

TUBERCULOSIS (TB) INFECTION CONTROL GUIDELINES FOR HOMELESS SHELTERS

For Shelter Staff and Clients

FOURTH EDITION
Spring 2005

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The San Francisco Tuberculosis & Homelessness Task Force accepted the challenge to develop shelter TB guidelines to help promote a standard of care for shelters throughout the city. Because of the invaluable input from shelter management, its directors and staff, and shelter service providers, these guidelines will go a long way in protecting both clients and staff from being exposed to TB.

For additional copies please call (650) 994-5864



Section 1: Purpose

A. Introduction

The purpose of the Tuberculosis (TB) Infection Control Guidelines for Homeless Shelters is to provide the management and staff who work at homeless shelters in the City and County of San Francisco with the tools for making appropriate decisions about persons seeking shelter at homeless facilities who may be suspected of having tuberculosis.

These guidelines will help to ensure that people seeking services from homeless shelters are not excluded from these services because of infectious disease concerns, but are directed into the appropriate health care delivery system with minimal risks to shelter staff. It is the hope of the San Francisco TB & Homelessness Task Force that these guidelines will be adopted and implemented as standardized policies for every homeless shelter in San Francisco. These guidelines are supported by the Department of Public Health, San Francisco General Hospital - Tuberculosis Control Program and Tom Waddell Health Center the DPH Health Care for the Homeless Program as well as other Homeless Programs.

B. Rationale for Tuberculosis (TB) Guidelines

Despite the recent decline in total number of TB cases in San Francisco, TB continues to persist as a health hazard in the homeless community. Homeless shelters are among the most likely places where TB can be transmitted in San Francisco.

Staff and residents of San Francisco homeless shelters often have varying or limited training and knowledge of tuberculosis, including the signs and symptoms of TB, the risk of getting TB, and the ways TB can be transmitted from one person to another. Staff and residents may not also be aware of the importance of baseline and periodic TB skin testing as a means of protection and early detection.

Standardizing TB guidelines at each San Francisco shelter, based on recommendations from the Centers for Disease Control and Prevention (CDC), will help to minimize or eliminate the possibility that homeless individuals seeking shelter for the evening will be turned away by shelter staff for unwarranted fears of contracting tuberculosis and will better facilitate TB control in San Francisco homeless shelters.

For more information about San Francisco TB epidemiology, please refer to “Profile of TB in San Francisco” on the TB Control Section webpage:
<http://www.dph.sf.ca.us/PHP/TB/TB.htm>

C. Goal of TB Infection Control Guidelines

The goal of these guidelines is to minimize or eliminate the spread of TB in San Francisco homeless shelters by providing uniform recommendations for TB screenings, TB training, and other preventive measures for both shelter staff and clients.

D. Objectives

1. To provide standardized guidelines to assist Homeless shelter staff in their efforts to house clients and control the spread of TB by:
 - Requiring TB screening
 - Early identification of suspected cases of active TB
 - Ensuring rapid evaluation of suspected cases by appropriate health care providers
 - Providing timely transportation to an appropriate health care facility if an evaluation cannot be done at the shelter.
2. To assist shelter staff with good decision-making tools when homeless persons arrive at shelters with signs and symptoms of illness, which could be perceived as active TB. This will help to prevent arbitrary exclusion of such persons from homeless shelters based on non-medical fears about TB.

Section 2: Shelter Management of TB Control

A. Engineering Controls (Mechanical Ventilation Systems): An Introduction

The following are excerpted from the CDC's Prevention and Control of Tuberculosis Among Homeless Persons:

3. The probability of TB transmission is affected by building ventilation.
4. Re-circulated air may contribute to transmission within a shelter.
5. Because even optimal ventilation does not preclude TB transmission, supplemental upper room germicidal ultraviolet (UV) air disinfections may be useful to further reduce the chance of transmission. For safety and efficacy reasons, UV fixtures should be planned, installed, and monitored after installation by an experienced consultant.

B. Engineering Control Recommendations

Please refer to **TB in Shelters: Reducing the Risk through Ventilation, Filters, and UV** referenced on page 14.

