Office of
Homeless Services

STANDARDS

Emergency Housing

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SECTION 1: Introduction

The mission of the Office of Homeless Services (OHS) is to make homelessness rare, brief, and non-recurring. OHS works collaboratively with a broad-based network of public and private providers focused on utilizing practices that are informed by data, honor the different perspectives of all stakeholders and are trauma informed. OHS works to maximize resources while monitoring emerging trends, tracking progress, and shifting priorities as needed. Admission into Office of Homeless Services emergency housing programs is based on the US Department of Housing and Urban Development definition of homelessness.

The US Department of Housing and Urban Development defines[1] people experiencing homelessness as:

- Individuals and families who lack a fixed, regular, and adequate nighttime residence, meaning:
  - An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground.
  - An individual or family living in a supervised shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by government programs); or
  - An individual who is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.
- Individuals and families who will lose their primary nighttime residence within 14 days, who have not identified a subsequent residence, and who lacks the resources or support networks needed to obtain other permanent housing.
- Unaccompanied youth under 25 years of age and families with children and youth who are defined as homeless under other federal statutes, who have not had a lease, ownership interest, or occupancy agreement in permanent housing for at least 60 days, have experienced persistent instability of two moves or more in the previous 60-day period and can be expected to continue in such status for an extended period of time.
- Individuals and families who are fleeing, or are attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening violence against the individual or a family member.

OHS has revised these Emergency Housing Standards to provide city-contracted agencies with a clear set of guidelines and requirements for the operation of emergency housing facilities in Philadelphia.

Compliance with the revised Emergency Housing Standards **is a city contractually agreed upon requirement and applies to all contracted emergency housing and case management service providers.**

[1]Homeless Emergency Assistance and Rapid Transition to Housing: Defining "Homeless," 76 Fed. Reg. 75994 (December 5, 2011) (codified at 24 CFR §91, 582.5, 583.5). https://www.hudexchange.info/resources/documents/HEARTH_HomelessDefinition_FinalRule.pdf

SECTION 2: Guiding Principles

The provision of emergency housing services is based on the following guiding principles (adopted from the Philadelphia CoC Coordinated Entry and Assessment-Based Housing Referral System):

- **Housing First:** Households at risk of or experiencing homelessness are housed quickly without preconditions or service participation requirements.
- **Housing Focused:** Assistance provided to households at risk of or experiencing homelessness is focused on moving to and maintaining permanent housing.
- **Prioritization:** Housing assistance is prioritized based on vulnerability and severity of service needs to ensure households needing help the most receive it in a timely manner.
- **Person Centered:** A trauma informed approach that is dignified, safe, and incorporates participant choice is utilized. Specifically,[2]
    - The individual needs of the participant are identified and then it is determined how best to provide assistance through coordination of departmental and community resources.
    - A partnership exists between the participant and the agency as demonstrated through direct participant involvement in all aspects of their case planning decisions.
    - Staff works with the participant to meet their basic needs in a coordinated manner, remembering that we have the tools, but the participant holds the plan.
- **Strength-Based:** An asset-based approach that focuses on the inherent strengths of participants and deploys theses personal strengths to aid in the achievements of the participants' goals. Specifically,
    - Every individual, group, family, and community have strengths.
    - Trauma, illness, and struggle may be injurious, but they may also be sources of challenge and opportunity.
    - There is no limit to a person's growth, achievement, or success.
    - We best serve participants by collaborating with them.
    - Every environment is full of resources.

CORE SERVICES:

- **Emergency Housing:** A clean and healthy living environment which includes, but is not limited to clean rooming, bedding, living space, and dining areas.
- **Meals:** Meals served which are safe, healthy (reduced sodium and sugar), and properly prepared.
- **Safe Environment:** A safe living environment which includes, but is not limited to: Secured building, safe operating facilities, and appliances, and properly operating sanitary facilities.
- **Housing-Focused Case Management:** Provision of housing focused case management services which includes but are not limited to: Intake/ Assessment including completion of the VI-SPDAT, housing planning, referrals (medical, mental health, social service, and behavioral health), monitoring, assistance with obtaining entitlements/benefits and increasing income, and follow-up.

[2]ICF International. (April 16, 2015). Client-Centered Case Management. Retrieved November 7, 2016 from http://www.acf.hhs.gov/sites/default/files/orr/orr_41615_case_management_webinar_final_508.pdf.

SECTION 3: Program Participant Entrance and Orientation

3.1 HUD Entry Assessment: Emergency housing staff must conduct a HUD entry assessment in HMIS with all participants, enrolling them in the HMIS project **at entry to the facility or within 24 hours after the referral of the participant to the facility.** The entry assessment must be conducted in a private area and must include the following:

- Entry or review and update of participant entry assessment information in HMIS: Staff must review basic profile data elements (age, race, sex, family composition, income/employment status, last known address, general assessment of stability, ability to care for self, presence of suicidal ideation, violent behavior, and ability to function in the group facility, acute health needs, other immediate needs, etc.) and other information forwarded with the participant from OHS.
- Review of Participant Rights **(See 3.4 "Participant Rights"):** Every participant must sign the "Participant Rights" document **(Appendix 1)** stating that they understand and agree with it. Each participant must receive a signed copy, and a signed copy must be stored in their participant file.
- Participants admitted after normal business hours must receive an entry assessment the next business day.

3.2 Participant Expectations and Policies: Emergency housing providers must develop expectations for residential living that protect the health and safety of those who stay in emergency housing. These policies must:

- Ensure that the emergency housing site/facility is safe for participants and staff.
- Adhere to the OHS principles of: Housing First, Housing Focused, Prioritization, Person-Centered, and Strength-Based. As such, the rules and policies must not be punitive, restrictive, or designed to punish or control behavior and must preserve participant dignity and respect, honoring participant choice.

3.3 Orientation: Emergency housing staff must provide all participants an orientation packet and an orientation to the program. Emergency housing staff must assist participants who have difficulty reading or are visually impaired by reading the information aloud and confirming the participant's understanding. Emergency housing staff must assist participants whose primary language is not English or participants who are hearing impaired by utilizing interpreter services, such as a language interpreter or a language access line. **The orientation packet and orientation must include, but is not limited to, a review of emergency housing service agreements and expectations,** including:

Program expectations and responsibilities, including, but not limited to:

- Review of the Office of Homeless Services Emergency Housing Placement Service Agreement **(Appendix 2)** and the Housing Placement Addendum to Service Agreement **(Appendix 3)** signed by each participant.
- Fire safety and evacuation procedures
- Medication policies
- Program expectations and policies of the specific program and/or provider (see 3.2 Participant Expectations and Policies)
- Complaint Procedure (See Section 5.1.c)
- Policy regarding participant belongings upon departure

The participant must sign an acknowledgement that they participated in the orientation and a copy of the orientation packet must be placed in the participant's record.

Recording of any special dietary needs (medical conditions, religious beliefs, vegetarian lifestyle, allergies, etc.)

Drug and Alcohol Testing Procedure: Emergency housing providers are permitted to conduct a urinalysis or request testing from the Department of Behavioral Health and Intellectual Disability Services to determine if participant would benefit from a referral to substance abuse treatment.

- **If the facility chooses to engage in drug and alcohol testing,** each participant must be informed of the testing procedures at the emergency housing facility to which they have been assigned.

Savings Program Policy: Each participant is to be provided with orientation which clarifies, for the participant and the emergency housing staff, the requirements of the Savings Program Policy. **(See Section 8.1 and Appendix 4: Office of Homeless Services Savings Program Policy and Procedures)**

Because the intent of the OHS Savings Program is to support the housing goals of the participant, OHS is requesting that participation in the Savings Program be made **an expectation** for all enrolled emergency housing participants. It is the expectation of the Office of Homeless Services that participants contribute **at least 30% of their monthly income** to their savings on at least a monthly basis.

Participants are only to make withdrawals from their savings account for the following reasons:

1. Security deposits for Permanent/Transitional/Rapid Rehousing
2. Permanent/Transitional/Rapid Rehousing expenses (i.e., beds for family members, kitchen items, etc.)
3. Other emergency situations as approved by the Case Manager

Any participant that chooses to decline to adhere to the savings policy and/or provide the Provider/Case Management with copies of monthly account statement will be given 30 days to make their own arrangements. Participants who make unauthorized withdrawals without permission from the Provider/Case Manager will be given 30 days to replace the withdrawn funds, however, if funds are not restored to the original balance before the withdrawal, they will be given 30 days to make their own arrangements.

Additional requirements for emergency housing programs which provide services to children (under the age of 18):

- Staff must review the Children Services Agreement **(Appendix 5)** signed with the head of household of each family entering emergency housing to ensure that the head of household understands the responsibilities of families with children. Each participant must receive a signed copy, and a signed copy must be stored in their participant file.
- Informing of any bedtime curfews
- Explanation of any children's supportive services (onsite and offsite)
- Review of the Child and Adult Food Care Program (Where applicable)
- Review of child abuse reporting policies and procedures
- Encouragement of enrollment in and attendance at school

3.4 Participant Rights:

Participants in all OHS emergency housing programs have the following rights:

- The right to be treated in a dignified manner by all emergency housing staff and participants.
- The right to live in a clean, safe environment.
- The right to confidentiality of all case records, manual or electronically stored, and all other participant information, except in cases involving criminal activity, danger to self or others, suspected child abuse, or reportable medical condition.
- The right to freedom from discrimination based on race, age, sexual orientation, gender, gender identity, color, creed, religion, ancestry, national origin, medical condition, physical disability, mental disability, and/or familial status.
- The right to access and receive services according to the gender with which the participant identifies.
- The right to dress in accordance with the gender with which the participant identifies.
- The right to access to housing assistance.

- The right to breastfeed a child in any location, public or private, whether the mother's breast is covered, in accordance with Philadelphia and Pennsylvania law.
- The right to leave the emergency housing premises to engage in other activities during the day or night, including work, training, housing appointments, and managing personal affairs (family matters and family-oriented activities, religious activities, community affairs, etc.)
- The right to overnight absences (i.e., spending time away from the emergency housing facility) **during special circumstances,** such as work or managing personal affairs (family matters and family-oriented activities, religious activities, child related activities such as camp or court ordered visits, etc.). The participant is expected to provide advance notice regarding the need for absence and, where applicable, documentation verifying the visit. **Please note participants who do not follow this process and are absent from the facility without authorization for 48 hours will be discharged from the emergency housing program and will be required to report to intake to re-apply for emergency housing. In addition, participants who do not follow this process and are absent from the facility without authorization for a total of 5 non-consecutive days (days that are not one after the other) will be discharged from the emergency housing program and will be required to report to intake to re-apply for emergency housing.**
- The right to be informed of program rules, regulations, policies, and codes of conduct.
- The right to be informed of the drug & alcohol testing procedures of the program (if applicable) and to receive assistance irrespective of refusal to be tested.
- The right to be informed of the prohibition on and consequences of the following activities (threats to health and safety):
  - Fire related incidents (which includes smoking in the building, lighting matches, starting fires, etc.)
  - Physical violence to other participants or staff.
  - Sexual violence to other participants or staff.
  - Terroristic threats towards other participants or staff.
  - Possession of a weapon on-site.
  - Destruction of emergency housing property or the property of staff or other participants.
  - Possession, sale, use, or distribution of drugs and alcohol on-site.
  - Illegal activity onsite (theft, rape, stealing, etc.).
  - **Persistent** verbal abuse.
  - Refusing reasonable mandatory searches conducted by staff and/or security.
  - **Incident** of smoking in the facility
- The right to be informed of the OHS procedures for termination.
- The right to register a **complaint.** A complaint is a statement of dissatisfaction with the emergency housing program, program staff, program facilities, and/or services provided. **All participants have the right to initiate a complaint with the Office of Homeless Services by contacting the Office of Homeless Services Comment Line at 215-686-4700.**

The Participant Rights must be posted in a central area on each floor area at the facility. Any participant who feels that one or more rights have been violated can contact the OHS Participant Response Line. **The Office of Homeless Services Comment Line Phone Number (215-686-4700) must be prominently displayed in the facility.**

SECTION 4: Emergency Housing Personnel Standards

All providers must abide by and be in compliance with all applicable city, state, and federal labor laws.

4.1 Requirements for Employment: Prior to hiring any emergency housing staff, the provider must set minimum educational qualifications and experience guidelines for employment eligibility.

- Each provider sets its own minimum educational qualifications and experience guidelines for its staff.
- Minimum qualifications for **all case management supervisory staff** must include a bachelor's degree in social work or related field from an accredited institution **and** at least three (3) years case management experience working with vulnerable populations.
- Minimum educational qualifications of case managers must include:
  - Completion of a bachelor's degree program in social work, social services, human services, sociology, psychology or a closely related field at an accredited college or university.
- If minimum qualifications are not met approval must be obtained by the OHS emergency housing director.
- Minimum experience guidelines **for all case management staff** must include demonstrating skills in the following areas:
  - Basic computer skills (Word, Excel)
  - Effective communication skills (both written and verbal)
  - Counseling and/or coaching skills
  - Ability to coordinate services with other agencies and programs.
  - Ability to address complex issues faced by program participants (including, but not limited to unstable housing history, substance abuse, mental health concerns, lack of employment and training, trauma, domestic violence, medical concerns, etc.)
  - Understanding of the National Association of Social Work Code of Ethics and National Association of Case Management Code of Ethics

4.2 Criminal Background Checks and Child Abuse Clearances

- Criminal background checks and child abuse clearances are required as follows:
  - **Single Adult Emergency Housing Providers:** All emergency housing staff and volunteers must obtain **criminal background checks prior to hire** and at **five (5) year intervals** thereafter.
  - **Family Emergency Housing Providers:**
    - » All staff and volunteers in emergency housing programs serving children must obtain a criminal background **check prior to hire** and at **five (5) year intervals** thereafter.
    - » All emergency housing staff and volunteers in emergency housing programs serving children must obtain a **child abuse clearance prior to hire** and **annually thereafter.**
- **All criminal record checks and child abuse clearances must be submitted to the OHS Assigned Program Analyst once every quarter- October, January, April, and July upon receipt of each new and renewed clearance.**

4.3 Criminal Conviction

- No person who has been convicted of any crime against a participant of any facility, or against a participant in a day-care or day-treatment program, may be hired as an emergency housing provider staff person.
- No person who has been convicted of murder, rape, indecent exposure, sexual assault, or arson may be hired as an emergency housing provider staff person.
- No person who has been convicted of any violent crime not otherwise described in sub-paragraph (b) may be hired as an emergency housing provider staff person for a period of ten (10) years following the date of the conviction.
- No person who has been convicted of any crime in connection with the operation of any facility, or any day-care or day-treatment program, not otherwise described in sub-paragraph (a), (b), or (c), may be hired as an emergency housing provider staff person for a period of ten (10) years following the date of conviction.

