DECLARATION OF DR. JOHN SWARTZBERG

I, Dr. John Swartzberg, declare and state as follows:

1. I am a clinical professor emeritus at the University of California at Berkeley's School of Public Health and a physician with board certifications in internal medicine and infectious disease. I have close to 50 years of experience in those fields spanning both clinical and academic work. I am also a past director of the UC Berkeley–UCSF Joint Medical Program and I continue to teach in that program. I am also the hospital epidemiologist and chair of the infection control committee at the Alta Bates Medical Center in Berkeley, California. My curriculum vitae is attached to this declaration as Exhibit 1.

2. I have been closely following developments in the spread of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the virus that causes the disease commonly referred to as COVID-19. I have also been interviewed for articles on the subject in numerous publications, including the New York Times, the Guardian, and Forbes, among others.

3. SARS-CoV-2 is highly infectious and carries a significant risk of causing severe symptoms and even death. It is estimated to be about ten times as infectious as influenza, a disease that annually causes tens of thousands of deaths in the United States, and its mortality rate is likely 10 times greater than influenza. Serious illness occurs in approximately 20 percent of cases.

4. The virus appears to pass from person to person primarily through respiratory droplets (by coughing or sneezing), and also through contact with surfaces that have been contaminated with the droplets.

5. People who are unhoused are at high risk for both contracting COVID-19 and suffering adverse outcomes like hospitalization and death. This is particularly true for people who are staying in shelters without individual rooms, as is very common. When people are gathered in close proximity to each other, especially if they are there for extended periods of time or in enclosed spaces, the virus can spread quite rapidly.

6. People are also at higher risk of serious illness and death from COVID-19 if they have underlying chronic health conditions, such as heart disease, diabetes, or compromised immune systems. People who are unhoused have much higher rates of these underlying conditions, meaning that they are

much more likely than the general population to suffer serious illness, including death, from COVID-19.

7. Tragically, we have already seen multiple cases where congregate shelters have created clusters of infection. For example, a shelter in San Francisco was reported to have had seventy confirmed cases of SARS-CoV-2, even though the shelter had already taken steps to reduce occupancy to less than half of its normal capacity.[1] The same is true of New York City's shelter system, which, as of over a week ago, had already seen nearly 400 people test positive for the virus.[2] I also understand a shelter in Maui had its first confirmed case of the virus on or around April 17.[3]

8. In my expert opinion, pushing people who are living in homeless encampments to move into congregate shelters increases their risk of contracting the virus (or transmitting it to others if they already have it). Plainly put, from an infectious disease perspective forcing people into congregate settings like shelters is significantly more dangerous than letting people remain unsheltered.

9. Conducting encampment sweeps and confiscating the belongings of people who are houseless, such as tents, sleeping materials, and food can increase the risk of adverse outcomes from COVID-19 for those who are subject to the sweep. Taking away a person's shelter, even informal shelter like tents, will foreseeably increase that person's exposure to the elements. Likewise, taking away belongings like food and medicine can worsen a person's overall health. These actions put someone at danger of developing a more aggressive infection that is less responsive to treatment.

10. The best solution to protect public health and the safety of people who are houseless is to secure individual housing units for those individuals and families, as many state and local governments around the country are doing by, for example, leasing hotels.

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[1] Thomas Fuller, *Major Outbreak in San Francisco Shelter Underlines Danger for the Homeless*, The New York Times (April 10, 2020), available at https://www.nytimes.com/2020/04/10/us/coronavirus-san-francisco-homeless-shelter.html .

[2] Nikita Stewart, *'It's a Time Bomb': 23 Die as Virus Hits Packed Homeless Shelters*, The New York Times (Apr. 13, 2020), available at https://www.nytimes.com/2020/04/13/nyregion/new-york-coronavirus-homeless.html.

[3] *2 from Maui homeless shelter quarantined; 1 positive for COVID-19*, Hawaii News Now (April 17, 2020), available at https://www.hawaiinewsnow.com/2020/04/17/homeless-shelter-maui-quarantine-tests-positive-covid-/.

