

**Testimony
on**

**The Disparate Impact of COVID-19 on Homeless People in New
York City**

**before the NYS Legislature
prepared by**

**Shelly Nortz, Deputy Executive Director for Policy
Coalition for the Homeless**

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Thank you for the invitation to testify on this important subject. My name is Shelly Nortz and I serve as the Deputy Executive Director for Policy with the Coalition for the Homeless. As many of you know, we have been on the frontlines of both service and advocacy since the pandemic hit New York City, and witness every day the devastating toll it has taken on our community. This week we and our colleagues will hold a virtual memorial gathering to remember the lives of members of the homeless community whom we have lost in the past few months.

Background

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. Less than 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 disastrous pandemic 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.

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 to be at particularly high risk.

Many unsheltered homeless individuals reasonably fear the spread of COVID-19 within the shelter system: As of May 13th, the Department of Homeless Services (DHS) reported 770 confirmed positive COVID-19 cases across approximately 174 shelter locations. As of that date, DHS had reported COVID-19-related deaths among 75 homeless people. 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.

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 making a comparison between mortality rates for homeless New Yorkers and 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.¹ As of May 13th, the overall New York City mortality rate due to COVID-19 was 187 deaths per 100,000 people. For sheltered homeless New Yorkers, it was 291 deaths per 100,000 people – or *56 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 is 139 deaths per 100,000 people.

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 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.²

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.³

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:

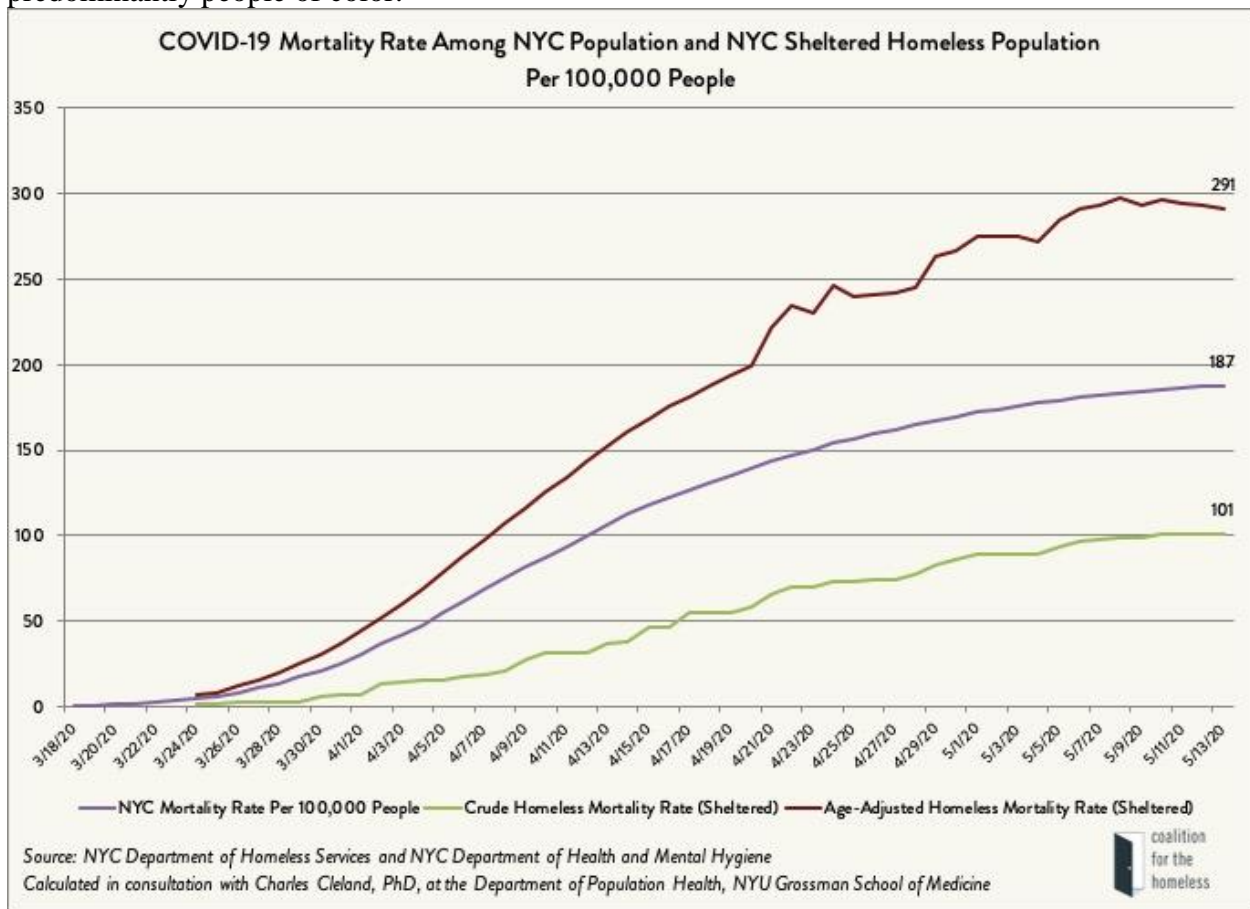
¹ Because age data are not available for unsheltered homeless New Yorkers, this calculation is not yet possible for that group.