- Conviction of any crime described in sub-paragraphs (a), (b), (c) or (d) shall be grounds for immediate termination of employment.

4.4 Child Protection: The following two items are applicable to all emergency housing facilities housing children:

- According to the PA Child Protective Services Law and current regulations, in no case shall an emergency housing provider hire an individual whose Child Line Clearance has verified that this person is named in the central register as the perpetrator of a founded report that such child abuse was committed within the five (5) year period immediately preceding the verification process. A founded complaint is an adjudication of child abuse.
- In no case shall an individual ever be hired if the person's criminal history record check information indicates a conviction of one or more of the felonies described in Title 18 of the PA Code relating to: criminal homicide, aggravated assault, stalking, kidnapping, unlawful restraint, rape, statutory sexual assault, aggravated indecent assault, indecent assault, indecent exposure, incest, concealing the death of a child, endangering the welfare of children, dealing in infant children, prostitution and related offenses, pornography, corruption of minors, sexual abuse of children, felony offense under the Act of April 14, 1972 (P.L. 233, No. 64), known as the Controlled Substance, Drug, Device and Cosmetic Act, committed within the five-year period immediately preceding verification. Act 127 of 1998 also prohibits hire if the applicant has been convicted of an equivalent crime listed above under the law of another state, or the attempt, solicitation, or conspiracy, to commit those offenses.

4.5 Personnel Policies: Emergency housing providers must have written personnel policies and procedures which include the following:

- A statement concerning **equal employment opportunity, without regard to race, age, sexual orientation, sex, gender identity, color, religion, ancestry, national origin, medical condition (reasonable accommodation required), disability, genetic information, familial status, marital status.**
- Consequences for the use and/or distribution of illegal substances.
- **Hiring of Participants:** A written policy that states that **participants may not be hired as staff at the emergency housing facility where they are sleeping.**
- **Sexual Harassment:** A written sexual harassment policy must include the following information:
  - A statement that sexual harassment is prohibited at the place of employment.
    - » Sexual harassment is the harassment of a person because of that person's sex. Harassment can include unwelcome sexual advances, requests for sexual favors, and other verbal or physical harassment of a sexual nature. Harassment does not have to be of a sexual nature, however, and can include offensive remarks about a person's sex. For example, it is illegal to harass a woman by making offensive comments about women in general. Both victim and the harasser can be either a woman or a man, and the victim and harasser can be the same sex. (https://www.eeoc.gov/laws/types/sexual_harassment.cfm)
  - A description of consequences for sexual harassment including immediate removal from the emergency housing site and termination of employment.
- **Workplace Violence:** A written workplace violence policy that includes the following information:
  - A statement that workplace violence is prohibited.
  - •A description of consequences for workplace violence including immediate removal from the emergency housing site and termination of employment.

4.6 Personnel Manual: A staff manual must be developed and distributed to all emergency housing staff by the emergency housing provider. All staff must sign a statement indicating that they have received the personnel manual and agree to abide by all of its policies and procedures. The manual is to include the following:

- **All requirements listed in Section IV: Emergency Housing Personnel Standards.**
- Conditions for employment.
- Conditions for termination of employment.
- Operational procedures for carrying out duties which may include but are not limited to the following areas: Residential living, case management services, maintenance, administration, fiscal management, etc.
- Expectations employee conduct and process for disciplinary action.
- Clear explanation of staff requirements including but not limited to:
  - Monitoring/evaluation requirements.

- Staff and participant rights.
- Clear lines of responsibility concerning supervision of the facilities and program staff.
- Procedures for addressing employee grievances.
- Drug screening policy and procedures.
- Mandated Reporter policies and procedures: Child abuse and neglect reporting.
- Requirements for HMIS compliance: Reporting and recordkeeping, including enrollments, assessments, case notes, referrals, housing applications, etc.
- Procedures for responding to emergencies.

4.7 Personnel Training and Orientation: The emergency housing provider must provide all staff with orientation, training, supervision, and technical assistance. Trainings will also include those required by OHS

- **Mandatory Training Topics:** Personnel training and orientation must include the following mandatory topics:
  - **The Purpose of Emergency Housing Services:** To work with participants to obtain stable housing arrangements (Rapid Re-Housing, private market housing, transitional housing, and/or permanent supportive housing).
  - **Working With Persons Experiencing Homelessness:** The orientation must address the lived experiences of the clients, who have faced serious challenges that brought them to this point, and how best to respond in a trauma-informed manner that draws upon their resilience, determination, and resolve. The orientation must also include a focus on client-centered services provided from a strengths-based perspective.
  - **Responding to Emergencies:** The training must include the following areas:
    - » Fire safety and evacuation procedures
    - » Emergency procedures for a handling a **medical health crisis** (First aid, contacting emergency services via 911, etc.)
    - » Emergency procedures for handling a **behavioral health crisis** (De-escalation, Mental Health First Aid, contacting the mental health mobile team, preparing a 302 Petition, contacting emergency services via 911, etc.)
    - » Procedures for responding to building maintenance emergencies (where applicable to designated staff)
    - » OHS Incident Reporting Procedures (see Section 5.1d)
    - » Emergency Preparedness Procedures
    - » De-escalating hostile situations
- **Participant Care:** The training and orientation must address the following:
  - » Trauma and trauma-informed care
  - » Procedures for ensuring participant confidentiality.
  - » Procedures for storing, handling, disposing, and securing medications (designated staff, see Section IX)
  - » Guidelines for the Prevention and Control of Infectious Diseases in Emergency Housing **(See Appendix 6)**
  - » Universal Precautions
  - » First aid training
  - » CPR training and certification (designated staff)
  - » Domestic Violence
  - » Sexual and Gender Minorities: The orientation must address the various issues and concerns of the sexual and gender minority population and how best to address their needs.
  - » Customer Service
- **Family Services:** In addition to all of the above, emergency housing providers serving families with children must provide training regarding the following:
  - » Child Abuse and Neglect: legal obligations regarding child abuse/neglect reporting and procedures
  - » PA Code Title 75, E, 4581: Restraint Systems (Proper restraint procedures when driving children in a vehicle)
  - » Developmental needs of children (ages 0-17) and childhood trauma

SECTION 5: Emergency Housing Operations

5.1 Basic Operational Requirements

- **Staff Coverage:** To ensure adequate coverage in emergency housing facilities, the emergency housing provide must maintain the following staff coverage standards:
  - » **One (1) direct service person per 20 individual adult participants** during daytime hours. (Direct service staff person does not include janitorial or kitchen personnel in the provision of adequate staff ratios) **Daytime hours: 1:20 adult participants**
  - » **One (1) staff person per 40 individual adult participants** shall be maintained during the nighttime hours. **Nighttime hours: 1:40 adult participants**
- **OHS Savings Program:** All emergency housing providers must establish internal mechanisms necessary to collect and maintain savings from any program participant (with income from any source) currently staying in their emergency housing facility who chooses to participate in the OHS Savings Program. **(See Appendix 4)** This includes, but is not limited to, hiring and training of additional staff as needed; acquiring and installing computers and software; setting up bank accounts; establishing secure filing systems; setting up staff email accounts for reporting, and developing appropriate administrative internal controls to insure procedural efficiency and integrity.
- **Complaint Procedure:** The emergency housing provider must establish a written process whereby participants are able to submit complaints regarding the program, program staff, program facilities, and/or services provided by the emergency housing provider to the emergency housing provider director or the director's designee.
- **Incident Reporting Process:** An **incident** is a specific occurrence (listed below) which happens at the emergency housing facility. When an incident occurs, the emergency housing provider **must notify the Office of Homeless Services as follows:**
  - » **Notification Immediately:** Provider must notify OHS of the following types of incidents immediately via telephone or email (followed up by a submitted Incident Report within 24 hours).
    - » Death
    - » Serious/major medical events
    - » Fire
    - » Major property destruction or failure
    - » Building emergencies requiring the evacuation
    - » Emergency relocation of participants or staff from the site
    - » Serious physical violence
    - » Sexual Violence
  - » **Notification Within 24 Hours:** Provider must notify OHS of the following types of incidents by submitting an Incident Report in HMIS within 24 hours.
    - » Fire related incidents (which includes smoking in the building, lit matches, electrical sparks, etc.)
    - » Physical violence
    - » Terroristic threats
    - » Child abuse and neglect
    - » Sexual harassment
    - » Drug use/sale/possession on the premises
    - » Weapon use/possession
    - » Communicable disease (see Section 9.9: Communicable Disease Control)
    - » Bedbugs (see Section 10.2e: Bedbugs)
- The emergency housing provider must ensure that **all incident reports are submitted in HMIS within 24 hours of occurrence.**
- **Incidents must be APPROVED in HMIS within 48 hours by designated supervisor.**
- **Hard Copy Incident Reports:** Hard copy incident reports are only to be submitted when submitting incident reports in HMIS is not an option (i.e., participants are not in HMIS, HMIS is inoperable).

5.2 Fire and Evacuation Procedure Guidelines

- **Drill Frequency**
  - **Twelve (12)** supervised fire and evacuation drills shall be conducted per year. Fire and evacuation drills should be conducted quarterly on each shift. **(If there are 3 Shifts drills should be conducted 4 times per year on each shift).**
  - Fire and evacuation drills shall be held **at unexpected times (including during sleeping hours) and under varying conditions** to simulate the unusual conditions that occur in case of fire. **Mealtimes: Either at the beginning or ending of mealtimes** to ensure that meals are uninterrupted).
  - **Participant participation:** Emergency evacuation drills shall involve the actual evacuation of participants to a selected assembly point and shall provide participants with experience in exiting through all required exits. All required exits shall be used during emergency evacuation drills.
- **Fire Drill Log:** Records shall be maintained of required emergency evacuation drills and include the following information:
  - Identity of the person conducting the drill.
  - Date and time of the drill. (Noting AM or PM).
  - Notification method used.
  - Number of staff on duty and participating.
  - Number of occupants evacuated.
  - Conditions (Special conditions during the drill, weather conditions when occupants were evacuated).
  - Problems encountered.
  - Time required to accomplish complete evacuation.
- Fire drills must be **recorded in a separate log which is readily available for review** by outside agencies.
- **All fire alarms must also be recorded in the Fire Drill Log; however, they must be identified as alarms (or false alarms where applicable). These alarms do not replace fire drills.**
- **Conducting A Supervised Fire and Evacuation Drill:** A supervised fire drill consist of the following:
  - Sound the alarm and note the time (Noting AM or PM).
  - Ensure that all participants leave the building, with traffic flow in the direction on the Evacuation Plan for the facility.
  - Provide assistance to anyone needing help in compliance with drill.
  - Check that all bells/gongs/flashing devices (for hearing impaired) or other hearing devices are properly working and can be heard throughout the facility. Additionally, see that all EXIT lights, directional lights, and emergency lights are in working and performance order.
  - If possible, without endangering staff, close all doors. This action will help contain a fire in a real situation and allow additional time in the overall evacuation procedures, which should include checking all rooms to see that no clients are left behind.
  - All participants should be accounted for outside the facility building or complex at the predetermined safe meeting place, as prescribed in the Fire Evacuation Plan. Thus, it would be helpful to know how many participants were in the facility prior to the drill.
  - Fill out the Fire Drill Log, noting amount of time needed to evacuate the facility and any problems encountered during the drill or actual fire.
- **Fire Drill Technical Assistance:** At least one fire drill per year should be conducted with City of Philadelphia Fire Department staff available to observe and provide technical assistance.
- **Fire Evacuation Plan:** The Fire Evacuation Plan is to be posted conspicuously on each floor, in multiple areas, so that it can be readily seen and followed by staff and participants.
- **Staff Training:** Employees shall be periodically instructed and kept informed of their duties and responsibilities under the plan. Such instruction shall be reviewed by the staff at least every two months. A copy of the plan shall be always readily available within the facility.
- **Orientation (Participants):** The summary of the Fire Evacuation Plan should be discussed with each client as part of intake orientation.

- **Participant Orientation:** Participants capable of assisting in their own evacuation shall be oriented to the proper actions to take in the event of a fire. The orientation shall include actions to take if the primary escape route is blocked. Participants shall be trained to assist each other in case of fire to the extent that their physical and mental abilities permit them to do so without additional personal risk.

***These procedures were developed in conjunction with the City of Philadelphia Fire Department*

5.3 Community Relations: The provider must develop a relationship with the police station and fire station assigned to the neighborhood, obtaining contact information of the lead officers. The relationship is beneficial for the provision of technical assistance regarding safety concerns and emergency operations management.

