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## MEMORANDUM

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DATE: May 11, 2020

TO: Dr. Tomas Aragon, San Francisco Chief Health Officer  
Dr. Grant Colfax, Director, Department of Public Health

FROM: President Norman Yee 

CC: Angela Calvillo, Clerk of the Board of Supervisors  
Members of the Board of Supervisors  
Board Legislative Aides

SUBJECT: Questions for Board of Supervisors' Briefing – May 12, 2020

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Dear Dr. Aragon and Dr. Colfax,

Thank you for your work to date to help guide San Francisco's response to the COVID-19 crisis. To better prepare you in advance of Tuesday's Board of Supervisors COVID-19 public health briefing, I have surveyed my colleagues on pressing questions that to date remain unanswered, including those submitted at previous Emergency Operations Center briefings. It is critical for both the members of our governing body and the general public to have accurate and clear information on the public health response to the COVID-19 crisis, particularly as the Board of Supervisors and the Mayor work together to phase in a recovery period and implement strategies that protect our most vulnerable communities from transmission. Please provide a briefing of these questions at the end of the Board of Supervisors meeting on May 12, 2020

Below are questions arranged to help you focus on the bigger issues.

### **Role of the Chief Health Officer**

1. We understand that, save for one incident, San Francisco has generally engaged in an informal agreement across all of the Bay Area counties that no local jurisdiction will deter from a universal application of public health decisions and standards for COVID-19 response without sign-off from each local Health Officer. What commitments, formal or informal, have been made on behalf of San Francisco with respect to the Chief Health Officer's guidance for San Francisco?
2. How often do you meet with your counterparts from the other five counties and the City of Berkeley? And who do you report out to after those meetings?
3. Is it the role of the CHO to initiate the drafting of San Francisco's Public Health Orders? Who has input and review of the Health Order from the City's policy body before the Chief Health Officer signs the document creating formal policy for the City and County of San Francisco? Does this include any members from the Board of Supervisors?

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### Demographics, Data & Transparency

4. According to a report, the API population represents over 50% of the deaths in San Francisco, but only a small % of those tested positive. Is there a reason why this discrepancy has not been investigated? Is there a lack of testing being done for the API population?
5. According to the City's DataTracker, almost a third of the COVID+ cases lack demographic data and are marked as "unknown" - why? What does that percentage of "unknowns" represent in terms of data sources? Are these private hospitals?
6. The Chief Health Officer has been in conversations with at least one Supervisor around issuing a health order requiring system-wide health data sharing across all hospitals and health clinics providing testing and treatment of COVID-19. Why have you not issued a health order to mandate this type of anonymized data disclosure? Is it because we are waiting for other counties to agree to do it at the same time? Is there a medical rationale as to why we are not mandating that private hospitals and health clinics share this information, including retroactively since the onset of testing? Where is that data?
7. What is San Francisco's R0, the mathematical term that indicates how contagious an infectious disease is, aka "the reproduction number"?
8. Given the importance of this number in determining an appropriate approach to targeting the allocation of limited resource and relaxing universal restrictions, why is this number not public? When was the Chief Health Officer planning on making this number public?

### Testing Asymptomatic & Vulnerable Populations

9. Dr. Philip has presented that the City's testing capacity is 5,800 San Franciscans a day with our existing supply chain, not including the testing capacity of private hospitals & doctors' groups, such as Kaiser, Sutter/CPMC, Brown & Toland, One Medical, etc.) Yet based on the DataTracker's cumulative tests reported, we have only tested 6 days worth of our testing capacity since testing began. Is the medical (not financial) rationale in service of the health and well-being of the public for why the CHO has not mandated that the City does not include the capacity of private hospitals and doctors' groups?
10. Why has the Chief Health Officer not issued a Public Health Order requesting information on the testing resources and supplies on-hand across the hospital/provider network? It seems that this information is critical to assessing the City's overall testing capacity.
11. Has the Chief Health Officer considered taking steps under this State of Emergency to consolidate resources across the hospital/provider network and develop a plan of prioritization of the deployment of those resources - in the event that they are in short supply? (Though with a

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testing capacity of 5,800 people a day, that doesn't seem to be the case, but in the event that this was the case.)

12. Doctors across the country grapple with making over who will get access to limited supplies of ventilators and life-saving resources. Has the Chief Health Officer considered an early prevention approach that focuses on consolidating testing and contact tracing resources across the network in order to avoid having to make these types of decisions after the fact?