1. A one-time engineering assessment of shelter ventilation is recommended in order to determine the most appropriate ventilation system. With proper filter maintenance in place, continued engineering assessment will be determined by engineering consulting group and shelter director.
2. Implementation of recommended engineering controls should be based on funding available and prioritized to areas where transmission is likely to occur.
3. Directors of shelter programs are responsible for ensuring that maintenance and monitoring are carried out in their facility according to a written schedule. Records should be kept confidential.
4. Filters used in ventilation systems should be the pleated type. They should be checked every month.
5. Filters should be replaced when fully loaded with dust, and at least every six months. Filter maintenance is recommended since it decreases the chances for spreading TB in shelter facility.

6. Janitorial staff shall be trained to change and maintain filters routinely.
7. Ventilation air outlets should be cleaned free of dust and lint every month.
8. Ventilation systems should be set to run continuously while the building is occupied.
9. Windows and doors should be kept open as often as possible to provide fresh air.
10. Small offices frequented by shelter clients should have working windows to provide fresh outside air, and/or a portable HEPA filter unit.
11. For crowded congregate rooms, such as TV lounges and lobbies, consider the use of upper room UV lamps and HEPA filter units to supplement the central ventilation system.

C. Respiratory Protection

1. A mask (disposable paper or cloth surgical mask) is a device worn to cover or partially cover the face. If worn on the client, it will prevent transmission, if worn on staff it will not provide adequate protection.

PLEASE NOTE: Asking someone to wear a mask can potentially make a client feel offended and singled out. A coughing client, as all clients, should be treated with dignity and respect.

2. Respiratory Protection Recommendations:
 - a. All homeless shelter staff or clients who are coughing should be encouraged to wear a mask to help prevent infection. Staff who are ill should be encouraged not to work until free of infection. Clients in homeless shelters who are actively coughing should be asked to wear a mask until they can be medically evaluated and treated for their illness.
 - b. It is recommended that each shelter post the following sign for client awareness and cough monitoring (enclosed in Appendix F).

“Masks are available to cover your cough. Please ask a shelter staff person for a mask, if you are coughing frequently and are willing to wear one. If your cough does not stop, a staff person may offer you one. Thank you for covering your cough!”

- c. Mask use is encouraged, but will be left to the discretion of shelter staff and management.

Section 3: TB Screening of Homeless Shelter Staff

A. Goals for screening/recommendations

1. All homeless shelter staff should be screened for TB on a biannual (every 6 months) to annual (every 12 months) basis. All homeless shelter staff will be required to show proof of TB screening.
2. If an employee has tested positive for TB in the past, s/he should not re-test. Instead, s/he should be screened with a chest x-ray (if no prior treatment) and a TB symptom assessment (questionnaire) to identify any symptoms of active TB.
3. Staff that has not had prior TB screening with a skin-test within the last 12 months will be required to undergo two step baseline TB skin testing. Having the TB blood test avoids this extra procedure.

B. Two step TB skin testing

Two step TB skin testing means that a second TB skin test is placed one week after the first skin test on all staff whose first skin test was negative (no skin reaction). This second tests helps to ensure that the employee with an old TB infection is identified. This technique helps avoid false converters and the fear of recent infection.

C. Staff who are Skin Test Positive (+PPD) or Blood Test Positive (+QFT)

1. Should have an initial chest x-ray or provide documentation regarding a chest x-ray (written report of a chest x-ray within the past 6 months).
2. Complete symptom questionnaire.
3. Receive a medical evaluation to determine need for further workup or treatment.

D. Staff who are suspected of having TB or are symptomatic

Staff who are suspected and symptomatic (show signs of disease) of active TB disease shall be required to have:

1. An immediate medical evaluation through either the San Francisco General Hospital (SFGH) TB Clinic and/or one of the homeless health care programs listed in the resource manual. The medical evaluation will include a doctor's interview, TB skin or blood test and chest x-ray within 48 hours.
2. Be immediately excluded from workplace until confirmed non-infectious.

E. Staff who are HIV positive/immunocompromised

Immunocompromised staff or residents will need TB screening by chest x-ray since TB skin testing may be falsely negative for these individuals.