5.4 Services for Sexual and Gender Minorities: The terms transgender and gender non conforming refer to people whose gender identify and/or gender expression is different from their sex assigned at birth. OHS and all emergency housing providers must comply with the Philadelphia Fair Practice Ordinance and HUD's Equal Access Rule as codified in 24 C.F.R. §5.

- **Non-Discrimination:** The emergency housing provider must have a policy prohibiting discrimination against persons based on their gender identity or sexual orientation, as well as race, color, religion, sex, disability, national origin, ancestry, or marital status and all other protected cases as stipulated in the Philadelphia Fair Practices Ordinance.
- **Interviewing:** The emergency housing provider must ensure privacy and confidentiality by conducting interviews on site and in a private area.
- **Inclusive Language:** The emergency housing provider must refer to participants respectfully and by using language which correctly refers to the individual's gender identity. Providers will support this policy by requiring that all participants be asked to identify their gender identity upon intake.
- **Access to Case Management and Supportive Services:** The emergency housing provider must support the decision made by transgender and gender non-conforming participants to access services consistent with their gender identity. The emergency housing provider must accept the participant's self-identification of their gender irrespective of physical appearance, surgical status, or identity documents.
- **Privacy:** The emergency housing provider must maintain at least one private restroom and private bathing facilities, space permitting, for participants who request additional privacy when using restroom and bathing facilities.

5.5 Discharge for Health and Safety Reasons: There will be instances during service provision when a participant demonstrates **inappropriate/ prohibited behavior** which threatens the safety of the participant or others in the facility and may present the need to discharge the participant from services. Providers should ensure that all measures and interventions are taken including the use of contracts and Participant Progress Reviews before discharge of any participant. **The assigned program analyst must also be notified prior to discharging a participant for health and safety reasons. (See Appendix 7: Office of Homeless Services Case Management Standards)**

SECTION 6: Case Management Service Operation Standards

6.1 Case Management Service Provision
The case manager provides services that assist participants in obtaining a stable housing arrangement, through an approach that models the guiding principles of housing first, housing focused, prioritization, person-centered, and strengths based.

- Case management services may be provided by case managers employed by the emergency housing provider or by a contracted agency.
- Case management services must be provided on site and in a private, closed-door area.
- Case management services must comply with OHS Case Management Standards **(See Appendix 7: Office of Homeless Services Case Management Standards).**
- Case management supervisors and case managers must ensure that all information pertaining to the participant is entered in the Homeless Management Information System (HMIS).
- All case management services must directly support the primary goal of assisting participants with obtaining housing. Required components include:
  - » Assessing participants for the most appropriate resolution to the participant's housing crisis.
  - » Completing and submitting all eligible participant housing referrals in a timely manner.
  - » Assisting participants with housing planning, including, but not limited to referrals to programs that offer housing counseling services, home buying seminars, credit repair workshops, tenants' rights information, and predatory lending counseling.
  - » Assisting participants with seeking alternative housing solutions outside of OHS
  - » Assisting participants with obtaining and increasing income
  - » Assisting participants with participation in the savings program.
  - » Building linkages and/or partnerships with service providers to help participants access community resources such as health care and treatment, job readiness and employment opportunities, benefits counseling, financial literacy, and educational services.
  - » Supporting participants in their employment, job search, and training by making any necessary adjustments in mealtimes, curfews, meeting times, phone access and/or other emergency housing rules, which may provide a barrier to employment.
  - » Posting any/all pertinent notices about TANF and other welfare-to-work notices in a well-lit public area.
- Although not required, the following supportive services are recommended for on-site delivery as needed:
  - » Childcare Services (daycare, afterschool programming, Bright Spaces, tutoring, etc.)
  - » Behavioral health services (e.g., Fasst/ Connections)
  - » Physical health services (e.g., visiting nurse)
- The emergency housing provider must conduct a community meeting, at least once per month, to provide participants updated information regarding the emergency housing program, provide participants with information regarding housing opportunities, and provide participants with an opportunity to voice concerns. The provider must maintain a sign in sheet and an agenda for each meeting.
- **Social Service Provider Access on Site:** To ensure that participants have access to social service providers who wish to meet with them on site, the emergency housing provider must make office space, phone, and other access available at to any and all social service providers assisting participants participating in the emergency housing program.
- **Maximum case management caseloads: The recommended staff ratio is 1 case manager per 20 households (1:20). The maximum caseload should be:**
  - » **Families:** Twenty-five (25) families per case manager **(1 case manager: 25 families)**
  - » **Single Adults:** Thirty-five (35) single adult participants (those without children) per case manager **(1 case manager: 35 single adult participants)**

SECTION 7: Homeless Management Information System Standards

The Homeless Management Information System (HMIS) is a HUD-required information technology system used to collect participant-level data and data on the provision of housing and services to individuals and families experiencing homelessness and persons at risk of experiencing homelessness. The HMIS allows the City to analyze data from within the homeless system and evaluate essential information related to the provision and assessment of services provided within all levels of the Continuum of Care, including outreach and prevention, emergency shelters, transitional housing, rapid re-housing, and permanent supportive housing, for single adults, youth and families.

All emergency housing providers must enter participant data into the City's designated HMIS. The Office of Homeless Services is available to provide technical assistance regarding HMIS related concerns.

7.1 HMIS Site Liaison

- Providers are required to **designate one or more staff persons to serve as HMIS Site Administrator(s).** The following information regarding staff who use HMIS must be provided to the OHS IT Unit Helpdesk at HMIS@phila.gov by the site administrator:
  - » Full name and job title
  - » Email address
  - » Immediate supervisor
- Tasks which the staff will perform, which may include Maintaining the configuration of beds/units, referrals, attendance, discharging participants, transferring participants, and case management and initial participant entry assessments.
- The HMIS Site Administrator is responsible for ensuring that the emergency housing provider complies with the technology standards required to operate the HMIS.
- The HMIS Site Administrator is the first responder for any of the emergency housing provider staff's HMIS-related technical issues and is responsible for carrying out specific HMIS system administration tasks.

7.2 HMIS Training: OHS will provide HMIS training for all emergency housing staff using the HMIS system according to their assigned responsibilities.

- The emergency housing provider must **ensure that all staff who utilize the HMIS participate in HMIS training through OHS.**
- OHS will ensure that the **confidentiality/user agreement is signed** by all emergency housing staff members who attend HMIS training.
- HMIS users who do not log into the system for a period of 90 days or longer will need to repeat their training by OHS.

7.3 HMIS Security

- HMIS participating providers are responsible for assuring that devices used to access the Philadelphia Continuum of Care's HMIS are protected. HMIS Participating Agencies must maintain anti-virus software on all PCs on their network. PCs that access the Internet must be configured to automatically download updated virus definitions. Steps should also be taken to prevent the intrusion of "adware" and "spyware" programs.
- Every computer that is used to access the HMIS must have a password-protected screen saver that automatically turns on when the computer is temporarily not in use. If an HMIS user will be away from the computer for an extended period, he or she is required to log off from HMIS before leaving the work area in which the computer is located.
- Upon successful completion of training and subject to approval by OHS, each user will be provided with a unique personal User Identification Code (User ID) and initial password to access the HMIS. The password may not be stored in a publicly accessible location and written information pertaining to the User ID, password, or how to access the HMIS may not be displayed in any publicly accessible location. The user is not permitted to divulge this password or to share this password with anyone.

7.4 HMIS Privacy

- The emergency housing provider is required to comply with privacy standards regarding the collection, maintenance and use of protected personal information recorded, used, or processed for the HMIS.
- The HMIS privacy standards include, but are not limited to, the following:

- The emergency housing provider must post a sign in places where personal protected information is collected from clients for the purpose of entering it into the HMIS, stating that OHS and its contracted provider agencies collect personal information for reasons that are discussed in the HMIS Notice of Privacy Practices. The sign must also state that the document is available upon request by any individual.
- Each agency must uphold relevant federal and state confidentiality regulations and laws that protect client records.
- Each agency shall only solicit or input into HMIS client information that is essential to providing services to the client and shall not knowingly enter false or misleading data under any circumstance.
- The emergency housing provider must allow any individual who provided protected personal information to inspect and receive a copy of the information collected about that individual in the HMIS. Each agency must offer to explain any information that is not understood.
- The emergency housing provider must secure any hard copy documents containing protected personal information that is either generated by or for HMIS, including, but not limited to, reports, data entry forms and signed consent forms.

7.5 HMIS and Case Management Services:

- The emergency housing provider must utilize the HMIS for all case management responsibilities.
- Please refer to the **Office of Homeless Services Case Management Standards (Appendix 7), Section 4.2: Required HMIS Documentation** for guidance regarding case management recordkeeping requirements and the HMIS.
- **Managing Data and Information:** The emergency housing provider is responsible for managing all data entered in the HMIS, to include HUD entry, interim, and exit assessments. All data must be entered within 24 hours of its collection. The following data elements are to be entered into HMIS for all participants:
  - Demographic Information (i.e., ethnicity, race, etc.) when not entered at intake.
  - Case notes regarding serious incidents that involve violence, calls to 911, and any other incidents that affect the health and safety of participants.
  - Income amount and income source, at entry and exit updated as necessary.
  - Discharge information, including destination upon discharge.
  - Homelessness verification
- The provider must ensure that participant data is entered properly by:
  - Conducting routine reviews of information entered in the HMIS to ensure that data is entered appropriately, accurately, and in a timely manner.
  - Ensuring that all participant cases are closed properly when a participant is discharged from the program.
- The emergency housing provider must utilize the HMIS for managing all referrals to emergency housing, which includes, but is not limited to:
  - **Ensuring that all incoming referrals are accepted within 24 hours of the referral submission.**
  - Maintaining referrals (e.g., extensions, changes, transfers) for all participants assigned to case management services.
  - Tracking all participant referrals through the HMIS Incoming Referral screen.
- **The emergency housing providers must enter data into the HMIS, even if there are no case management support staff available.** The emergency housing provider must identify staff who will be responsible for ensuring that pertinent information is entered and updated as needed.

SECTION 8: Supportive Services

8.1 Savings Program: All OHS participants are expected to save 30% of their income to be used to secure transitional and /or permanent housing. Because the intent of the OHS Savings Program is to support the housing goals of the participant, OHS is requesting that participation in the Savings Program be made **an expectation** for all enrolled emergency housing participants. It is the expectation of the Office of Homeless Services that participants contribute **at least 30% of their monthly income** to their savings on at least a monthly basis.

Participants are only to make withdrawals from their savings account for the following reasons:

- Security deposits for Permanent/Transitional/Rapid Rehousing
- Permanent/Transitional/Rapid Rehousing expenses (i.e., beds for family members, kitchen items, etc.)
- Other emergency situations as approved by the Case Manager

Any participant that refuses to adhere to the savings policy and/or provide the Provider/Case Management with copies of monthly account statement will be given 30 days to make their own arrangements. Participants who make unauthorized withdrawals without permission from the Provider/Case Manager will be given 30 days to replace the withdrawn funds, however, if funds are not restored to the original balance before the withdrawal, they will be given 30 days to make their own arrangements.

All emergency housing providers must adhere to the Office of Homeless Services Savings Program Policies and Procedures (Appendix 4: Office of Homeless Services Savings Policy and Procedures).

8.2 Supportive Services for Families with Children: Emergency housing providers who serve families with school-aged children must provide:

- **Educational Support**
  - » Encourage school enrollment and attendance by school aged children (ages 3 in September to age 17).
  - » Encourage parents to ensure that their children attend school daily and on a timely basis (or that parents arrange supervision of their children's travel to and from school).
  - » Set aside a **quiet area** and **set time** for children's homework to be completed, recognizing the need for exceptions in times of extreme weather.
  - » Cooperate with parents and collaborate with School District personnel to ensure that the educational needs are met for children residing at the facility.
- **Meals**
  - » Provide breakfast early enough so that children attending school have the option to start the day with a nutritious meal.
  - » Fully participate in the Child and Adult Food Care program (where applicable).

SECTION 9: Medication and Health

All emergency housing providers must have written policies and procedures for the storing, handling, and disposing of participant medication, based on consultation with a registered nurse, pharmacist, or other qualified health professional. All participants must have access to their own medications as they request it.

9.1 Medication Storage: Each emergency housing provider must have written procedures for **storing** participant medications.

- All emergency housing providers must ensure that there are provisions made for safeguarding medications, including individual lockers with locks and/or locked cabinets with keys held by staff.
  - » Emergency housing providers who serve **families with children,** must ensure that all **prescription and non¬prescription medications,** except emergency medications (e.g., nitroglycerin), are in a s**ecured/locked area.**
- Emergency housing providers must ensure that there is labeled refrigerator space available for medications requiring refrigeration.
- Emergency housing providers must submit a copy of the medication storage, handling, and disposal policy. The provider must ensure a copy of the policy is forwarded to the assigned program analyst.

9.2 Handling Medication: All emergency housing providers must have written procedures for **handling** participant medication.

- **Collecting/Accessing Medication**
  - » The emergency housing provider must inform the participant of the medication policy during orientation.
  - » The emergency housing provider must document any and all medications received from the participant in a maintained log.
  - » The emergency housing provider must provide **the participant with a receipt for all medications received from the participant.**
  - » Participants **must have access to their own medications as they request it.**
  - » Participants **may not have access to other participants' medication.**

b. Disposal of Medication

- The emergency housing provider must have written procedures for the disposal of used sharps (i.e., syringes and needles).
- When a participant exits the emergency housing program, the participant must be given their medication bottles or reminded to take their medications with them.
- The emergency housing provider must have a policy regarding medications left by participants after exiting, including the safe disposal of any unclaimed medications.