13. Increasing access to testing is the single biggest topic of concern on bi-weekly Emergency Operations Center (EOC) calls. What progress have you made on developing and issuing clear protocols and priorities for testing and contact tracing? What benchmarks and deadlines have you set in order to release these protocols?

14. Dr. Aragon, you have said that the State and Center for Disease Control (CDC) has not issued guidance on how to operationalize asymptomatic testing. We also understand that as the County's Chief Health Officer, you have a tremendous amount of discretion which the CDC encourages localities to utilize - and which you have utilized in many other instances. We also know that as COVID-19 cases have leveled off in some demographics, we have seen confirmed cases increase in our congregate settings, including outbreaks at shelters, SRO residential hotels and senior facilities. What is the public health plan on how to operationalize asymptomatic testing in the City's highly transmissive congregate sites, particularly those where residents are mingling also with the general population as essential workers and to obtain essential services? In your medical opinion, what is the frequency that we need to operationalize mass testing in congregate facilities?

15. How quickly can the City implement concrete plans to expand testing sites, both for the general public and inside of congregate sites? (There are many barriers to SRO and housing insecure residents being able to access symptomatic testing at a CityTest site, ranging from language access, immigration status and limited mobility. What is the plan to ensure that testing can be batched on-site in congregate settings such as testing in SNFs, including the Jewish Home who is still waiting?

16. We have known since January of this year that our congregate facilities are not only the most transmissive settings but house the most vulnerable residents in the City, including demographics that SF General and UCSF doctors have identified as the biggest concerns for overwhelming our hospital system. What is our public strategy addressing outbreaks in these congregate settings and mandating steps to stop the spread in these "hot spots"?

17. What is the public health rationale behind issuing a Public Health Order for required testing in SNFs but not in other congregate settings?

18. Given the more than 100 confirmed cases of COVID-19 across at least 40 SRO buildings, what is the public health rationale for not issuing a mandatory health order for case investigation, contact tracing, testing, and isolation/quarantine in SROs?

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19. SRO residents are being told when they call the clinical hotline that there are no isolation/quarantine (I/Q) units available for them - is this why testing is not being done, so that the City doesn't have to temporarily shelter low-income residents whose current living situation prohibits them from successfully self-isolating? Who makes this determination on behalf of the Department of Public Health and does the Chief Health Officer sign off on it?
20. Given the 100+ cases in the City's shelter system, what is the public health rationale for not having a Health Order mandating and outlining a process for testing in shelters?
21. From a health perspective, do you think we can responsibly re-open the City without knowing the extent of the COVID-19 spread in congregate settings?
22. Given the value placed on organized contact tracing universally across the globe, it is clear that we cannot develop a strategy for phasing in a re-opening of the City without a robust contact tracing plan in place, which ostensibly would be led by public health officials. Why has the Chief Health Officer not issued a Health Order outlining criteria for a citywide contact tracing program? (The Department of Human Resources has stated that they have developed a volunteer program for contact tracers, but there is no clear criteria or set of standards for implementing this program. They claim they have over 70 people who have "volunteered", but it's not clear how they were selected, why others who have volunteered have been denied, or what role the Chief Health Officer has had in reviewing, vetting or developing a plan for expanding this program beyond 70 people.)
23. Homelessness and behavioral health have long been public health crises that have been underresourced and without a clear City plan for addressing. COVID-19 has obviously exacerbated the existing crisis on our streets. Please explain the street-level behavioral health response to those in crisis currently and for the foreseeable next 18 months.
24. SF General Hospital and UCSF doctors, as well as many doctors and public health officials think that the homeless and housing insecure cannot effectively self-isolate and that the majority of this population fits into the "most vulnerable" category (i.e., over the age of 60, and with multiple pre-existing health conditions?) that have long been the top users of the City's Emergency Room services and are most at-risk of overwhelming our hospital system. What is the CHO's opinion of this?
25. Why has there no Health Order ordering the commandeering of quarantine units? You told several Supervisors that you were going to issue health guidance that confirmed that housing the homeless and housing insecure in private rooms was the best medical guidance for addressing this population's unique challenges in this pandemic. What is the public health criteria for accessing a quarantine/isolation unit, beyond the "most vulnerable" criteria which the majority of unhoused individuals fit? Are there different protocols for those individuals with behavioral health challenges versus other illnesses? DPH clinicians working in the hotels and the Department of Homelessness have both said there is a list of priority individuals who meet pre-

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specified criteria for priority referral into a hotel isolation room, but that the public health staff and case managers at the hotels don't have access to that criteria or understand the referral process. Can you explain the medical rationale and prioritization? Is this the list that Dr. Bland created from his study? Or is this a new internal list of prioritization?