11. On March 22, the Centers for Disease Control issued guidance on addressing the risks of COVID-19 among people who are experiencing homelessness. A true and correct copy of that guidance is attached as Exhibit 2. With regard to homeless encampments, that guidance states: "Unless individual housing units are available, do not clear encampments during community spread of COVID-19. Clearing encampments can cause people to disperse throughout the community and break connections with service providers. This increases the potential for infectious disease spread."

12. In my expert opinion, failing to follow this guidance by clearing encampments will put lives at risk by increasing transmission of the virus among a vulnerable population (particularly if people are pushed to move into congregate shelters) and creating conditions that could lead to worse health outcomes for people who are subject to encampment sweeps. This, in turn, will increase the likelihood that the virus will spread throughout the wider community, further straining local hospitals and health care facilities.

I, JOHN SWARTZBERG, declare under penalty of perjury under the laws of the State of California and the United States that the foregoing is true and correct and that this declaration was executed on 4/23/2020, in Lafayette, California.

DocuSigned by:
John Swartzberg
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JOHN SWARTZBERG, M.D.

EXHIBIT 1

UCB-UCSF Joint Medical Program
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John Swartzberg, MD, FACP

Education

1962 - 1966 University of California Berkeley, CA
BA

- Pi Sigma Alpha Honorary Society

1966 - 1970 University of California Los Angeles, CA
MD

1970 - 1973 University of Colorado Denver, CO

- Internship and Residency in Internal Medicine

1973 - 1975 Stanford University Palo Alto, CA

- Postdoctoral Fellowship in Infectious Diseases

Board Certification

1973: Board Certified in Internal Medicine

1975: Board Certified in Infectious Diseases

Academic Appointments

1976 – 1984: Assistant Clinical Professor of Medicine, University of California, San Francisco

1984 – 1990: Associate Clinical Professor of Medicine, University of California, San Francisco

1984 – 1990: Associate Clinical Professor of Health and Medical Sciences, University of California, Berkeley

1990 – Present: Clinical Professor of Medicine, University of California, San Francisco

1990 – 2011: Clinical Professor of Health and Medical Sciences, University of California, Berkeley

2012 – Present: Emeritus Clinical Professor, University of California, Berkeley

Work Experience

1975 – 2001: Internal Medicine Private Practice. Berkeley, CA

1975 – 2010: Infectious Disease Consultant. Berkeley, CA

1975 – Present: Hospital Epidemiologist, Alta Bates Hospital, Berkeley, CA

1976 – 2010: Infectious Diseases Consultant, UCB Student Health Service

1990 – 2003: Associate Director, UCB-UCSF Joint Medical Program

2001 – Present: Chair, Editorial Board, UCB Wellness Letter & Health After 50 Newsletter and berkeleywellness.com

2001 – 2010: Director, UCB-UCSF Joint Medical Program

2003 – 2016: Member, Scientific Advisory Board, Clorox Corporation

2010 – 2017: Chair, Scientific Advisory Board, OnLife Corporation

2012 – Present: Member, Board of Regents, Samuel Merritt University

50,Professional Societies and Organizations

Fellow, American College of Physicians

Member, Infectious Disease Society of America

Committees and Organizations

2008 – Present: Member, Editorial Board, American Journal of Medical Quality

2007 – 2013: Advisory Board, UC Berkeley Extension

2005 – Present: Interdisciplinary MPH Program Faculty Advisory Group

2005 – 2011: Preventive Medicine Advisory Committee

2001 – 2003: UCB School of Public Health Strategic Planning Committee

1975 – present: Chair, Infection Control Committee, Alta Bates Hospital

1992 – 2011: Co-chair or Member, Curriculum Committee, UCB-UCSF Joint Medical Program

2001 – 2011: UC Office of the President Medical Student and Workforce Advisory Committee

2003 – 2100: Chair, Appointments and Promotions Committee, UCB-UCSF Joint Medical Program

2003 – 2011: Member, UCB School of Public Health Curriculum Committee

2002 – 2011: Deans Advisory Council, UCB

2006: Chancellor’s Pandemic Flu Preparedness Task Force

2006 – Present: Chairman of the Corporate Board, Bay Area Albert Schweitzer Fellowship