9.3 Securing Medication: The emergency housing provider must have a record-keeping system for securing medication, participant access to medication, **and/or the disposal of medications.**

9.4 Medication Procedure Training: The emergency housing provider must ensure that all staff who manage the storage, handling, or disposal of medication receive training on all the emergency housing medication policies and procedures.

9.5 First Aid

- The emergency housing provider must maintain first aid supplies and make them available to participants free of charge.
- First aid supplies must include, but are not limited to:
  - » A variety of gauze pads
  - » Individually wrapped antiseptic wipe packets
  - » A breathing barrier
  - » Non-latex gloves
  - » Band-aids
  - » Hypo-allergenic tape
  - » Bandage scissors
  - » Tweezers
  - » First aid instruction booklet
- The emergency housing provider must ensure that all staff receive first aid training.

9.6 Personal Hygiene Supplies: The emergency housing provider must ensure that feminine hygiene supplies, e.g., sanitary pads, tampons are on hand and available to participants upon request.

9.7 Behavioral/Medical Health Crisis: The emergency housing provider must ensure that all staff members receive training on behavioral/medical health crisis procedures.

9.8 CPR: A minimum of one staff person on each shift must be certified in CPR.

9.9 Treatment of Lice

- Over the counter lice treatment medication, such as RID must be made available to participants.
- Prescription lice treatment medication, such as Kwell, must be obtained from the participant's medical practitioner.
- The treatment of lice **must be performed in strict accordance with manufacturers or medical practitioner's recommendations.**
- Lice treatment medication must be in a secured area, accessible to staff.

9.10 Communicable Disease Control: The emergency housing provider must respond to communicable diseases, **according to mandatory guidelines. (See Appendix 6: Guidelines for the Prevention and Control of Infectious Diseases in Emergency Housing.)**

- Prevention:
  - » Hand Washing
    - **All bathrooms, diaper changing areas, and food preparation areas must have signs reminding staff and participants to wash their hands after using the bathroom or changing diapers and before food preparation or eating.**
- Respiratory Hygiene
  - » Cover mouth and nose when coughing or sneezing.
  - » Use tissues and dispose in no-touch waste containers.
  - » Wash hands with soap and water or use hand sanitizer after soiling hands with respiratory secretions.

The emergency housing provider must **immediately inform OHS of any communicable disease outbreak** by completing an incident report and submitting it to OHS within 24 hours. Communicable diseases include:

- Covid-19
- E. coli 0157:H7
- Hepatitis A
- Infectious Diarrhea
- Influenza
- Lice
- Measles
- Meningitis (due to any cause)
- Mumps
- Norovirus
- Novel Influenza A (H1 N1)
- Pertussis (Whooping Cough)
- Rubella
- Salmonella
- Scabies
- Shigella
- Staph (MRSA) Skin Infections
- Tuberculosis
- Varicella (Chickenpox and Shingles)

Section 10: Facilities Management

10.1 Building Compliance:

Code Compliance: The emergency housing provider must ensure that all facilities comply with applicable sections of the following Philadelphia Code of General Ordinances codes that are enforced by Licenses and Inspections (L&I):

- Housing Code
- Plumbing Code
- Building Code
- Electrical Code
- Fire Code
- Public Health Department Regulations

Zoning and Licensure: The emergency housing provider must ensure that all facilities are properly zoned and licensed in accordance with L&I and Health Department Regulations.

All facilities must **prominently display the Philadelphia Commission on Human Relations Anti-Discrimination poster.**

The emergency housing provider must inform the Office of Homeless Services **immediately** if an inspection of the program facilities is conducted by the City of Philadelphia License and Inspection or Philadelphia Department of Public Health and provide the Office of Homeless Services with all written reports and ensure that all citations are addressed in a timely manner.

10.2 Environmental Health: The emergency housing provider must ensure that participants reside in facilities that are clean, well maintained, and in good operating condition.

Properly Functioning Systems: The emergency housing provider must ensure that all facilities consist of properly functioning systems, which include:

- HVAC
- Fire Alarm and Suppression
- Kitchen/Cooking appliances and ventilation
- Plumbing and sanitation
- Electricity and illumination

Obvious Hazards: The emergency housing provider must ensure that all facilities are free of obvious hazards, which include, but are not limited to:

- Tripping hazards
- Dangerous or sharp protruding edges or corners (cutting)
- Toxic materials such as paint, kerosene, gasoline, industrial cleaners, etc. Materials which are required for cleaning and maintenance must be stored in a secured location and used according to the manufacturer's instructions.

Pollutants: The emergency housing provider must ensure that various pollutants are not a threat to the health and safety of participants. These pollutants include, but are not limited to:

- Carbon Dioxide
- Radon
- Mold
- Pesticides

Non-flammable Materials: All bedding, curtains, and carpets used in emergency housing facilities must be made of non-flammable or flame-resistant material approved by the federal Participant Product Safety Commission.

Bed Bug Prevention and Treatment: All reports of bedbug sightings should be reported as an incident (see Section 5.1d: Incident Reporting Process). Certification that the bed bugs have been eradicated from an exterminator must be maintained by the emergency housing provider and made available to OHS upon request.

10.3 Ensuring the Safety of All Participants: Emergency housing providers are expected to take the necessary steps to ensure the safety of all participants and staff.

Space Configuration:

- Unless a site is a designated couple's facility, all single men and women should be housed in separate facilities or separate secure areas of the same facility.
- Sexual and Gender Minorities **are not to be housed separately unless they request to be housed separately (space permitting).**
- The provider may set apart intoxicated participants in a separate, safe, space in order to reduce harm or disturbance to others for a period of time, until the participant is able to manage independently.

The participant must be monitored by emergency housing staff for the participant's safety and the safety of others.

Care must be taken to ensure the safety and privacy of sleeping and bathing arrangements of vulnerable participants (those at risk of being taken advantage of or abused) **where there is more than one target population. Vulnerable groups include:**

- Families with dependent children or youth
- Participants with physical and/or mental disabilities
- Participants with developmental disabilities
- Participants who are elderly
- Transgender and gender non-conforming participants
- Lesbian, gay, bisexual, and queer participants

Reasonable accommodations must be provided for individuals with physical and/or mental disabilities, as set forth in the American with Disabilities (ADA) Act, in the most integrated setting appropriate to their needs. This would include, for example, conducting classes in a room in the emergency housing facility that does not require walking up stairs. For more information on the City of Philadelphia requirements of the American Disabilities Act, please refer to the following website: http://www.phila.gov/mcpd/accommodations.html. In addition, federal guidance can be obtained at: https://www.ada.gov/

10.4 Ensuring the Safety of Children

Childproofing Facilities: Emergency housing providers who serve families with children must ensure that their facilities are "childproofed," including, but not limited to:

- Covering electrical outlets
- Ensuring that there are no dangerous or sharp protruding edges or corners.
- Storage of chemicals/cleaning supplies in secured areas
- Ensuring that upper windows have window guards or are kept closed.
- Protective covering for radiators, hot pipes, etc.
- Ensuring that the facilities are clean, well-maintained, and in good operating condition.

Sleeping Arrangements: emergency housing facilities that serve families with children must provide:

- An **individual bed for each child five years of age or over**
- A crib, "pack n' play" or "baby box" for all children under 2 years old.
  - The provider must ensure that **infants and toddlers never sleep alone in an adult bed OR in the same bed with adults or children.**
  - **Loose sheets, pillows of any kind, blankets, crib bumpers, stuffed animals, and toys must not be placed inside the crib, "pack n' play, or "baby box'.**
  - The provider must ensure that parents are informed that **infants must always be placed to sleep on their back.**

Recreational/Play Space: Emergency housing providers who serve families with children must provide an indoor recreational/play space, and must:

- Ensure that safe durable toys and equipment are available by purchasing toys and equipment or pursuing donations.
- Ensure that all recreational/play spaces are clean and well maintained.
- Ensure that all equipment is safe and fully operational.
- Identify the neighborhood recreation centers and playgrounds in the area and notify the families of such.

Infants and Toddlers

- All emergency housing facilities that serve families must be able to accommodate newborns/ infants, including those with serious health conditions requiring the use of monitors, nebulizers, etc.
- The emergency housing provider must provide space and equipment for infant care (e.g., refrigeration) that is accessible by the parent or guardian 24 hours a day/ 7 days a week.
- **As stated above, the emergency housing provider must provide a crib, "pack n' play" or "baby box" for each child two years of age or under.**
- **Diaper Changing Stations:** All emergency housing facilities that admit diaper-aged children must have diaper changing stations in each family bathroom near sinks for hand washing after each diaper change.

- » Sinks must not be in or near food preparation or eating areas.
- » Containers for diaper disposal must be available.

All bathrooms, diaper changing areas, and food preparation areas must have signs reminding staff and participants to wash their hands after using the bathroom or changing diapers and before food preparation or eating.

10.5 Emergency Preparedness

All emergency housing facilities must have the following in order to prepare for an emergency:

- Emergency preparedness procedures **in writing (Addressing system wide emergencies such as flooding, power outages, biochemical emergencies, etc.).**
- Shelter-in-place plan **in writing** (Addressing emergencies which require participants and staff to remain in the facility).
- Evacuation plan both in writing and posted. (Addressing emergencies which require participants and staff to leave the building.)
- Emergency contact information posted in an area accessible to all staff.
- Emergency generators (where applicable)
- **Clearly visible** exit signs and floor plans

The emergency housing provider must ensure that all building emergencies that threaten the health and/or safety of participants residing at their facility are reported according to the **OHS Emergency Housing Standards, Section 5.1d Incident Reporting Process.**

SECTION 11: Food Preparation and Distribution

11.1 Food Service Operations

The emergency housing provider must comply with the City of Philadelphia Department of Public Health Code regulating Eating and Drinking and Catering Establishments (Title 6 — Philadelphia Health Code).

All providers receiving food from OHS must also comply with Get Healthy Philadelphia Nutritional Standards. **(See Appendix 8)**

Prior to the construction, remodeling or alteration of any food service facility, properly prepared plans and specifications must be submitted to and approved by the Department of Public Health and OHS must be notified.

11.2 Meals

The emergency housing provider must ensure that three meals are provided (breakfast, lunch, and dinner) to participants daily.

The emergency housing provider must ensure that all meals are well balanced, nutritious and adequate in quality and quantity to meet basic dietary needs of participants according to the Federal Recommended Daily Allowances (RDA).

The emergency housing provider must comply with Get Healthy Philadelphia Nutrition Standards. **(See Appendix: 8.)**

The emergency housing provider must ensure that special efforts are undertaken to ensure that pregnant, nursing women and children receive nutritious foods that exceed basic requirements and support healthy growth and development.

The emergency housing provider must ensure that all attempts are made to meet the special dietary needs of the population served. Special needs include but are not limited to:

- Dietary restrictions **based on medical conditions**.
- Dietary restrictions **based on religious beliefs.**
- Dietary restrictions **based on a chosen vegetarian lifestyle.**
- Dietary restrictions **based on allergies.**

The emergency housing provider must ensure that meal preparation avoids excessive use of sodium or salt, fat and sugar.

The emergency housing provider must ensure that **portable meals** (e.g., box/bag lunch) are provided, upon request, by participants who indicate that they must be away from the facility during mealtime (employment, educational courses, medical appointments, etc.).

The emergency housing provider must ensure that **meals are set aside** for participants (and their children) who are working or engaging in activities that result in missing regular mealtimes (employment, educational courses, support groups, etc.).

11.3 Meals (Serving Children)

The emergency housing provider must ensure that juice, fresh fruit, and vegetables are offered to participants on a daily basis.

Emergency housing providers that serve infants and children must provide the following, on a 24-hour basis:

- An adequate supply of the common types of milk-based and soy-based infant formula, and other baby food and food supplements. (These items may be obtained on occasion from the Office of Homeless Services.)
- Provisions for storing, preparing, and serving the formula.
- Refrigerated baby food and/or medications to parents when needed.
- Provisions for nursing mothers, including storage and refrigeration of breast milk.

The emergency housing provider must ensure that meals and snacks provided to participants are in compliance with Child and Adult Care Food Program (CACFP) requirements (participating emergency housing providers only)

Section 12: Monitoring

12.1 Program Monitoring: The emergency housing provider will be regularly monitored by the Office of Homeless Services to ensure compliance with all applicable regulations and requirements. In addition, monitoring may be initiated in order to investigate complaints made by participants or incidents reported by the provider. Federal, state, and/or other City representatives or their designees may also conduct inspections and programmatic audits as required. These monitoring visits may occur anytime during the contract year or thereafter depending on the time emergency services were rendered.

The emergency housing provider must cooperate with all federal, state, and/or City monitoring review processes, providing reviewers with access to staff, facilities, participants, and program manuals and records as requested.

The provider may be monitored for any of the following which may include, but is not limited to:

- Compliance with the General Provisions and contractual agreements
- Compliance with funding source requirements (where applicable)
- Program performance and outcomes
- Facilities and program operations
- Participant satisfaction and overall service provision

Monitoring visits may be informal or formal, including announced or unannounced visits, and at varied times of day or night, including after hours.

- Should issues and deficiencies be identified in the visit report, the provider must ensure that they are addressed in a corrective action plan that is submitted, in a timely manner, to the monitoring agency.
- The provider must ensure that the corrective action plan is implemented in a timely manner.