Section 4: Shelter Staff Orientation and Training Curriculum Outline

A. Required Training

All employed and volunteer staff working at homeless shelters in San Francisco will:

1. Review a pre-training TB video, “Shelters and TB: What Staff Need to Know” within 30 days of starting work;
2. Attend a TB training provided by trained shelter staff or TB Outreach & Prevention Services (see educational resources for contact information). Shelter directors are required to call TOPS at (415) 597-7950 to schedule training for all new staff members within 60 days of their starting work.

B. TB Training Outline

TB training shall include at a minimum the following topics:

1. What is Tuberculosis?
 - TB prevalence in San Francisco
 - TB prevalence among the homeless population
2. Tuberculosis transmission: How it is given to others.
3. Interpretation of TB skin testing: What a positive skin test means.
4. The difference between TB infection and TB disease.
5. Who is at risk for TB infection and disease?
 - TB and HIV connection
 - Poor health
 - Drug use
6. The signs and symptoms of active TB disease.
7. The difference in TB skin test requirements for homeless shelter staff, case-managed clients, drop-in clients, and the reasons for these differences.
8. How to effectively ask a client about TB symptoms.
9. How to evaluate and handle clients who seek shelter and are suspected of having active TB disease.
10. Treatment and preventive therapy.
11. TB prevention measures: How can shelter staff protect themselves?
 - Where masks are stored
 - Importance of using tissues to cover coughs and other

- preventive measures
 - Ventilation
- 12. Identifying and referring persons for medical evaluation (Cough Alert Policy).
- 13. TB policies and procedures.
- 14. Patient TB Clearance and information card.
- 15. Referral mechanisms:
 - TOPS Clinic
 - TB Clinic
- 16. The importance and means of maintaining confidential client information and records.

Section 5: TB Screening of Shelter Clients/Residents

A. Shelter Admission

All homeless shelter staff will be instructed that clients who have a cough and are seeking shelter will not be turned away. Shelter staff have the option of offering a mask to a client who is coughing.

1. Recommendations for admitting a client with a cough
 - a. When a client with a cough is identified, he or she should be taken aside by shelter staff and asked if he/she has had a **cough for more than three weeks**.
 - b. Shelter staff must ask if the client has had **one or more** of the following **clinical symptoms of TB Disease**.
 - § Unexplained weight loss
 - § Night Sweats
 - § Fever
 - § Chronic Fatigue/Malaise
 - § Bloody phlegm
 - c. Advise client to cover their nose and mouth with tissue when coughing. Anyone who has a chronic cough will be asked to wear a mask.
 - d. If deemed necessary, segregate client from the other residents until a medical evaluation can be performed.
 - e. All clients who have a chronic cough for **three weeks or more** plus **more than one clinical symptom** should be referred to SFGH TB Clinic, SFGH Emergency room (ER), and/or homeless health care programs for a medical evaluation as soon as possible, and preferably early the next morning.

B. Clients receiving shelter services for more than 3 days (cumulative within a 30-day period) at any shelter.

1. If symptomatic with a cough, client will need medical evaluation ASAP, preferably the next morning.

2. If no symptoms are present, clients should complete screening for TB within 10 days of notification or risk losing their shelter bed.

C. TB Screening Policy

All shelter clients will be required to show evidence of TB clearance within 10 days after admission to the shelter.

D. Management of Coughing Shelter Clients

Coughing clients identified by shelter staff should follow procedures of the Cough Alert Policy below developed by the San Francisco TB Control Program (See Appendix G for shelter specific template). Shelter management will insure that this policy is followed and is part of routine employee orientation.

Definition of “coughing client”:

1. An client coughing throughout the night **or**
2. Coughing for more than 2-3 weeks without improvement (especially if the cough is accompanied with >5 lbs weight loss, night sweats and fever) **or**
3. Coughing up blood

Procedures:

1. Instruct patient to cover nose and mouth when coughing and offer a mask to wear.
2. Record the date, client name, bed number, and give the information to assigned shelter public health liaison/supervisor
3. The assigned shelter liaison or designee will then notify the TB Control liaison, of the patient needing evaluation.
4. Assigned shelter liaison or case management staff will notify the coughing client confidentially that a CXR and urgent medical evaluation will be needed and will provide the information on where and how the patient will get the evaluation.
5. Evaluation should occur ASAP through the following mechanisms:
 - TB Clinic (SFGH campus, Bldg 90, Wd 94): Monday 1-5pm, Tuesday and Thursday 9am-6 pm, and Friday 8:30am-12 noon
 - Emergency Room at SFGH
 - Other (see appendix B, page 16)