2007 – 2016: American Journal of American Epidemiology editorial board

2014 – 2017: Executive Board, UC Berkeley Emeriti Association

2017 – Present: President, UC Berkeley Emeriti Association

Publications

Swartzberg JE (ed.) The Wellness Report: Eating for Optimal Health, 2009 - 2017

Swartzberg JE (ed.) The Wellness Report: Dietary Supplements, 2009 - 2017

Swartzberg, JE, Pereira, W (eds.) The Wellness Report: Men's Health, 2009 - 2017

Swartzberg, JE, Stachel, L (eds.) The Wellness Report: Women's Health, 2009 - 2017

Swartzberg, JE, Krauss, R (eds.) The Wellness Report: Controlling Your Cholesterol, 200 2017

Rees, Rachel K, Swartzberg, John E. Feline-transmitted Sporotrichosis: A case study from California. *Dermatology Online Journal* 17 (6): 2, 2011

Shortell, S, Swartzberg, JE. The Physician As Public Health Professional in the 21st Centu *Journal of the American Medical Association* 300: 2916-2919, 2008 (Dec.)

Ng C and Swartzberg JE. Evaluation of hospital policies regarding surgeons infected with bloodborne pathogens. *Infection Control and Hospital Epidemiology* 2005; 26(4):410-4.

Lashof, J. C., Margen, S., Swartzberg, J. E., & Herskowitz, I. (2002). Regulating natural health products [4] (multiple letters). *Science*, *296*(5565), 46-47.

Swartzberg, John E. and Margen, Sheldon (eds.) The Complete Home Wellness Handbook. New York: Rebus, 2001.

Steinbach A; Swartzberg J; Carbone V. " The Berkeley Suitcase Clinic: homeless services by undergraduate and medical student teams." Academic Medicine, 2001 May, 76(5):524.

Swartzberg J and Margen S. Eat, Drink, and Be Healthy: The Harvard Medical School Gui to Healthy Eating (Book Review). Am J of Epimiol. 2001. 154(12): 1160-1161.

Chen, J. L., Barrett, T., Jamasbi, R. J., Morley, B. P., & Swartzberg, J. E. (2002). Infections associated with intra-spinal catheter-pump systems for severe pain management [2]. *Journa of Hospital Infection*, *50*(4), 322-323. doi:10.1053/jhin.2001.1156

Swartzberg, John E. and Margen, Sheldon (eds.) The UC Berkeley Wellness Self-Care Handbook. New York: Rebus, 1998.

Wertz RK, Swartzberg JE. Computerized interpretation of minimum inhibitory concentratio antimicrobic susceptibility testing. Am J Clin Pathol. 1981 Mar; 75(3):312-319.

Swartzberg JE, Maresca RM, Remington JS. Clinical study of gastrointestinal complication associated with clindamycin therapy. J Infect Dis. 1977 Mar; 135 Suppl: S99-103.

Swartzberg JE, Maresca RM, Remington JS. Gastrointestinal side effects associated with clinidamycin. 1,000 consecutive patients. Arch Intern Med 1976 Aug;136(8)876-879.

Swartzberg JE, Krahenbuhl JL, Remington JS. Dichotomy between macrophage activation and degree of protection against Listeria monocytogenes and Toxoplasma gondii in mice stimulated with Corynebacterium parvum. Infect Immun. 1975 Nov; 12(5):1037-1043.

Swartzberg JE, Remington JS. Transmission of Toxoplasma. Am J Dis Child. 1975 Jul; 129(7):777-779.

Swartzberg J, Kern F Jr. Hepatitis B antibody. JAMA 1973 Apr 23; 224(4): 527.

Swartzberg JE, Heibron D, Hinman F Jr. Disuse and increased function of the dog ureter. Effect on length. Urol Int. 1971; 26(1):51-64.

Media and Honors

National book tour for The Complete Home Wellness Handbook, 2001 – 2003.

Television: Four to eight appearances annually for the last 17 years on local news, commenting on health matters. 2006 and 2007 appearance on "California Connected" PBS show (organic products). CNN appearance 2006.