The formal monitoring review process may include, but is not limited to:

- An entrance letter and interview
- Interviews with program staff at various levels
- Interviews with participants
- Participant satisfaction surveys
- Site visit and tour of program facilities and residential areas
- Review of participant, personnel, and or administrative/operational records
- Billing, invoicing, and any documentation to support expenditures.
- Review of provider manuals (policies and procedures)
- Identification of problem areas in the delivery of the contracted services
- An exit interview to discuss critical issues and deficiencies identified.
- A written monitoring report documenting all findings and recommendations.
- A required corrective action plan to include date for remediation of issues from the provider to address any critical issues and deficiencies identified during the review.
- A review to ensure that corrective actions have been implemented as expressed in the corrective action plan.

Office of
Homeless Services

STANDARDS

Emergency Housing Case Management

The mission of the Office of Homeless Services (OHS) is to make homelessness rare, brief, and non-recurring. One of the many ways OHS accomplishes this mission is by contracting with qualified emergency housing service providers to provide housing-focused case management services to adults and families in need of emergency housing. The case manager works collaboratively with the participant to develop a housing plan and coordinates assistance to adults and families ensuring access to an array of services and benefits.

The primary mission of the social work profession is to enhance human well-being and to help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty (NASW, 2008). A case manager is a professional person designated to assume primary responsibility for assessing the needs of a participant, arranging and coordinating the delivery of essential goods and services provided by other resources, and working directly with the participant to ensure that the goods and services are provided in a timely manner[3].

Case Management Standards

The OHS emergency housing case manager provides services that assist participants in obtaining a stable housing arrangement. The provision of case management services must be based on the following guiding principles (adopted from Philadelphia CoC Coordinated Entry and Assessment-Based Housing Referral System):

- **Housing First:** Households at risk of or experiencing homelessness are housed quickly without preconditions or service participation requirements.
- **Housing Focused:** Assistance provided to households at risk of or experiencing homelessness is focused on moving to and maintaining permanent housing.
- **Prioritization:** Assistance is prioritized based on vulnerability and severity of service needs to ensure households needing help the most receive it in a timely manner.
- **Person Centered:** A trauma informed approach that is dignified, safe, and incorporates participant choice. Specifically[4],
  - » The individual needs of the participant are identified and then it is determined how best to provide assistance through coordination of departmental and community resources.
  - » A partnership exists between the participant and the agency as demonstrated through direct participant involvement in all aspects of their case planning decisions.
  - » Staff works with the participant to meet their basic needs in a coordinated manner, remembering that we have the tools, but the participant holds the plan.
- **Strength-Based:** An asset-based approach that focuses on the inherent strengths of participants and deploys theses personal strengths to aid in the achievements of the participants' goals. Specifically[5],
  - » Every individual, group, family, and community have strengths.
  - » Trauma, illness, and struggle may be injurious, but they may also be sources of challenge and opportunity.
  - » There is no limit to a person's growth, achievement, or success.
  - » We best serve participants by collaborating with them.

The case manager will engage in three major phases of the helping process (Rooney, & Larsen, p. 33-43):

- **The Initial Phase:** Exploration, Engagement Assessment, and Planning.
- **The Continuing Phase:** Implementation and Goal Attainment
- **The Closing Phase:** Discharge and Evaluation

[3]Hepworth, D.H., Rooney, R.H., & Larsen, J.H. (1997). Direct Social Work Practice (5th Ed). . Pacific Grove, CA. Brooks/Cole Publishing Co., p.27-8.
[4]ICF International. (April 16, 2015). Client-Centered Case Management. Retrieved November 7, 2016 from http://www.acf.hhs.gov/sites/default/files/orr/orr_41615_case_management_webinar_final_508.pdf.
[5]Kirst-Ashman, K. & Hull, C.H. (2006). Understanding Generalist Practice (4th ed.). Belmont, CA: Thomson Higher Education, p. 21.

SECTION 1: Initial Phase: Exploration, Engagement Assessment, and Planning

(Hepworth, Rooney, & Larsen, 1997, 33-43). The initial phase of service consists of obtaining vital information regarding the participant's situation, establishing rapport with and enhancing the motivation of the participant, formulating an assessment, negotiating goals, and making referrals.

1.1 HUD Entry Assessment: Emergency housing staff must conduct a HUD entry assessment in HMIS with all participants, enrolling them in the HMIS project **at entry to the facility or within 24 hours after the referral of the participant to the facility.** The entry assessment must be conducted in a private area and must include the following:

- Entry or review and update of participant entry assessment information in HMIS: Staff must review basic profile data elements (age, race, sex, family composition, income/employment status, last known address, general assessment of stability, ability to care for self, presence of suicidal ideation, violent behavior, and ability to function in the group facility, acute health needs, other immediate needs, etc.) and other information forwarded with the participant from OHS.
- Review of Participant Rights **(See 3.3 "Participant Rights"):** Every participant must sign the "Participant Rights" document **(Appendix 1)** stating that they understand and agree with it. Each participant must receive a signed copy, and a signed copy must be stored in their participant file.
- Participants admitted after normal business hours must receive an entry assessment the next business day. **(Emergency Housing Standards, Section 3.1 HUD Entry Assessment)**

1.2 Initial Contact: Purpose of Initial Contact: The purpose of the initial contact is to introduce the case manager to participant and to arrange the initial interview.

- The case manager must **initiate contact** with the participant **within 5 days of referral** to the assigned facility and/or assignment of the case.
- **All information from the initial contact must be documented in the Homeless Management Information System (HMIS).**

1.3 Initial Interview: The purpose of the initial interview is to conduct an initial assessment of the participant's needs, and to develop a housing plan in collaboration with the participant which takes into account participant strengths and capabilities. The purpose of assessment is to obtain information regarding the participant and the participant's situation, including a brief social history indicating prior living arrangements, identification of the participant's needs, and current reasons for homelessness.

Conducting the Initial Interview

- The case manager must **conduct the first interview** with the participant **within 10 days of initial contact** (within 15 days of referral).

During the initial interview, the case manager must:

- The case manager must explore and discuss possible remaining housing options other than emergency housing including, but not limited to diversion opportunities (family, friends, and other safe external opportunities) and communicate that the goal is to have the client move on as soon as possible.
- **The case manager must review eligibility information with the participant.** Information to be reviewed must include, but is not limited to:
  - **Homeless verification** (Declaration of Homelessness from OHS intake which demonstrates due diligence to verify participant homelessness)
  - **Financial eligibility** (e.g., verification of income, income eligibility, financial resources, etc.)
  - Any other eligibility requirements (e.g., citizenship where applicable, need for service, etc.)

- Complete all required assessments including, but not limited to: HUD assessment, Vulnerability Service Prioritization Decision Assistance Tool (VI-SPDAT), and any other assessments required.
- Complete a housing plan (See Housing Planning, Section 1.3).
- Obtain a signed Consent to Release Information.

The case manager must also ensure that the following areas are discussed:

- The person-centered housing planning process which includes input from the participant regarding what the issues need to be addressed and how best to address them.
- Income Disclosure
- Participation in the Savings Program
- Participation in medical, mental health, and/or substance abuse treatment services if appropriate
- Participant option to participate in services and potential outcomes.

All information from the initial interview must be documented in the Homeless Management Information System (HMIS) within 24 hours. Hardcopy/ scanned materials such as copies of identification, birth certificates, social security cards, medical cards, etc. income documentation and verification of eligibility, and signed materials must also be placed in the participant hardcopy record. Should a participant refuse to provide any required materials, the refusal must be documented along with a signed statement of refusal and must be followed up with another attempt to secure copies of the materials at a later time.

1.4 Housing Planning: The purpose of housing planning is to address any challenges which impair/inhibit the participant from obtaining and sustaining housing. The housing planning process must be collaborative, interactive, and must include input from the participant regarding goals.

Completing the Housing plan:

- **The housing plan must be developed during the initial interview.**
  - » The housing plan must outline specific measurable goals, specific steps to be taken, timeframes for completion, and clear lines of responsibilities for all parties involved (participant, case manager, other partners, etc.).
  - » The case manager must explore and discuss possible remaining housing options **other than emergency housing** including, but not limited to diversion opportunities (family, friends, and other safe external opportunities) and communicate that the goal is to have the client move on as soon as possible.
- The housing plan **must be written with input from the participant** and must be based on the assessment conducted in the initial interview and subsequent interviews.
- The housing plan must include steps/plan to address barriers to obtaining housing.
- The housing plan must address needs that the participant discussed during assessment.

The case manager must ensure that the housing plan is signed by the participant and the case manager. Should a participant refuse to sign the plan, the refusal must be documented and must be followed up with another attempt to secure the signature at a later time.

The case manager must ensure that the housing plan is updated at least monthly.

All completed housing plans must be approved and signed by the case management supervisor within 7 days of completion.

All information must be documented in the Homeless Management Information System (HMIS). Hardcopy materials such as signed housing plans must also be placed in the participant hardcopy record.

SECTION 2: Continuing Phase: Implementation and Goal Attainment

(Hepworth, Rooney, & Larsen, 1997, 33-43) The continuing phase of service is the action oriented or change oriented phase of service, translating plans formulated between the case manager and the participant into actions. Case managers must select and implement interventions which help to accomplish the participant's goals and tasks, while at the same time taking into account the participant's view of their situation, and the uniqueness of the participant's situation.

2.1 Biweekly Meeting: The purpose of the biweekly meeting is to monitor the participant's achievement of goals established in the housing plan, making adjustments, additions, or deletions when necessary. During the meetings, the participant collaborates with the case manager to explore various housing options. The case manager also offers the participant information and referral services to other appropriate resources. The case manager supports, encourages, and assists the participant with obtaining housing and other supportive services as needed.

The case manager **must meet face to face** with each assigned participant on a **biweekly basis (every other week).** If the participant does not come to the scheduled meetings, the case manager must document the no-show.

In the biweekly face to face meetings with the participant, the case manager must address the following on an ongoing basis:

- Supportive counseling to participants with an emphasis on obtaining a stable housing arrangement.
- Assisting participants with the completion of all applicable housing applications for which the participant is eligible (those beyond CEA-BHRS)
- Collaborating with the participant regarding progress on achievement of established housing plan goals.
- Collaborating with the participant regarding implementation of and barriers to the participant's housing plan.
- Preparation for responsibilities of maintaining permanent housing (including but not limited to obtaining or increasing income, budgeting, tenant rights/responsibilities, credit repair)
- Linkages and referrals for participants to supportive services as needed (including, but not limited to medical, mental health, substance abuse, employment and training, childcare, life skills, and mainstream financial and other resources, etc.)
- Follow-up with the participant regarding referrals for services
- Assisting the participant with coordinating services and resources to meet needs.
- Review of the participant's participation with the OHS Savings Program and/or other savings programs.
- The participant's adjustment to the emergency housing community.

All information must be documented in the Homeless Management Information System (HMIS). Hardcopy materials such as verification of referrals and housing applications (checklists, informational fact sheets, acceptance/rejection letters, PPRs and other documentation) must also be placed in the participant hardcopy record.

2.2 Participant Progress Reviews (PPR): The purpose of the PPR meeting is to bring all relevant parties together to review the progress of the participant. This process assists the participant in moving forward toward obtaining a stable housing arrangement.

Conducting Participant Progress Reviews: All providers are to establish a schedule for Participant Progress Reviews (PPR), identifying participants who:

- Are experiencing serious challenges or barriers.
- Are making exceptional progress towards their goals; or
- Are preparing to move to transitional or permanent (RRH or PSH) housing.

The PPR review team participants should include the participant, case management staff, behavioral health staff and/or Department of Human Services staff, if appropriate, and emergency housing staff.

During the PPR meeting, the PPR team is to discuss the following:

- The present status of the participant and any progress or challenges.
- Participant strengths and accomplishment of goals, as well as address barriers and challenges for the participant.
- A plan to address challenges and barriers to achieving stable housing.

If necessary, the participant and case manager may need to establish a written participation agreement contract that contains specific measurable goals, specific steps to be taken, timeframes for completion, and clear lines of responsibilities for all parties involved (participant, case manager, other partners, etc.).

Document behaviors that lead to discharge

- **The case manager must ensure that the agreement is signed by the participant and the case manager.** Should a participant refuse to sign, the refusal must be documented and must be followed up with another attempt to secure the signature at a later time.

All information must be documented in the Homeless Management Information System (HMIS). Hardcopy materials such as signed contract must also be placed in the participant hardcopy record.

SECTION 3: Closing Phase: Exit and Evaluation

(Hepworth, Rooney, & Larsen, 1997, 33-43) The exit phase of services is the phase of service during which assessment is made regarding the attainment of goals, planning for maintenance of change is conducted, the helping relationship is terminated, and evaluation of the results of the assistance is conducted. There are three types of exit from OHS services: Planned exits, unplanned exits, and involuntary discharges/exits for health and safety.

3.1 Planned Exit: Purpose of the planned exit process: The purpose of the planned exit process is to review with the participant the progress toward meeting housing plan goals, to discuss the new responsibilities and challenges that accompany a new housing arrangement, and to assist the participant with obtaining any resources needed to support the new housing arrangement.

- The case manager must review the participant's service and housing plan goals and discuss achievements, outstanding goals, and challenges.
- The case manager must collaborate with the participant in order to plan to address any outstanding goals.
- The case manager must support the participant in preparing for the new responsibilities that accompany the new living arrangement (e.g., budgeting, maintaining a household, utilizing community resources, etc.).
- The case manager must assist the participant with securing and arranging any resources needed for the new housing arrangement (i.e., furniture, moving, deposits, etc.).
- The case manager **must complete a HUD exit assessment** in the Homeless Management Information System (HMIS) on the day that the participant exits the program, and if possible, **should conduct an exit interview.**

3.2 Unplanned Exit: Purpose of the unplanned exit process: The purpose of the Unplanned Exit process is to ensure that participant departures from services due to unexpected circumstances are addressed and recorded in an appropriate manner.