E. Confirmation and screening tests for active TB

Symptomatic clients will be expected to complete a medical evaluation that includes a TB test, a chest x-ray, doctor’s assessment and possibly other diagnostic tests at SFGH TB Clinic, SFGH ER and/or homeless health care programs. The evaluation must be done as soon as possible and **within 48 hours**. Clients must be assured that if they do

have active TB disease, they will be treated at SFGH and upon release will be assisted in finding stable housing until completion of their TB treatment.

F. Medical Treatment of Active TB Cases

Clients with medically confirmed active TB will not be admitted until clearance is provided in writing by SF TB Control. .

Section 6: APPENDICES

Appendix A. Glossary of Terms Related to TB

TB Infection - A condition in which TB bacteria are alive but inactive in the body. People with TB infection have no symptoms, do not feel sick, cannot spread TB to others, and usually have a positive skin test reaction. However, they may develop TB disease later in life if they do not receive preventive therapy.

TB Disease - An illness in which TB bacteria are multiplying and attacking different parts of the body. The symptoms of TB disease include weakness, weight loss, fever, no appetite, chills, and sweating at night. Other symptoms of TB disease depend on where in the body the bacteria are growing. If TB disease is in the lungs (pulmonary TB), the symptoms may include a bad cough, pain in the chest, and coughing up blood.

TB Skin Test (Mantoux PPD Skin Test) - A test that is often used to detect TB infection. A positive reaction indicates TB infection.

TB Blood Test, Quantiferon (QFT) – A test, like the TB skin test that is used to detect TB infection. A positive result indicates TB infection.

Chest x-ray - A picture of the inside of your chest. An x-ray can show whether TB bacteria have damaged your lungs.

Contact - A person who has spent time with a person with infectious TB.

Sputum - Fluid from lungs which is tested to see whether there are TB bacteria present.

Isoniazid (INH) - A drug used to prevent TB disease in people who have TB infection.

Multidrug-resistant TB (MDR-TB) - TB disease caused by bacteria that are resistant to more than one of the drugs often used to treat TB.

Directly Observed Therapy (DOT) - A strategic method of helping patients take their medicines for TB. If you get DOT, you will meet with a health care worker every day or several times a week. You will meet at a place you both agree on. This can be the TB clinic, the shelter, under the freeway or any other location.

Appendix B. TB Health Resources

TB Screening

**Tuberculosis Outreach and
Prevention Services (TOPS) -
SFDPH Satellite Clinic**

1060 Howard St., 3rd Floor
(415) 865-5200
8AM - 4:30PM M-F
Testing Hours: M,T,W 8:30AM-
12:30PM (*with a written referral on
agency letterhead*)

**Health Care for the Homeless
Tom Waddell Health Center**

50 Lech Walsea (Ivy) Street
M-F 8:00 a.m. - 8:00 p.m.
S-S 9:00 - 5:00 p.m.
(415) 554-2950

St. Anthony's Clinic

105/107 Golden Gate Ave.
(415) 241-8320
M-F 8:15 a.m. - until they close (new
drop-ins)
(*Clients must not have insurance or
Medi-Cal in order to be seen*)

Glide Health Services

330 Ellis (4th Floor)
(415) 674-6140

Haight Ashbury Free Clinic

558 Clayton Street
(415) 487-5632

**Mission Neighborhood Health
Center**

240 Shotwell Street (Francis)
(415) 552-3870

Native American Health Center

160 Capp Street
(415) 621-8051

North East Medical Services

1520 Stockton Street
82 Leland Avenue
2308 Taraval Street
(415) 391-9686

San Francisco Free Clinic

4900 California Street (11th Ave.)
(415) 750-9894

South of Market Health Center

551 Minna Street
(415) 626-2951
M-TH 8:00 am - 5:00 pm
F 8:00 am - 1:00 pm
Sat 8:30 am- 1:00 pm

Southeast Health Center

2401 Keith Street (Armstrong)
(415) 671-7000

Department of Public Health District Health Centers

Castro - Mission Health Center

3850 17th Street (Noe)