Radio: Multiple times annually for local radio news and NPR. Monthly appearance on the "The Consumer man", KOMO, Seattle, WA. Bimonthly appearance on Ohio NPR "Health Matters"

Print: Many interviews (e.g. SF Chronicle, New York Times, LA Times)

Editorial: Monthly editorial for the UC Berkeley Wellness Letter.

Teacher of the Year, UC Berkeley School of Public Health: 1998

Consultation

Bay Area Rapid Transit: 2012, 2015, 2020

McKesson Corporation: 2020

CooperVision: 2020

EXHIBIT 2

Centers for Disease Control and Prevention

Coronavirus Disease 2019

People Experiencing Homelessness and COVID-19

Interim Guidance

This interim guidance is based on what is currently known about coronavirus disease 2019 (COVID-19). The Centers for Disease Control and Prevention (CDC) will update this interim guidance as needed and as additional information becomes available.

This guidance is intended to provide key actions that local and state health departments, homelessness service systems, housing authorities, emergency planners, healthcare facilities, and homeless outreach services can take to protect people experiencing homelessness from the spread of COVID-19.

Background

People experiencing unsheltered homelessness (those sleeping outside or in places not meant for human habitation) may be at risk for infection when there is community spread of COVID-19. This interim guidance is intended to support response planning by local and state health departments, homelessness service systems, housing authorities, emergency planners, healthcare facilities, and homeless outreach services. Homeless shelters and other facilities should also refer to the Interim Guidance for Homeless Shelters. Community and faith-based organizations can refer to the Interim Guidance for Community and Faith-based Organizations for other information related to their staff and organizations.

COVID-19 is caused by a new coronavirus. There is much to learn about the transmissibility, severity, and other features of the disease. Everyone can do their part to help plan, prepare, and respond to this emerging public health threat.

Lack of housing contributes to poor health outcomes, and linkage to permanent housing should continue to be a priority. In the context of COVID-19, the risks associated with sleeping outdoors in an encampment setting are different than with staying indoors in a congregate setting such as an emergency shelter or other congregate living facility. Outdoor settings may allow people to increase distance between themselves and others. However, sleeping outdoors often does not provide protection from the environment, quick access to hygiene and sanitation facilities, or connection to healthcare. The balance of risks should be considered for each individual experiencing unsheltered homelessness.

Partnerships

Reaching and protecting people experiencing unsheltered homelessness during the COVID-19 outbreak will require coordination across several local sectors. To prevent negative outcomes from lack of services, community leaders should continue activities that protect people experiencing homelessness, including supporting continuity of homeless services, healthcare, behavioral health services, food pantries, and linkages to permanent housing. Plans need to be clearly communicated to all stakeholders.

- **Homeless outreach teams and public health outreach workers** will often be the front lines. These workers need to be prepared to protect themselves and their clients, provide health education information, and help direct their clients to care as necessary (see box).
- **State and local health departments, homelessness service systems, housing authorities, and emergency planners** will need to identify where people without housing can be isolated and receive care if they are suspected to have COVID-19, are awaiting COVID-19 testing results, or are confirmed to be positive COVID-19 cases. These plans should also include transportation protocols.
- **Hospitals and healthcare facilities** should ensure that they are involved in planning the logistics for safely discharging COVID-19 patients to a designated location if they do not require hospitalization but lack housing.
- **Law enforcement** should be apprised of plans related to protecting people experiencing unsheltered homelessness from COVID-19 in order to best work in coordination with homelessness service systems and state and local health

departments.

- **People experiencing homelessness themselves** are an important resource to help navigate their communities and keep their friends and family members safe. Consider developing an advisory board with representation from people experiencing homelessness to ensure plans are implementable in the community.

Prevention measures

Encampments:

- Unless individual housing units are available, do not clear encampments during community spread of COVID-19. Clearing encampments can cause people to disperse throughout the community and break connections with service providers. This increases the potential for infectious disease spread.
- Encourage people staying in encampments to set up their tents/sleeping quarters with at least 12 feet x 12 feet of space per individual.
- Ensure nearby restroom facilities have functional water taps, are stocked with hand hygiene materials (soap, drying materials) and bath tissue, and remain open to people experiencing homelessness 24 hours per day.
- If toilets or handwashing facilities are not available nearby, provide access to portable latrines with handwashing facilities for encampments of more than 10 people.