Voluntary Discontinuation of Services: There will be instances during the course of service provision, where a participant chooses to discontinue services and opts to leave the program before fulfillment of the housing plan.

- The case manager **should conduct an exit interview** to discuss the participant's housing arrangement after exiting emergency housing on the day that the participant exits the program.
- The case manager **must complete a HUD exit assessment** in the Homeless Management Information System (HMIS) on the day that the participant exits the program.

Discharge for Health and Safety Reasons: There will be instances during the course of service provision when a participant demonstrates inappropriate/ prohibited behavior which threatens the safety of the participant or others in the facility and may present the need to discharge the participant from services.

- **Inappropriate/Prohibited Behaviors (Any behavior that compromises and/or threatens the health and safety of emergency housing staff and/or other participants):**
  - » Physical violence to other participants or staff.
  - » Sexual violence to other participants or staff.
  - » Terroristic threats towards other participants or staff.
  - » Possession of a weapon on-site.
  - » Destruction of emergency housing property or the property of staff or other participants.
  - » Possession, sale, use, or distribution of drugs and alcohol on-site.
  - » Illegal activity onsite (Examples: theft, rape, stealing, etc.).
  - » **Persistent** verbal abuse.
  - » Refusing reasonable mandatory searches conducted by staff and/or security.
  - » **Incident** of smoking in the facility.

If a participant demonstrates inappropriate/prohibited behaviors which threaten the safety of the participant and/or others in the facility, the participant must be given a Notice of Discharge for Health and Safety form to begin the involuntary exit process for inappropriate/prohibited behavior.

The case manager must ensure that **all possible interventions have been attempted prior to discharge for health and safety reasons as well as non-health and safety reasons** (which includes, but is not limited to counseling, planning, participant progress review meetings, referrals and follow-up, and contracting).

The case manager must ensure that there is **documentation to support** the request that the participant is to be restricted from services.

Agreement on the action to be taken must be obtained from the Participant Progress Review Team (case management staff, behavioral health staff and/or Department of Human Services staff, if appropriate, and emergency housing staff). **Obtaining agreement from the Team may not be possible in situations involving violent or destructive behavior needing immediate response.**

3.3 Process for Discharge for Health and Safety Reasons:

Notice of Discharge for Health and Safety Documentation: The notice to restrict a participant from services for inappropriate/prohibited behaviors that threaten the safety of the participant and/or others in the facility must be provided, **in writing** on the Notice of Discharge for Health and Safety Form to the participant when a decision is made to terminate services, providing the following information:

- The reason for the decision to terminate services.
- The effective date of the discharge of services.
- The form must be signed by both the case manager and the supervisor.
- **Notification:** Upon deciding to discharge a participant from any emergency housing site, **the emergency housing provider must inform the OHS Emergency Housing Analyst assigned to their program of the decision before the participant is discharged except in instances of violence or threats of violence.**

Participant Appeal:

- The participant must be informed of their right to appeal the provider's decision to discharge them from services due to inappropriate/prohibited behavior.
- The participant must be permitted to respond to the Notice of Discharge for Health and Safety (Request Appeal, Not Request Appeal, or Refuse to Sign).
- If the participant requests an appeal, the **Participant Request for Appeal** form must be completed and signed by the participant. The signature of the participant on this form begins the appeal process. **Violent and/or destructive participants may have to sign the appeal at a different time and/or location.**
- **The provider must ensure that the appeal documentation is forwarded to the Office of Homeless Services within 48 hours of the participant signing the appeal.**
- Participants who have appealed may remain in emergency housing during the appeal process or be discharged to make other arrangements while waiting for their appeal hearing, **depending on the nature of the participant's behavior.**

Participants who have been discharged from services under the Discharge for Health and Safety policy and who refuse to sign the paperwork or otherwise do not sign appeal documentation within 30 days will not be offered an appeal. The participant must return to intake to request assistance.

- If a participant is discharged for any Health and Safety reason and requests an appeal within 30 days of discharge, they may sign the appeal documents and request an appeal hearing.
- If a participant is discharged for any Health and Safety reason and requests an appeal after 30 days of discharge, they will not be offered an appeal. If the participant needs further services, they must return to the OHS intake.
- If the participant is discharged for threats, acts of violence or destruction the participant may be directed, as part of an agreement for further services, to participate in a mental health evaluation, therapy, behavioral health counseling and other

activities to address inappropriate behaviors which may threaten the health and safety of themselves or others in emergency housing.

Levels of Appeal

If the emergency housing administrative team (director, case management supervisor, case manager) determines that a participant must be discharged for health and safety reasons the participant may appeal the decision through the Office of Homeless Services (OHS)

The final level of appeal is through OHS administration.

- The case manager must submit all pertinent/ relevant information to OHS administration who will schedule an appointment for the hearing. Decisions made at this level are final.
- If OHS administration grants the appeal and the participant is allowed to return to an emergency housing program, a final agreement must be written with specific expectations and timeframes. If the participant violates the agreement, the participant may be discharged.
- If OHS administration upholds the decision to terminate services, the participant may be discharged from emergency housing.
- Participants may appeal OHS decisions to terminate services to the Department of Human Services and/or the Department of Housing and Urban Development if they are discharged from programs funded by these entities.

All information must be documented in the Homeless Management Information System (HMIS). Hardcopy materials such the Notice of Health and Safety Discharge and the signed Participant Request for Appeal must also be placed in the participant hardcopy record. **On the day that the participant exits the program,** whether that is pending appeal or following termination of services, the case manager **must complete a HUD exit assessment** in the Homeless Management Information System (HMIS).

3.4 Transfers Between Emergency Housing Providers:

The Office of Homeless Services (OHS) would prefer that contracted emergency housing providers provide service to all families/ individuals referred to their program, however it is understood that there are times when for safety reasons a family/individual may require a change of environment at a different emergency housing site. If, **after the emergency housing provider has extended every offer of service and intervention possible** to a family/individual residing at their emergency housing site, it is believed that the family/ individual may be better served by a different program at another emergency housing site, then the provider must follow the "Provider to Provider Transfer Process" (See Policy Document: Office of Homeless Services Provider to Provider Transfer Process).

3.5 Participant Record: Exit

For all types of exits, the case manager must complete a HUD exit assessment in HMIS **on the day that the participant exits emergency housing.** The case manager must ensure that:

- All necessary screens are completed, and information is accurate.
- **Housing plan status is updated.**
- The close out screen is completed.
- Any notes about re-entry to that program are entered in the event that the participant returns to OHS for re-placement.

The case management supervisor, prior to approval of closing the participant record, must review the record to ensure all information has been documented appropriately.

All information must be documented in the Homeless Management Information System (HMIS). This includes participant case notes regarding exit assessment.

SECTION 4: Recordkeeping Requirements

4.1 Participant Record Maintenance: The case manager is responsible for ensuring that both Homeless Management Information System or HMIS (electronic) and hardcopy records are maintained for all participants. Hard copy records containing personal protected information that are either generated by or for the HMIS (including, but not limited to reports, data entry forms, and signed consent forms) must be supervised by agency staff when in a public area. When agency staff is not present, the information must be secured in areas that are not publicly accessible. Hard copy records containing personal protected information must be disposed of through means such as crosscut shredding and pulverizing. Please refer to the Emergency Housing Standards, Section 7.5, HMIS and Case Management Services, for further additional guidance regarding documenting information in the HMIS.

4.2 Required HMIS Documentation

The following are to be documented and completed in HMIS:

Participant Information:

- **Eligibility Verification and Determination:** Eligibility determination and verification of participant need for services.
- **Demographic Information:** Demographic information (Information regarding the participant and any and all accompanying family members).
- **Assessments:** All required assessments (Initial HUD assessments and annual updates, VI-SPDAT, and any other assessments required)
- **Case Notes:** Case notes (Initial Contact, initial interview, biweekly meetings, housing plan goals and objectives, Participant Progress Review notes, updates regarding linkages and referrals, updates regarding housing applications and completion of forms, planned and unplanned discharge information, participant transfer information, and all other follow-up information). **Case notes must be entered in HMIS within 72 hours of the contact with the participant.**
- **Linkages and Referrals:** Arrangement of linkages and referrals with supportive services as needed including, but not limited to medical, mental health, substance abuse, employment and training, childcare, housing counseling, life skills, and mainstream financial resources, etc.

Housing Information: Housing referrals to the OHS Clearinghouse and other appropriate housing resources.

Financial Information: All updates regarding the participant's financial status (employment, mainstream resources, readily available resources, savings updates, etc.).

4.3 Required Hard Copy Documents

These documents may eventually be scanned into the HMIS system.

Participant Information:

- **Eligibility Verification and Determination:** Eligibility documentation (Declaration of Homelessness, Outreach letters, hospital referral letter/forms, other organizational letters/referrals, etc.).
- **Identification:** Copies of identification, birth certificates, social security cards, medical cards.
- **Participant Rights and Agreements:** The following signed documents: Participant Rights, Service Agreement, Housing Addendum, and Children Services Agreement (if applicable).
- **Discharge and Appeals Process:** Signed Office of Homeless Services Discharge and Appeals Process.
- **Consents to Releases of Information:** All consents to releases of information.
- **Notice of Discharge for Health and Safety:** Notice of Discharge for Health and Safety forms and all accompanying documentation, including any Request for Appeal forms.

Housing Information: All documentation required for housing applications and forms (including but not limited to: housing applications, eviction notices, utility documentation).

- **Housing plan:** Initial and updated signed housing plans.
- **Referral documents:** Letters, applications, referral forms, tracking forms documenting participant linkage with/referral to supportive services.
- **Financial Information:** All documentation regarding the participant's financial status (SSI/SSD letters, paystubs, W-2 forms, eligibility calculation sheets, readily accessible resources forms, unemployment insurance, Compass print out, etc.). The Savings Program Agreement (where applicable).
- **Correspondence:** All correspondence with external sources and resources on behalf of the participant.

4.4 Record Retention Period: In accordance with City of Philadelphia contract General Provisions Section 6.5, the Provider is responsible for retaining accounting books, client case records, documentation and all records pertaining to the Participant for a period of (5) years after the expiration of the contract involved. If there is the existence of any claim, investigation, litigation, formal complaint or audit started before the (5) year expiration of the records, the Provider shall retain the records until there is resolution of the issue/activity.

Appendices

Participant Rights

Participants in all OHS emergency housing programs have the following rights:

- The right to be treated in a dignified manner by all emergency housing staff and participants.
- The right to live in a clean, safe environment.
- The right to confidentiality of all case records, manual or electronically stored, and all other participant information, except in cases involving criminal activity, danger to self or others, suspected child abuse, or reportable medical condition.
- The right to freedom from discrimination based on race, age, sexual orientation, gender, gender identity, color, creed, religion, ancestry, national origin, medical condition, physical disability, mental disability, and/or familial status.
- The right to access and receive services according to the gender with which the participant identifies.
- The right to dress in accordance with the gender with which the participant identifies.
- The right to access to housing assistance.
- The right to breastfeed a child in any location, public or private, whether or not the mother's breast is covered, in accordance with Philadelphia and Pennsylvania law.
- The right to leave the emergency housing premises to engage in other activities during the day or night, including work, training, housing appointments, and managing personal affairs (family matters and family oriented activities, religious activities, community affairs, etc.)
- The right to overnight absences (i.e. spending time away from the emergency housing facility) during special circumstances , such as work or managing personal affairs (family matters and family oriented activities, religious activities, child related activities such as camp or court ordered visits, etc.). The participant is expected to provide advance notice regarding the need for absence and, where applicable, documentation verifying the visit. Please note participants who do not follow this process and are absent from the facility without authorization for 48 hours will be discharged from the emergency housing program and will be required to report to intake to re-apply for emergency housing. In addition participants who do not follow this process and are absent from the facility without authorization for a total of 5 non-consecutive days (days that are not one after the other) will be discharged from the emergency housing program and will be required to report to intake to re-apply for emergency housing.
- The right to be informed of program rules, regulations, policies and codes of conduct.
- The right to be informed of the drug & alcohol testing procedures of the program (if applicable) and to receive assistance irrespective of refusal to be tested.
- The right to be informed of the prohibition on and consequences of the following activities (threats to health and safety):
  - » Fire related incidents (which includes smoking in the building, lighting matches, starting fires, etc.)
  - » Physical violence to other participants or staff.
  - » Sexual violence to other participants or staff.
  - » Terroristic threats towards other participants or staff.
  - » Possession of a weapon on-site.
  - » Destruction of emergency housing property or the property of staff or other participants.
  - » Possession, sale, use, or distribution of drugs and alcohol on-site.
  - » Illegal activity onsite (theft, rape, stealing, etc.).

  - » **Persistent** verbal abuse.
  - » Refusing reasonable mandatory searches conducted by staff and/or security.
  - » Repeated incidents of smoking in the facility
- The right to be informed of the OHS procedures for termination.
- The right to register a complaint. **A complaint** is a statement of dissatisfaction with the emergency housing program, program staff, program facilities, and/or services provided. **All participants have the right to initiate a complaint with the Office of Homeless Services by contacting the Office of Homeless Services Comment Line at 215-686-4700.**

By signing this document I verify that I have read and understand and agree with the participant rights listed above.