(415) 485-7500

Chinatown Public Health Center

1490 Mason Street (Broadway)

(415) 364-7600

Maxine Hall Health Center

1301 Pierce (Ellis)

(415) 292-1300

Ocean - Park Health Center

1351 24th Avenue (Irving)

(415) 682-1900

Silver Avenue Family Health Center

1525 Silver Avenue (San Bruno Ave.)

(415) 715-0300

Follow-Up Evaluation, Care and Intervention

San Francisco TB Clinic

Ward 94, Bldg. 90, SFGH campus
1001 Potrero Ave.
M - 1-3 p.m.
T, TH. 9:00 - 5:30 p.m.
F- 8:00 - 10:30 a.m.
CLOSED ON WEDNESDAYS
(415) 206-8524

San Francisco General Hospital Emergency Room

1001 Potrero Ave.
24 hours
(415) 206-8111

Health Care for the Homeless Tom Waddell Health Center

50 Lech Walsea (Ivy) Street
M-F 8:00 a.m. - 8:00 p.m.
S-S 9:00 - 5:00 p.m.
(415) 554-2950

South of Market Health Center

551 Minna Street
(415) 626-2951
M-TH 8:00 am - 5:00 pm
F 8:00 am -1:00 pm
Sat 8:30 am- 1:00 pm

Health Care for Homeless Veterans

Dept. of Veterans Administration
205 13th St.
(415) 487-6800
M-F 9:00 - 11:30 a.m. (Drop-in)
M-F 1:00 - 4:00 p.m. (Appointments)
Closed on Wednesdays

Larkin Street Youth Center

1044 Larkin St
(415) 673-0911
M-Tues, 12 p.m. - 6:30 p.m.
Th-Fri., 11 a.m. - 6:30 p.m.
(Youth 21 & under) Closed on
Wednesdays

Glide Memorial Church Clinic

330 Ellis
(415) 771-6300 M & Thurs 1-5 p.m.

St. Anthony's Clinic

105/107 Golden Gate Ave.
(415) 241-8320
M-F 8:15 a.m. - until they close (new
drop-ins)
*(Clients must not have insurance or
Medi-Cal in order to be seen)*

Engineering Controls (Workplace Tools)

TB in Shelters: Reducing the Risk thorough Ventilation, Filters, and UV. Francis
J. Curry National TB Center. <http://www.nationaltbcenter.edu>

Education

TB Outreach & Prevention Services (TOPS) - SFDPH Satellite Clinic

973 Market St., 2nd Fl., San Francisco, CA 94103

(415) 597-7950

* TOPS is available to conduct all staff TB Training and to provide the pre-training video. Shelter directors can call TOPS to set up staff training schedules.

American Lung Association of San Francisco & San Mateo Counties

2171 Junipero Serra Blvd. Ste. 720, Daly City, CA 94014

(650) 994-5864

* The ALA/SFSM offers a range of TB literature, brochures, TB videos available for borrowing or for a minimal fee.

DEFINITIONS: According to the Stewart B. McKinney Act, 42 U.S.C. ' 11301, et seq. (1994), a person is considered homeless who "lacks a fixed, regular, and adequate night-time residence and; and... has a primary night time residency that is: (A) a supervised publicly or privately operated shelter designed to provide temporary living accommodations... (B) an institution that provides a temporary residence for individuals intended to be institutionalized, or (C) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings." 42 U.S.C. ' 11302(a) The term "'homeless individual' does not include any individual imprisoned or otherwise detained pursuant to an Act of Congress or a state law." 42 U.S.C. ' 11302(c)

This definition is usually interpreted to include only those persons who are literally homeless -- that is, on the streets or in shelters -- and persons who face imminent eviction (within a week) from a private dwelling or institution and who have no subsequent residence or resources to obtain housing. The McKinney definition of homelessness serves large, urban communities, where tens of thousands of people are literally homeless. However, it may prove problematic for those persons who are homeless in areas of the country, such as rural areas, where there are few shelters. People experiencing homelessness in these areas are less likely to live on the street or in a shelter, and more likely to live with relatives in overcrowded or substandard housing (U.S. Department of Agriculture, 1996).