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/

³ <https://www.washingtonpost.com/nation/2020/04/07/coronavirus-is-infesting-killing-black-americans-an-alarmingly-high-rate-post-analysis-shows/?arc404=true>

“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; and having a public kindergarten through 12th-grade education that too often leads to functional health illiteracy.”⁴

The age-adjusted COVID-19 mortality rate per 100,000 population calculated by the NYC Department of Health and Mental Hygiene as of May 6th for total deaths (confirmed and probable COVID-19 deaths) was 209.4 among Black New Yorkers, 195.3 for Hispanics/Latinx, 107.7 for Whites, and 90.8 for Asians. It is worth noting that all of these rates are exceeded by the 293.4 age-adjusted mortality rate for homeless people living in NYC shelters, who are predominantly people of color.



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

⁴ <https://jamanetwork.com/journals/jama/fullarticle/2764788>

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.

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.⁵⁶ 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.

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 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. 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 United States Centers for Disease Control and Prevention issued updated guidance to address community spread of the pandemic after the first evidence of infection unrelated to travel.

⁵ O’Connell, J. (2005). Premature Mortality in Homeless Populations: A Review of the Literature. National Health Care for the Homeless Council via: <http://sbdww.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>

⁶ <https://www1.nyc.gov/site/doh/covid/covid-19-prevention-and-care.page>

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 10,000 infections in New York. On March 2nd, the Mayor announced the launch of an early COVID-19 detection system (through which people with symptoms would be tested for 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 the NYC Department of Health and Mental Hygiene (DOHMH) with shelter providers directing planning and protocols to be followed in the period of limited spread of the virus, and other protocols 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.⁷

Evidence of community spread in New York City to two individuals who had not traveled abroad soon followed on March 5th, 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.”

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

But there was a problem: COVID-19 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

⁷ This guidance was supplied to the Coalition for the Homeless by the Department of Homeless Services on March 16, 2020.

infections by mid-April, hopeful that the policy could be shifted to mitigation, but that was not to be.⁸

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.⁹ 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, and the virus was spreading like wildfire.

The first confirmed COVID-19 infection of a homeless person came to our 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 the NYC Department of Health and Mental Hygiene on March 13th. The Department 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 be infected with COVID-19, because the tests for all of the similar pathogens were coming back negative.

On March 15th, a Sunday, Gov. Cuomo closed the schools. The same day, the NYC Department of Health and Mental Hygiene 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 the guidance 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

⁸ Sexton, J., Sapien, J. Two Coasts. (May 16, 2020) *One Virus. How New York Suffered Nearly 10 Times the Number of Deaths as California*. <https://www.propublica.org/article/two-coasts-one-virus-how-new-york-suffered-nearly-10-times-the-number-of-deaths-as-california>

⁹ https://www.treatmentactiongroup.org/wp-content/uploads/2020/03/community_letter_covid_19_nyc-.pdf

dedicated facility, where they can be housed and supported for the full course of their illness as recommended by the NYC Health Department.”

To date, this guidance has yet to be followed for the vast majority of unsheltered homeless people 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 infections have become ubiquitous.

The Department of Homeless Services did not change its protocols for sending people with COVID-like illness 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 COVID-19 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 the Department of Health and Mental Hygiene:¹⁰

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

¹⁰ https://www.coalitionforthehomeless.org/wp-content/uploads/2020/04/HomelessPersonsandCOVID-19Letter_03-17-20.pdf

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 was now temporarily an isolation facility), and 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 Gov. 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 not just for homeless New Yorkers, but for all of us.

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.”

Despite this order, the City has been far too slow in moving homeless New Yorkers out of congregate shelters and into safe, private spaces. As of May 16th, just 7,986 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. Moreover, the majority of these individuals are in double-occupancy rooms, which risks the possibility that the virus may be transmitted between roommates. More than half of homeless single adults remain in congregate shelters and safe havens, at elevated risk of exposure to COVID-19. The past two 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 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.

Two 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. Many people who rent rooms by the week have lost their jobs and housing, as have others who were unstably housed. 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, and have partnered with Doctors Without Borders to open one shower trailer in midtown Manhattan, and another set to open this week in Harlem. But these emergency responses will prove unsustainable in the absence of 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

In order to immediately address the disparate impact the coronavirus pandemic is having on homeless people, including those who are members of minority communities, 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 safe indoor places for them 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, and handwashing stations, restrooms, showers, and laundry facilities.

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 statewide rental assistance legislation, including Emergency Rental Assistance, Home Stability Support, and Housing Access Voucher programs.
- 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.
- 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.
- 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.

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.