Participant Name (Print) _____

Participant Signature _____

Date _____

Emergency Housing Placement Service Agreement

Participant Name:_____ **OSH Case #:** _____

Intake Worker: SH/BH : _____ **Service Agreement Date:** _____

This is a service agreement between the above-named participant and the Office of Homeless Services

The Office of Homeless Services agrees to provide the following services and programs through contracted emergency housing providers in order to help enable the participant to resolve their housing crisis and obtain stable housing.

1. Temporary emergency housing for a period **ordinarily not to exceed six months.**
2. Information about supportive services for special populations which include, but are not limited to: Children, participants with disabilities, protective service needs, disabilities, sexual minorities, and veterans.
3. Linkages and referrals for services which include, but are not limited to: medical, behavioral health (mental health and substance abuse), domestic violence, sexual minority services, children's services, veteran, educational, and employment.
4. Ongoing case management services.
5. Rental assistance for relocation or eviction prevention for eligible participants.
6. Housing assistance to obtain permanent and/or transitional housing.
7. A savings program to enable participant to save income toward housing.

The participant agrees to cooperate with the following as a recipient of services:

1. To receive case management services offered.
2. **To abide by all health and safety rules and regulations in emergency housing which protect all who reside at the facility. Please note, the following behaviors are prohibited in emergency housing:**
    - Fire related incidents (which includes smoking in the building, lighting matches, starting fires, etc.)
    - Physical violence to other participants or staff.
    - Sexual violence to other participants or staff.
    - Terroristic threats towards other participants or staff.
    - Possession of a weapon on-site.
    - Destruction of emergency housing property or the property of staff or other participants.
    - Possession, sale, use, or distribution of drugs and alcohol on-site.
    - Illegal activity onsite (theft, rape, stealing, etc.).
    - **Persistent** verbal abuse.
    - Refusing reasonable mandatory searches conducted by staff and/or security.
    - Repeated incident of smoking in the facility.

The above-mentioned behaviors are a threat to the health and safety of others in the facility and will result in termination/discharge from services.

3. To participate in behavioral health services if needed which may include drug testing, and referral for mental health or substance abuse treatment.
4. To cooperate with the Office of Homeless Services and other housing services providers to obtain stable housing.

5. To make a full-faith effort on to obtain stable housing which includes seeking private market housing. (Review and sign the Office of Homeless Services Housing Placement Addendum to Service Agreement)
6. Families With Children: The parent(s) or guardian(s) agree to provide adequate and appropriate care and supervision for all children in their care. (Review and Sign OSH Children's Service Agreement).
7. To provide advance notice regarding the need for overnight absence from the emergency housing program and, where applicable, provide documentation to the emergency housing provider verifying the visit (i.e. documentation from the hospital, court orders, etc.). **Please note participants who do not follow this process and are absent from the facility without authorization for 48 hours will be discharged from the emergency housing program and will be required to report to intake to re-apply for emergency housing. In addition participants who do not follow this process and are absent from the facility without authorization for a total of 5 non-consecutive days (days that are not one after the other) will be discharged from the emergency housing program and will be required to report to intake to re-apply for emergency housing.**

To the Participant: Your signature means you understand and consent to the terms of this Service Agreement.

To the Worker: Your signature means you have provided the required services and information during the intake process.

Participant Signature _____ Date _____

2nd Participant Signature _____ Date _____

Emergency Housing Staff Signature _____ Date _____

Housing Placement Agreement

Participant Name: _____ **OSH Case #:** _____

Shelter Case Manager: _____ **Date:** _____

The mission of the Office of Homeless Services (OHS) is **to make homelessness rare, brief, and non-recurring.** As your Case Manager, I agree to work with you to connect you with housing opportunities and resources that will assist you with ending your current housing crisis, including but not limited to:

Security deposit, first and last month's rent

- Assistance with paying off utility bills
- Rapid Re-housing (rental assistance)
- Transitional Housing
- Permanent Supportive Housing
- Private Market Housing
- Other public and private housing programs in the community

As a participant seeking stable housing, I understand and agree to the following:

- Acceptance into a housing program does not mean that I will be able to move in immediately.
- I understand I will need to work with my Case Manager to submit required documentation and attend meetings and appointments that will help me get housing.
- I understand that if I am offered a suitable housing option, I will be expected to accept so that I can end my experience of homelessness and resolve my current housing crisis.
- If I turn down a suitable, available housing option, I understand I will be given 30 days to make my own housing arrangements.
- I understand that if I decline to save at least 30% of my income to help resolve my current housing crisis and end my experience of homelessness, I will be given 30 days to make my own housing arrangements.
- I understand I may appeal this decision prior to the end of the 30 days through my Case Manager to OHS. Discharge may be reconsidered if there are extenuating circumstances that sufficiently support the reason for declining (turning down) housing.

Participant Signature _____ Date _____

2nd Participant Signature _____ Date _____

Case Manager Signature _____ Date _____

Children Services Agreement

Healthy Meal Participation: OHS provides healthy and nutritious meals to family emergency housing programs in compliance with Philadelphia Nutrition Standards. In addition, select provider who provides services to children and families must adhere to the State of Pennsylvania Child and Adult Food Program (CACFP). Children, up to 17 years, are required to eat meals prepared by your emergency housing program unless they are under 6 months and exclusively breast or formula fed. If your child participates in breakfast or lunch programs in school, day care or Head Start programs, you must present written documentation from each program verifying your child's participation.

(Init) _____

Breastfeeding Accommodation: OHS is committed to creating an environment supportive and conducive to breastfeeding. Lactating participants must be provided reasonable accommodations to express breast milk and must be guaranteed the right to breastfeed in public spaces, irrespective of whether or not the mother's breast is covered during or incidental to the breastfeeding.

(Init) _____

School Attendance: All children of school age are required to attend school unless a notice of sickness or emergency circumstance is presented to emergency housing staff. You are entitled to assistance with school enrollment, transportation and school uniforms. Please see your case manager or the emergency housing staff for assistance.

(Init) _____

Immunizations: Children 0-6 years of age must be appropriately immunized before placement into emergency housing. After placement, parents must ensure that children receive follow up immunizations as required by the Philadelphia Department of Public Health.

(Init) _____

Medical/Dental Assessments: Children 3-8 years of age must have a medical and dental assessment within 60 days of emergency housing placement. You may receive a waiver from this requirement if your child has undergone these assessments within 6 months prior to emergency housing placement, however, you must present verifying documents to your case manager when requested.

(Init) _____

Medical/Dental Care: All children of school age must have a medical and dental care follow-up according to the clients' primary physicians'/dentists' instructions in order to ensure that children are in good health. This includes general health follow-up and follow-up after medical emergencies. Parents with children who are assessed to need specific medical treatment must ensure that their children participate in the medical treatment plan, which includes but is not limited to: attending appointments, physical therapy, and medication.

(Init) _____

Behavioral Health Care: Parents with children who are assessed to need behavioral health assistance must ensure that their children participate in behavioral health treatment, which includes but is not limited to: attending appointments, therapy/counseling, and medication.

(Init) _____

Children Services Agreement

Discipline: Parents are not permitted to use corporal punishment, discipline which is harmful to the health and wellbeing of their children. This includes, but is not limited to: Spanking, slapping or other forms of hitting with hands or any other instruments, any form of punishment that inflicts pain, use of restraints or isolating a child in an inappropriate space, denial of meals or other basic needs, verbal abuse or ridicule, assignment of excessive or inappropriate chores or work, punishment for bed-wetting or actions relating to toilet training, allowing children to discipline other children. (Philadelphia Department of Human Services Resource Parent Handbook, p.41). Parents experiencing difficulty managing the behavior of their children must request assistance from the case manager.

(Init) _____

- I understand that the emergency housing provider must ensure the health and safety of children who participate in their program/reside at their facility.
- I understand that the provider must address any concerns which threaten the health and safety of children who participate in their program/reside at their facility, which may include contacting the Department of Human Services.
- OHS reserves the right to terminate my emergency housing services for any threats to the health and safety of children residing at an OHS contracted program. I understand that I have a right to appeal the termination of emergency housing services, according to OHS discharge and appeal process.

Parent/Guardian Signature _____ Date: _____

Emergency Housing Staff Signature _____ Date: _____

Office of
Homeless Services

POLICY AND PROCEDURES

Savings Program

The Office of Homeless Services is requesting that all participants participate in the OHS Savings Program. Therefore, the Office of Homeless Services requires all Emergency Housing Providers (" Providers") to establish internal mechanisms necessary to review the Savings Program with participants and to ensure compliance with the Savings Program policy.

Savings Program Policy Requirements

PARTICIPANT SAVINGS POLICY

Because the intent of the OHS Savings Program is to support the housing goals of the participant, OHS is requesting that participation in the Savings Program be made **an expectation** for all enrolled emergency housing participants. It is the expectation of the Office of Homeless Services that participants contribute **at least 30% of their monthly income** to their savings on at least a monthly basis.

Participants are only to make withdrawals from their savings account for the following reasons:

1. Security deposits for Permanent/Transitional/Rapid Rehousing
2. Permanent/Transitional/Rapid Rehousing expenses (i.e., beds for family members, kitchen items, etc.)
3. Other emergency situations as approved by the Case Manager

Any participant that refuses to adhere to the savings policy and/or provide the Provider/Case Management with copies of monthly account statement will be given 30 days to make their own arrangements. Participants who make unauthorized withdrawals without permission from the Provider/Case Manager will be given 30 days to replace the withdrawn funds, however, if funds are not restored to the original balance before the withdrawal, they will be given 30 days to make their own arrangements.

Participants are expected to open up a savings account with a traditional bank or credit union (i.e., Santander, Bank of America, Citizens Bank, Police and Fire Credit Union, etc.), however, if this is not possible, other options include non-traditional savings accounts such as Chime, Ally, Sofi, etc.

PROVIDER RESPONSIBILITY

ORIENTATION

The Provider is expected to conduct an orientation which clarifies for staff and participants the expectations of the Savings Program process and promotes uniform understanding of all issues of compliance. Within two weeks of admission to an OHS emergency housing facility, participants must receive an orientation from the Provider/Case Management about the Savings Program. The orientation should be scheduled during the initial Case Management meeting (within 15 days of referral) and must provide clearly defined procedures that participant and staff are to follow - through the opening of a savings account, monthly deposit requirement (at least 30% of monthly income), and withdrawal policy.

Within two weeks of admission to the facility, the participant's case manager must have an initial meeting with each participant, to verify income and review any SSI, SSA, Unemployment, and/or Public Assistance award or verification letters. (Although participation in the Savings Program is an expectation, this initial meeting is an ideal opportunity to outline the benefits of a participant's participation in the Savings Program).

Once the participant has received this orientation and had the initial meeting with their case manager, the participant can start participating in the Savings Program.

All participants must sign the Savings Program Agreement form that indicates the participant understands what is required and is willing to comply with the terms of the agreement based on the OHS Savings Program Policy. Both the participant and the Provider/Case Manager providing the orientation must sign the Savings Program Agreement form; a copy of this signed form must be kept in the participant's official record.

Providers/Case Managers shall establish a system of regular correspondence with the participant for savings balances, changes in income, and withdrawals.

DEPOSITS

The Provider must maintain hard copies of each **Monthly Account Statement** provided by the participant during their bi-weekly meetings with the Provider/Case Management from the financial institution. Each monthly account statement must include the year-to-date balances of all savings deposits, and a copy of which must be kept in the participant's file.

WITHDRAWALS

Participants are only to make withdrawals from their savings account for permanent/transitional/ Rapid Rehousing expenses, or upon discharge from Emergency Housing, or other emergency situations as approved by their Case Manager.

PARTICIPANT

INCOME REPORTING/VERIFICATION

Although participation in the Savings Program is an expectation, each emergency housing participant is responsible for reporting and verifying all earnings/ entitlements received to their case manager. The participant is responsible for reporting and verifying all changes in income/entitlements to their case manager in writing (i.e., updated income verification forms) during their bi-weekly Provider/Case Management meetings.

ORIENTATION

The Savings Program orientation is to clarify for staff and participants the requirements of the Savings Program process and promote uniform understanding of all issues of compliance. Within two weeks of admission to an OHS emergency housing facility, all participants must receive and attend an orientation from the Provider/Case Management about the Savings Program.

All participants must review and sign the **Savings Program Agreement form** with the Provider/Case Management. Both the participant and the Provider/ Case Management providing the orientation must sign the Savings Program Agreement form; a copy of this signed form must be kept in the participant's file.

Savings Program Agreement Form

The Office of Homeless Services is requesting that all participants participate in the OHS Savings Program. Therefore, the Office of Homeless Services requires all Emergency Housing Providers ("Providers") to establish internal mechanisms necessary to review the Savings Program with participants and to ensure compliance with the Savings Program policy.

Participant Savings Policy

Because the intent of the OHS Savings Program is to support the housing goals of the participant, OHS is requesting that participation in the Savings Program be made an expectation for all enrolled emergency housing participants. It is the expectation of the Office of Homeless Services that participants contribute **at least 30% of their monthly income** to their savings on at least a monthly basis.

Participants are only to make withdrawals from their savings account for the following reasons:

1. Security deposits for Permanent/Transitional/Rapid Rehousing
2. Permanent/Transitional/Rapid Rehousing expenses (i.e., beds for family members, kitchen items, etc.)
3. Other emergency situations as approved by the Case Manager

Any participant that chooses to decline to adhere to the savings policy and/or provide the Provider/Case Management with copies of monthly account statement will be given 30 days to make their own arrangements. Participants who make unauthorized withdrawals without permission from the Provider/Case Manager will be given 30 days to replace the withdrawn funds, however, if funds are not restored to the original balance before the withdrawal, they will be given 30 days to make their own arrangements.