DEMOGRAPHICS: Two trends are largely responsible for the rise in homelessness over the past 15-20 years: a growing shortage of affordable rental housing and a simultaneous increase in poverty. Persons living in poverty are most at risk of becoming homeless, and demographic groups who are more likely to experience poverty are also more likely to experience homelessness. Recent demographic statistics are summarized below.

AGE: In 1998, the U.S. Conference of Mayors' survey of homelessness in 30 cities found that children under the age of 18 accounted for 25% of the urban homeless population (U.S. Conference of Mayors, 1998). This same study found that unaccompanied minors comprised 3% of the urban homeless population. A 1987 Urban Institute study found that 51% of the homeless population were between the ages of 31 and 50 (Burt, 1989); other studies have found percentages of homeless persons aged 55 to 60 ranging from 2.5% to 19.4% (Institute of Medicine, 1988).

GENDER: Most studies show that single homeless adults are more likely to be male than female. In 1998, the U.S. Conference of Mayors' survey found that single men comprised 45% of the urban homeless population and single women 14% (U.S. Conference of Mayors, 1998).

FAMILIES: The number of homeless families with children has increased significantly over the past decade; families with children are among the fastest growing segments of the homeless population. Families with children constitute approximately 40% of people who become homeless (Shinn and Weitzman, 1996). In its 1998 survey of 30 American cities, the U.S. Conference of Mayors found that families comprised 38% of the homeless population (U.S. Conference of Mayors, 1998). These proportions are likely to be higher in rural areas; research indicates that families, single mothers, and children make up the largest group of people who are homeless in rural areas (Vissing, 1996).

ETHNICITY: In its 1998 survey of 30 cities, the U.S. Conference of Mayor found that the homeless population was 49% African-American, 32% Caucasian, 12% Hispanic, 4% Native American, and 3% Asian (U.S. Conference of Mayors, 1998). Like the total U.S. population, the ethnic makeup of homeless populations varies according to geographic location. For example, people experiencing homelessness in rural areas are much more likely to be white; homelessness among Native Americans and migrant workers is also largely a rural phenomenon (U.S. Department of Agriculture, 1996).

VICTIMS OF DOMESTIC VIOLENCE: Of 777 homeless parents interviewed in ten U.S. cities, 22% said they had left their last place of residence because of domestic violence (Homes for the Homeless, 1998). In addition, 46% of cities surveyed by the U.S. Conference of Mayors identified domestic violence as a primary cause of homelessness (U.S. Conference of Mayors, 1998).

VETERANS: Research indicates that 40% of homeless men have served in the armed forces, as compared to 34% of the general adult male population (Rosenheck et al., 1996). In 1998, the U.S. Conference of Mayors' survey of 30 American cities found that 22% of the urban homeless population were veterans (U.S. Conference of Mayors, 1998).

PERSONS WITH MENTAL ILLNESS: Approximately 20-25% of the single adult homeless population suffers from some form of severe and persistent mental illness (Koegel et al., 1996). According to the Federal Task Force on Homelessness and Severe Mental Illness, only 5-7% of homeless persons with mental illness require institutionalization; most can live in the community with the appropriate supportive housing options (Federal Task Force on Homelessness and Severe Mental Illness, 1992).

PERSONS SUFFERING FROM ADDICTION DISORDERS: Surveys of homeless populations conducted during the 1980s found consistently high rates of addiction, particularly among single men; however, recent research has called the results of those studies into question (Koegel et al., 1996). Briefly put, the studies that produced high prevalence rates greatly over represented long-term shelter users and single men, and used lifetime rather than current measures of addiction. While there is no generally accepted "magic number" with respect to the prevalence of addiction disorders among homeless adults, the frequently cited figure of about 65% is probably at least double the real rate for current addiction disorders among all single adults who are homeless in a year.

EMPLOYMENT: Declining wages have put housing out of reach for many workers: in every state, more than the minimum wage is required to afford a one- or two-bedroom apartment at Fair Market Rent¹ (National Low Income Housing Coalition, 1998). In fact, in the median state a minimum-wage worker would have to work 87 hours each week to afford a two-bedroom apartment at 30% of his or her income, which is the federal definition of affordable housing. Thus, inadequate income leaves many people homeless. The U.S. Conference of Mayors' 1998 survey of 30 American cities found that 22% of the urban homeless population were employed (U.S. Conference of Mayors, 1998). In a number of cities not surveyed by the U.S. Conference of Mayors - as well as in many states - the percentage is even higher (National Coalition for the Homeless, 1997).

