the Health Commissioner's order from the day before, the City has been far too slow in moving homeless New Yorkers out of congregate shelters and into safe, private spaces. As of June 2nd, nearly 10,000 homeless single adults were in commercial hotels, including approximately 3,500 who had been sleeping in these settings prior to the start of the pandemic. The majority of these individuals are in double-occupancy rooms, which risks the possibility that the virus may be transmitted between roommates. Nearly half of homeless single adults remain in congregate shelters and safe havens, at elevated risk of developing COVID-19. The past two-and-a-half months have been fraught with confusion and chaos for homeless New Yorkers and those serving them, with no end to the disruption in sight.

For those struggling to survive on the streets, new challenges and risks arise daily. In the early morning hours of May 6th, the City and State initiated a nightly shutdown of the subways between the hours of 1 a.m. and 5 a.m., with a specific goal of removing homeless people taking refuge in the transit system. The results of this shutdown are punitive and counterproductive: Forcing homeless individuals into the elements and onto the streets while failing to offer them a safer place to go, such as private hotel rooms, places them – and the public at large – at greater risk. Adding to the cruelty was the extreme and unseasonable cold weather during the first days of the shutdown, which left



Photo courtesy of Coalition for the Homeless

those evicted from the subways with little choice but to be shuttled to intake and assessment shelters where too many found themselves sleeping on the floor, in violation of the legal right to shelter codified in the *Callahan* consent decree. As noted above, many unsheltered homeless individuals reasonably fear exposure to COVID-19 within the shelter system. Accounts of large numbers of people bedding down on the streets each evening to avoid the subway shutdown gauntlet are now frequent, and the number of newly homeless people seeking help continues to rise as those in the most tenuous housing are pushed out of double-ups and weekly room rentals. For all the fanfare about outreach to help bring those from the subways into shelters, as of May 28th only 281 people had gone into and stayed in a shelter placement. When asked, neither the Mayor nor the Commissioner of the Department of Social Services could answer how many of these people who have stayed in shelter placements already had an assigned bed in the shelter system.

Months into this crisis, Coalition for the Homeless' programs continue to see vastly increased need for basic necessities like food, clothing, and access to toilets and showers. We now distribute nearly 3,000 additional meals per week, along with masks, hand sanitizer, phones, and cash cards through our nightly mobile soup kitchen, the Grand Central Food Program. At one site alone, the need soared from a seasonal average of 180 people seeking a hot meal each night to well over 400. We have partnered with Doctors Without Borders/MSF to open one shower trailer in midtown Manhattan, and recently opened another in Harlem. But these emergency responses will be unable to meet the dramatically increasing need, which requires immediate and comprehensive action by the City and State governments to assist homeless individuals to access safe, private spaces and long-term housing.

## URGENT ACTION

A recent public opinion survey by Hart Research Associates shows broad public support for Federal action to address housing insecurity in the wake of the COVID-19 pandemic:<sup>19</sup>

The vast majority of the public, on a bipartisan basis, believes the government should:

- Provide emergency rental assistance for people who are struggling to afford the rent and are at serious risk of eviction as a result of the coronavirus outbreak (93% favor);
- Expand funding for homeless assistance programs that minimize the number of people living in large shelters by providing them with alternative individual spaces for isolation and self-quarantine (90% favor); and
- Enact a uniform, nationwide policy that stops all evictions during the coronavirus outbreak (89% favor).

Federal programs and Congressional proposals to achieve these aims are being advanced in Washington, and similar measures are needed at the state and local level as well. In order to immediately address the disparate impact the coronavirus pandemic is having on homeless people, including people of color, the City and State must take immediate and comprehensive action, grounded in the principles of public health and human rights.

They must immediately:

- Provide thousands of single-occupancy hotel rooms for all homeless individuals living in congregate shelters and those living on the streets or sleeping in the subway system in order to facilitate appropriate social distancing, with access to private bathrooms and showers, as well as the safety of an indoor place in which to isolate and recover.
- Implement free, widespread, voluntary testing for all homeless New Yorkers and those serving them.
- End the criminalization of street homelessness, by reversing the closure of the subways between 1 a.m. and 5 a.m., ending the Subway Diversion Program, and ceasing all street sweeps.
- Ensure that individuals who are unsheltered have access to basic hygiene supplies and facilities, including masks and face coverings, hand sanitizer, clean clothes and socks, blankets, wipes, handwashing stations, restrooms, showers, and laundry facilities.
- Publish detailed COVID-19 statistics on infection, hospitalization, and mortality among homeless New Yorkers, including family composition, age, shelter status and type of shelter, race, and other relevant demographics, including risk factors.
- Engage community health centers, including Health Care for the Homeless and street medicine providers, in the contact tracing corps to ensure that the communities most isolated from mainstream health services are reached in that effort.



Photo courtesy of Olivia Berke

<sup>19</sup> <https://www.opportunityhome.org/poll-the-public-highly-concerned-about-housing-instability-during-covid-19-expects-major-action-from-congress/>

While taking immediate action to keep homeless New Yorkers safe during the pandemic, the City and State must also act for the medium- and long-term to:

- Advocate that the Federal government include \$100 billion for emergency rental assistance in the next stimulus package in order to provide rent subsidies for New Yorkers experiencing homelessness and those at risk of losing their homes.
- Support a broader Federal housing relief package including robust investments in affordable housing (which would also create jobs) and universal access to housing vouchers for those who are homeless or at risk of losing their homes.
- Support and enact statewide rental assistance legislation, including the Emergency Rental Assistance Program, Home Stability Support, and Housing Access Vouchers.
- Establish medical respite and supportive housing with on-site medical services in lieu of nursing homes for homeless people in need of nursing and personal care services who do not require inpatient care but cannot live safely in a shelter.
- Prioritize the production of permanent supportive housing in the State and City budgets.
- Initiate the redesign of emergency shelter facilities, with the expectation that the risk of exposure in future pandemics will require the provision of private rooms including bathrooms for each individual or household, and with attention to the principles of safety, public health, and individual autonomy.



***“Housing has become the front line defense against the coronavirus.  
Home has rarely been more of a life or death situation.”  
- Leilani Farha, former UN Special Rapporteur***

Leilani Farha, former UN Special Rapporteur on the right to adequate housing, rightfully and eloquently acknowledged: “Housing has become the front line defense against the coronavirus. Home has rarely been more of a life or death situation.” Mass homelessness has for too long been an unacceptable reality in New York City and elsewhere, and the failure of elected officials to proactively protect people has resulted in countless preventable deaths. In the aftermath of this pandemic, we must fully recommit to ending homelessness by providing all people with the basic dignity and safety of permanent housing. As this crisis has vividly demonstrated, housing is health care, and the absence of it can be deadly.



coalition  
for the  
homeless

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**COALITION FOR THE HOMELESS  
129 FULTON ST  
NEW YORK, NY 10038**

TELEPHONE: (212) 776-2000  
FACSIMILE: (212) 964-1303  
EMAIL: [INFO@CFTHOMELESS.ORG](mailto:INFO@CFTHOMELESS.ORG)