26. For Dr. Colfax: What is the Department of Public Health's process for soliciting feedback from DPH staff staffing hotels, or overall emergency COVID-19 response and how are those best practice recommendations considered and/or integrated into future operations?

27. Is there a Chief Health Officer's medical opinion and guidance on the creation of safe camping sites? Why has there been no formalized process or plan issued? Neighborhood groups are being told that the City's new process for addressing encampments is to close off residential alleyways and designate the public alleyways as sanctioned encampments. If these decisions are public health policies, where is the Public Health Order to ensure a standardized and accountable process? If these are general policy decisions, why have they not been brought to the Board of Supervisors?

28. Where is the written public health plan for addressing homeless encampments citywide so that the elected officials can make the necessary decisions to allocate resources where they are needed?

### **Mid/Long-term Plans for Surge Capacity & Treatment**

29. Thankfully, those residents able to shelter in place and self-isolate have largely obeyed the emergency orders and we have not experienced a network-wide surge. Given the relaxing on restrictions, the assumption is that the Chief Health Officer feels confident that we will not be expecting a surge in the next several months. What is the plan for reallocating public health resources that were being warehoused or held in case of a surge, including DPH non-essential employees?

30. What plans are being prepared now to factor in other future emergencies that are likely to occur in the next several months, including poor air quality as a result in spikes in summer dry brush and forest fires?

31. Response to those in crisis currently and over the coming months

32. Now that Remdesivir has been authorized for emergency use in the United States, how are you ensuring that the drug is being distributed equally throughout the hospitals in San Francisco, including in private hospitals? Will the Chief Health Officer issue system-wide protocols that address this?

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The following questions are related, but I will not ask for these questions to be answered on May 12, 2020. However, I will ask that you return to answer these questions in our future meeting.

### Essential Businesses and Industries

33. How many times have you been contacted by a representative of the Mayor’s Office? How many times have you been contacted by a Supervisor? What is your normal report-out of communications?
34. How do you make your determinations as to what is essential and what is not? What is the process that you undertake with the City Attorney’s Office to define what is in the best interest of the public’s health? What are the criteria, and are they weighed against the greatest good or crafted through an equity lens? Does the criteria include analyzing the highest and best use of city resources to support the State of Emergency?
35. For example: please explain the public health rationale to open up San Francisco golf courses (which account for 5% of the City’s total land mass) to the general public for emergency health and recreation space with appropriate social distancing... and then to close down this emergency resource to only a small fraction of San Franciscans? Is this the highest and best use of this property during the State of Emergency? Is the tailored recreation of a small percentage of San Franciscans who have other options to recreate (we won’t go so far as to define golf as exercise) more important than utilizing these areas for safe camping sites, for example?
36. Another example: Please explain the medical rationale for why construction of housing projects with 10% affordability requirements is healthier and more necessary than for housing projects paying in-lieu fees?
37. When you approve the exemption of certain industries from your mandatory health order, what requirements do you put in place to protect the now-essential workers of those industries? For example, what protocols have been issued to protect construction workers and day laborers?
38. Do you know how many of the Latinx community who tested positive during the UCSF Mission Study were manual laborers or working in service industry jobs where they were not afforded the same protections as other “essential” workers?
39. What safety standards, (including metering or pre-scheduled appointments) will need to be implemented for the Chief Health Officer to feel comfortable allowing small businesses to resume modified business, including curbside pick-up and outdoor dining?
40. The Director of Emergency Management has said that the Bay Area and San Francisco will likely not follow the Governor’s relaxing of the statewide Shelter In Place, but rather adhere to more stringent requirements. Assuming this is accurately the Chief Health Officer’s medical

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opinion, please explain the medical rationale and what steps the City - including the Department of Public Health - must take to achieve the necessary benchmarks to adopt the Governor's approach.

Thank you for your continued collaboration and consideration of these ongoing requests for information. We look forward to having you at the Board of Supervisors for the emergency briefing.