IMPLICATIONS: As this fact sheet makes clear, people who become homeless do not fit one general description. However, people experiencing homelessness do have certain shared basic needs, including affordable housing, adequate incomes, and health care. Some homeless people may need additional services such as mental health or drug treatment in order to remain securely housed. All of these needs must be met to prevent and to end homelessness.

RESOURCES

Aron, Laudan Y. and Janet M. Fitchen. "Rural Homelessness: A Synopsis," in Homelessness in America, Oryx Press, 1996. Available for \$43.50 from the National Coalition for the Homeless, 1012 14th Street, NW, Suite 600, Washington, DC 20005; 202/737-6444.

Burt, Martha and Barbara Cohen. America's Homeless: Numbers, Characteristics, and Programs that Serve Them, 1989. Available for \$9.75 from The Urban Institute, Publications Orders, 2100 M St. NW, Washington, DC 20037; 202/833-7200.

¹ FMRs are the monthly amounts "needed to rent privately owned, decent, safe, and sanitary rental housing of a modest (nonluxury) nature with suitable amenities." Federal Register. HUD determines FMRs for localities in all 50 states.

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Appendix D.

National Homeless Resources

American Affordable Housing Institute

P.O. Box 118
New Brunswick, NJ 08903

California Coalition for the Homeless

1010 S. Flower Street
Los Angeles, CA Tel: 213-746-7677

Church & Temple Housing

502 1/2 S. Main Street
Los Angeles, CA 90013
Tel:213-627-3832

Coalition for the Homeless

500 Eight Avenue
New York, NY 10018
Tel:212-695-8700

Common Cents New York, Inc.

500 Eighth Avenue
New York, NY 10018 Tel:212-736-6437

Community for Creative Non-violence

425 Second Street, NW
Washington, D.C. 20001
Tel:202-393-4409

Community Workshop on Economic Development

100 S. Morgan Street
Chicago IL. 60607

Dayspring Center

1537 N. Central
Indianapolis, IN 46202
Tel:317-635-6785

Enterprise Foundation

505 American City Building
Columbia, MD 21044 Tel:301-964-1230

The Ford Foundation

320 East 43 Street
New York, NY 10017

Friends Committee on National Legislation

245 Second Street, NE
Washington, D.C. 20002-5795

Goddard-Riverside Community Center

593 Columbia Avenue
New York, NY 10024
Tel: 212-873-6600

Habitat for Humanity

121 Habitat Street
American, GA 31709-3498
Tel:912-924-6935

Homelessness Information Exchange

1830 Connecticut Avenue
Washington, DC 20009
Tel:202-462-7551

House Pins, Inc.