Communications:

Provide straightforward communications to people sleeping outside in the appropriate language. Identify people who are influential in the community who can help communicate with others. Post signs in strategic locations to provide information on hand hygiene, respiratory hygiene, and cough etiquette. Request up-to-date contact information for each person.

Information to share includes:

- The most recent information about COVID-19 spread in their area
- Advice to avoid crowded areas if COVID-19 is circulating in their community
- Social distancing recommendations
- Hand hygiene instructions, cough etiquette instructions, and advice not to share personal items
- How to recognize the symptoms of COVID-19 and what to do if they are sick
- What to do if their friends, family, or community members are sick
- How to isolate themselves if they have symptoms
- Updated information on where to find food, water, hygiene facilities, regular healthcare, and behavioral health resources if there have been local closures or changes

People at Higher Risk of COVID-19

Some people who are experiencing unsheltered homelessness may be at higher risk of moderate to severe disease because of certain conditions. Pay particular attention to preventing disease among these individuals.

Isolation housing

Local partners should plan for where individuals and families with suspected or confirmed COVID-19 experiencing unsheltered homelessness can safely stay. These should include places where people who are confirmed to be positive and those awaiting test results can be isolated. Additionally, if a person needs to be hospitalized, a plan should be in place for how they will safely recover after discharge. Ideally, these individuals will be housed for the duration necessary, as outlined in the recommendations for discontinuation of isolation. Isolation housing could be units designated by local authorities or shelters determined to have capacity to sufficiently isolate these individuals. If medical care is not necessary and if no other options are available, advise the individual on how to isolate themselves while efforts are underway to provide additional support. In each scenario, identify how to safely transport patients to and from healthcare and housing

facilities.
Behavioral health teams should be involved in the planning for these sites to facilitate continued access to support for people with substance abuse or mental health disorders. In some situations, for example due to severe untreated mental illness, an individual may not be able to comply with isolation recommendations. In these cases, community leaders should consult local health authorities to determine alternative options.

A local surge in the need for medical care may require jurisdictions to establish isolation sites and alternate care sites (ACS) where patients with COVID-19 can remain for the duration of their isolation period. These are typically established in non-traditional environments, such as converted hotels or mobile field medical units. Isolation sites are intended to be locations for patients who do not require medical care, while ACS are intended be locations for patients who require some degree of medical care. Isolation sites can be used for people with COVID-19 who are currently experiencing homelessness and cannot be discharged to a congregate setting. For more information, please see Alternate Care Sites and Isolation Sites.

Homeless services outreach staff

When COVID-19 is spreading in your community, assign outreach staff who are at higher risk for severe illness to other duties. Advise outreach staff who will be continuing outreach activities on how to protect themselves and their clients from COVID-19 in the course of their normal duties. Instruct staff to:

- Greet clients from a distance of 6 feet and explain that you are taking additional precautions to protect yourself and the client from COVID-19.
- Screen clients for symptoms consistent with COVID-19 by asking them if they have a fever, new or worsening cough, or shortness of breath.
    - If the client has a cough, immediately provide them with a surgical mask to wear.
    - If urgent medical attention is necessary, use standard outreach protocols to facilitate access to healthcare.
- Continue conversations and provision of information while maintaining 6 feet of distance.
- Maintain good hand hygiene by washing your hands with soap and water for at least 20 seconds or using hand sanitizer (with at least 60% alcohol) on a regular basis.
- Wear gloves if you need to handle client belongings. Wash your hands or use hand sanitizer (>60% alcohol) before and after wearing gloves.
- If at any point you do not feel that you are able to protect yourself or your client from the spread of COVID-19, discontinue the interaction and notify your supervisor. Examples include if the client declines to wear a mask or if you are unable to maintain a distance of 6 feet.
- Provide all clients with hygiene products, when available.
- Street medicine and healthcare worker outreach staff should review and follow recommendations for healthcare workers.
- Review stress and coping resources for yourselves and your clients during this time.

Page last reviewed: March 22, 2020