80 Second Street
South Portland, ME 04106
Tel:207-799-6116

IMPACT

110 Maryland Avenue, NE
Washington, D.C. 20002
Tel:202-544-8636

Interfaith Coalition for Housing United Methodist Church

100 Maryland Avenue, NE
Washington, D.C. 20002
Tel:202-488-5653

**Interfaith Council for the Homeless of
Union County**

724 Park Avenue
Plainfield, NJ 07060 Tel:908-753-4001

The Interfaith Nutrition Network

148 Front Street
Hempstead, NY 11550
Tel:516-486-8506

**MAZON, A Jewish Response to
Hunger**

2940 Westwood Blvd., Suite 7
Los Angeles, CA 90064

McAuley Institute

1320 Fenwick Lane
Silver Spring, MD 20910
Tel:301-588-8110

**Metropolitan New York Coordinating
Council On Jewish Poverty**

9 Murray Street
New York, NY 10007-2296
Tel:212-267-9500

**The National Alliance to End
Homelessness**

1518 K Street, NW
Suite 206
Washington, D.C. 20005
Tel:202-638-1526

**The National Coalition Against
Domestic Violence**

P.O. Box 34103
Washington, D.C. 20043-4103
Tel:202-638-6388

National Coalition for the Homeless

1621 Connecticut Avenue, NW
Washington, D.C. 20009
Tel:202-460-8112

**National Congress for Economic
Community Development**

1612 K Street, NW, Suite 510
Washington, D.C. 20006

Legal Action Center for the Homeless

220 E.44th Street
New York, NY 10009 Tel:212-529-4240

Local Initiatives Support Corporation

733 Third Avenue, Eighth Floor
New York, NY 10017 Tel:212-529-4240

**National Interfaith Hospitality
Networks**

121 Morris Avenue
Summit, NJ 07901 Tel:908-273-1100

**Network, A National Catholic Social
Justice Lobby**

806 Rhode Island Avenue, NE
Washington, D.C. 20018
Tel:202-526-4070

The Partnership for the Homeless

305 Seventh Avenue
New York, NY 10001 Tel:212-645-3444

**Religious Action Center of Reform
Judaism**

2027 Massachusetts Avenue
Washington, D.C. 20036
Tel:202-287-2800

Rotocare

c/o Dr. Mark Campbell
69 E. Hamilton Avenue
Campbell, CA 95008

Salvation Army

799 Bloomfield Avenue
Verona, N 07044 Tel:201-239-0606

Second Harvest

116 South Michigan, Suite 4
Chicago, IL 60603 Tel:312-263-2303

Travelers Aid International

1001 Connecticut Avenue
Washington, D.C. 20036
Tel:202-659-9468

United States Catholic Conference
1312 Massachusetts Avenue, NW
Washington, D.C. 20005-4105
Tel:202-541-3185

United States Conference of Mayors
1620 Eye Street, NW
Washington, D.C. 20006
Tel:202-293-7330

Appendix E.

MASKS ARE AVAILABLE TO COVER YOUR COUGH.

Please ask a shelter staff person for a mask, if you are coughing frequently and are willing to wear one.

If your cough does not stop, a staff person may offer you one.



Appendix F **COUGH ALERT POLICY AND PROCEDURES** **TEMPLATE for San Francisco Shelters**

Purpose: For the early identification of active TB cases and the prevention of TB transmission in homeless shelters.

Problem: Congregate settings that house immunocompromised individuals pose two-fold risk for TB transmission and disease progression. Unsuspected active TB can result in extensive spread to staff and shelter clients. In San Francisco, the prevalence of TB infection in homeless individuals is approximately 30 – 40%, which is as high as rates in the developing world. High HIV infection rates of homeless individuals in shelters and SROs (8.5% and ~12% respectively, early 1990s) compound the problem. In 2002, homeless TB cases increased by 65% and over half of all homeless TB cases were HIV infected. Malnutrition and other debilitating medical problems are common among the homeless and substance users entering shelters and detox units putting them at increased risk of TB exposure and disease progression.

The “cough alert” policy has been developed to protect the safety of shelter/detox clients and staff from tuberculosis. Shelter employees play a key role in detecting communicable diseases because of their familiarity with the clientele and facilities. This policy is to be implemented by facility staff working closely with clients or monitoring the sleeping rooms at night. The cough alert should be instituted as defined below:

Definition:

1. Individuals coughing throughout the night **or**
2. Patient coughing for more than 2-3 weeks without improvement (especially if the cough is accompanied with >5 lbs weight loss, night sweats and fever) **or**
3. Coughing up blood

Procedures:

1. Instruct patient to cover nose and mouth when coughing and offer a mask to wear.
2. Record the date, client name, bed number, and give the information to assigned shelter public health liaison/supervisor name .
3. The assigned shelter liaison or designee will then notify the TB Control liaison name (include phone number) of the patient needing evaluation.
4. Assigned case management staff will notify the coughing client confidentially that a CXR and urgent medical evaluation will be needed and will provide the information on where and how the patient will get the evaluation.
5. Evaluation should occur ASAP through the following mechanisms:
 - TB Clinic (SFGH campus, Bldg 90, Wd 94): Monday 1-5pm, Tuesday and Thursday 9am-6 pm, and Friday 8:30am-12 noon
 - Emergency Room at SFGH
 - <<ENTER ADDITIONAL MEDICAL EVALUATION SITES HERE>>
6. Any patient being referred to TB Clinic for evaluation must bring a completed TB 47 referral form to the clinic.