Participants are required to open a savings account with a traditional bank or credit union (i.e., Santander, Bank of America, Citizens Bank, Police and Fire Credit Union, etc.), however, if this is not possible, other options include non-traditional savings accounts such as Chime, Ally, Sofi, etc.

My signature below confirms that the policy has been reviewed with me by the Provider/Case Management and I agree to the terms of Savings Program Policy and Procedures:

Participant Signature _____ Date: _____

Case Manager _____ Date: _____

Case Manager Supervisor _____ Date: _____

Office of
Homeless Services

POLICY AND PROCEDURES

Savings Program

All OHS clients are expected to save 30% of their income to be used to secure transitional and/or permanent housing. Therefore, the Office of Homeless Services requires all Emergency Housing Providers ("Providers") to establish internal mechanisms necessary to collect and maintain savings from any client (with income from any source) currently staying in their emergency housing facility in the OHS Savings Program. This includes, but is not limited to, hiring and training of additional staff as needed; acquiring and installing computers and software; setting up bank accounts; establishing secure filing systems; setting up staff email accounts for reporting, and developing appropriate administrative internal controls to insure procedural efficiency and integrity.

Savings Program Policy Requirements

CLIENT SAVINGS POLICY

Because the intent of the OHS Savings Program is to support the housing goals of the client, staff should support clients to participate in the Savings Program and to only make withdrawals from their savings account for permanent/transitional housing expenses, or upon discharge from Emergency Housing.

MASTER SAVINGS ACCOUNT

Providers shall establish and maintain a master savings account at a local banking institution with sub-accounts setup for each client who chooses to save. These sub-accounts should be available for use within 30 days of a client's placement at a Provider's facility.

Participants who do not have income at intake are expected to seek and obtain any benefits for which they are eligible. In the event that accrued interest exceeds any fees applied to the master account during any given period, such interest should be allocated to client accounts.

Providers shall establish a system to effect deposits and withdrawals to client accounts in a timely manner. Additionally, providers must hear and resolve all grievances resulting from challenges to balances or specific areas of the process. **(See Grievance Procedures).**

Providers shall remove any employee from the savings process that violates the client trust by misrepresenting facts, falsifying records, extorting funds, stealing or knowingly not adhering to the established process.

Providers shall establish a system of regular correspondence with the client's assigned case managers for savings balances, changes in income, and withdrawals.

CLIENT SAVINGS AND DISCHARGES OR TRANSFERS

Upon discharge from your emergency housing program, the client's savings balances should be reconciled and presented to the client on the day of discharge. If for some reason you cannot make the check available on the day of discharge, the client must be presented a written statement with an authorized signature containing the date and time the check will be available for pick up. In no circumstances must a client be made to wait more than 72 hours post-discharge to receive their savings balance. In the event that the client files a grievance challenging the savings balance, the resolution must occur within 72 hours of the client's discharge.

In the event that a client is moving to another emergency housing, transitional, or other subsidized housing program that requires a transfer of a specified amount of the client's savings, you must obtain a Request for Payment from the new housing provider or the client's case manager. This documentation must include the actual amounts to be transferred to the housing provider along with the legal name of the organization and an identified contact person. The client and the client's case manager must authorize the savings transfer request.

UNCLAIMED SAVINGS

If a client is discharged from your facility for any reason and does not return to claim their savings balance, you must hold their account open for one year post the day of discharge. After one year, you must turn such balances over to: **The Bureau of Unclaimed Property, Pennsylvania Treasury, North Building, 2nd Floor, Harrisburg, PA 17120.** It is recommended that you report such accounts to OHS at least 90 days before the account is transferred to the State so that we may search for the individual in our system.

DECEASED CLIENTS

In the event of a client's death, funds can be released only if the person claiming the funds has a Letter of Administration from the City of Philadelphia Wills. **THIS MUST BE DONE IN THE ABSENCE OF A WILL.** 12 months after date of death, or discharge from emergency housing (whichever occurs first), funds remaining unclaimed in such accounts will be turned over to: The Bureau of Unclaimed Property, Pennsylvania Treasury, North Building, 2nd Floor, Harrisburg, PA 17120.

Roles and Responsibilities

THE PROVIDER

ORIENTATION

The Provider is expected to conduct an orientation which clarifies for staff and clients the requirements of the Savings Program process, and promotes uniform understanding of all issues of compliance. Within two weeks of admission to an OHS emergency housing facility, clients must receive an orientation from the Savings Program Representative about their expectation to participate in the Savings Program. The orientation should be scheduled during the first two weeks of client's arrival at the facility, and must provide clearly defined procedures that clients and staff are to follow - through the collection, deposit, disbursement, reconciliation, and grievance processes.

Within two weeks of admission to the facility, the client's case manager must have an initial meeting with each client, to verify income and review any SSI, SSA, Unemployment, and/or Public Assistance award or verification letters. Once the client has received this orientation and had the initial meeting with their case manager, the client is expected to start participating in the Savings Program at that point during their stay in Emergency Housing.

All clients must sign a Savings Program Agreement form (created by the Provider) that indicates the client understands what is required and is willing to comply with the terms of the agreement based on the OHS Savings Program Policy. All clients participating in the Savings Program must also be provided instructions for completing a money order, and informed of the collection and disbursements schedules. Both the client and the Savings Program Representative providing the orientation must sign the Savings Program Agreement form; a copy of this signed form must be kept in the client's official record.

For staff, the employee manual should be updated to include Savings Program policy and procedures, and specific consequences for any violation of client trust. Providers must notify OHS in writing of staff changes within five (5) business days.

COLLECTIONS

The Provider should designate specific dates and times savings will be collected.

Payments from clients into savings accounts must be done by money order. Upon receipt of client monies, the Savings Program Representative must issue a date stamped Receipt Form to the client (generally a cash or money order receipt form) that must be signed by both parties. The client should receive the original receipt and the provider must keep a copy for their records and reporting purposes. All monies are to be held in a safe in a locked office until deposited into a financial institution within three (3) business days.

Clients are required to keep all personal transaction documents in a secure location.

DEPOSITS

Providers must deposit client money orders into savings accounts within 72 hours of collection. The Provider must maintain hard copies of each monthly Statement of Deposits from the financial institution, and make them available to OHS for scheduled audits.

All clients must be provided an individual **Monthly Client Account Statement** that contains year-to-date balances of all savings collected, a copy of which must be kept in the client's official file.

DISBURSEMENTS/WITHDRAWALS

Each emergency housing program must establish a set schedule of days and times when client savings checks or withdrawals will be disbursed. **It is required that there be a minimum of two days per week that disbursements are made.**

The Provider must utilize the Request for Payment Form (RFP) (client's withdrawal), which identifies the reason for the withdrawal; indicates the amount of the requested withdrawal; and provides signature spaces for the client, the case manager, and the Savings Program Representative.

For internal control purposes, there must be at least two signatures on the RFP. Any employee who signs the RFP cannot be a signatory on the provider checks.

If a client decides to withdraw their savings and leave Emergency Housing to make their own housing arrangements, any decision on re-eligibility for OHS services must be made by an OHS supervisor or administrator. A Withdrawal of Savings/Self-Discharge form must be completed, and a copy of it kept in the client's official record.

UNCLAIMED SAVINGS

In circumstances where a client has left emergency housing without withdrawing their savings, the Provider is required to hold the savings in the custodial account for one year. The Provider must make a good faith effort to contact the client using OHS data systems or other mechanisms to determine if the client is in another shelter, or has some known address in the community. If the emergency housing provider is still unable to contact the client after one year, all unclaimed savings belonging to the client must be sent to **The Bureau of Unclaimed Property: Pennsylvania Treasury; the North Building, 2nd Floor; Harrisburg, PA 17120.** Savings are held by the PA Treasury Department for seven years. To obtain unclaimed savings submitted to the Treasury, a client must contact the Pennsylvania Treasury Department.

RECONCILIATION

The Provider must reconcile all deposits of savings and withdrawals on a monthly basis. Using the Savings Spreadsheet Log (created by the Provider), client receipts and other forms associated with this process should be tested for accuracy during this time. Should a discrepancy arise regarding the year-to-date balances, the Savings Program Representative must report all findings to the client and the client's case manager, as well as take the necessary steps to resolve the discrepancy, or report them to an authority within the organization that can make the appropriate corrections.

Additionally, the Savings Program Representative must meet with each client at least monthly to discuss the status of the client's year-to-date savings balance. At this time the client will be given a Monthly Client Account Statement, which should also be forwarded to the client's assigned Case Manager for the case record.

GRIEVANCE

The Provider must establish a Client Grievance Procedure that will assist the emergency housing program and client to effectively identify and resolve issues involving any step in the savings process. Providers must hear and resolve all grievances resulting from challenges to balances or specific areas of the process. A Grievance Form should be created and made available that lists the methods for filing a complaint, and captures the relevant issues and potential resolutions on each step of the grievance process. The Grievance Procedure/Policy should be included in the orientation process, and signed off on by the client in the Savings Program Agreement.

Grievances must be heard within 48 hrs (2 business days) of filing. Clients discharged from emergency housing must have their grievance reviewed by an Office of Homeless Services representative within 72 hours (3 business days). **OHS retains the right to investigate with the intent to resolve all disputes unsettled by provider after five (5) business days.**

CLIENT APPEALS

OHS serves as arbitrator in all unresolved grievances between the Provider and the client on amounts applied to and reimbursed from savings. OHS shall review all pertinent documentation submitted by the Provider including client receipts, savings logs and monthly savings statements. OHS assumes honesty on behalf of the client until credible evidence is presented by the Provider to disprove this claim.

TRANSFERRED SAVINGS BALANCES

When a client transfers from one emergency housing facility to another, the Provider holding the client's savings must arrange for transfer of the client's savings balance to the new emergency housing provider. The process can occur in one of three ways:

- The client can make a request for payment to be made to the new emergency housing facility. The current Provider must contact the new Provider to acquire the appropriate information to complete the transfer.
- The new Provider can make the request for the client, but must submit a request for payment signed by the client.
- In instances where the client or the new Provider fail to make the request, the Provider holding the savings must make a good faith effort to locate the client and collaborate with the new emergency housing provider to transfer the savings balance.

CLIENT

INCOME REPORTING/VERIFICATION

Each emergency housing participant is responsible for reporting and verifying all earnings/entitlements received to their case manager. The client is responsible for reporting and verifying all changes in income/ entitlements to their case manager within five (5) days of the change in income.

ORIENTATION

The Savings Program orientation is to clarify for staff and clients the requirements of the Savings Program process, and promote uniform understanding of all issues of compliance. Within two weeks of admission to an OHS emergency housing facility, all clients must receive and attend an orientation from the Savings Program Representative about their expectation to participate in the Savings Program. All participants must review and sign the Savings Program Agreement form with the Savings Program Representative; participate in a training on how to complete a money order; informed of the collection and disbursements schedules; and have the formal procedures for savings-related grievances explained to them. Both the client and the Savings Program Representative providing the orientation must sign the Savings Program Agreement form; a copy of this signed form must be kept in the client's official record.

Clients are required to keep all personal transaction documents in a secure location.

GRIEVANCES

Clients who wish to make a complaint regarding their savings shall initiate

Office of Homeless Services Oversight

AUDITS

OHS will audit each savings program at least once per year, or as needed, to ensure there are no violations of client trust, and that all corrective measures are implemented as suggested. After completion of the audit, the audited Provider will receive a detailed Audit Report of all findings and recommendations for corrective action within a reasonable timeframe. The OHS Budget Officer will provide technical assistance to the emergency housing provider to help address the issues that require immediate attention. The Provider must keep documents available on file for five (5) years, even if an audit has been conducted by OHS. Each provider will be notified in writing of the audit date and must make available all pertinent records, including:

- Signed Client Savings Program Agreements
- Bank statements for savings accounts
- Completed and signed income disclosure agreements
- Savings Spreadsheet Logs
- Money Order receipts
- Compliance with OHS Savings Program Policy and Procedures
- Evidence of correspondence and collaboration with Case Management

COMPLIANCE & PERFORMANCE REVIEWS

OHS staff will conduct provider orientation and training, as well as on-going technical assistance, as required. OHS representatives will conduct periodic reviews of the Internal Controls established by the Provider to ensure sufficient checks and balances; detect, minimize, and prevent errors in process; as well as prevent unauthorized account activity. Quarterly analysis of performance trends in collections, transactions and client participation will be provided to each Provider. These quarterly reports are to assist the Provider in:

- Monitoring Savings Program participation;
- Assessing activities that cause these trends;
- Correcting procedures to maximize participation

CORRECTIVE ACTION PLAN (CAP) REVIEW

A corrective action plan addressing all audit findings is due fourteen (14) days after receipt by Provider of the audit review from OHS. OHS will review each CAP and respond to it within fourteen (14) days. If additional corrections are required, your agency will be notified and expected to respond within 7- 14 days. Complete implementation of all corrective actions is expected to occur within 30 days.

STANDARDIZED PROCEDURES

OHS has established minimum standardized procedures each savings program must incorporate. Questions regarding savings programs policies and procedures can be addressed by your assigned OHS analyst.

Definitions

Savings Program Provider /Client Agreement:
Individual agreement tailored according to a participant's or family's net income.

Collection Schedules:
Denotes the times that savings deposits/disbursements will be accepted from or given to clients (listed on the Provider/Client Agreement and also posted on Client Information Bulletin Board.)

Money Orders and Money Order Receipts:
Copies of MO's with corresponding receipts in chronological order.

Monthly Reconciliation:
Signed by client - a statement of the client's monthly Savings Program transactions, with a copy to the case manager for compliance verification.

Request for Payments:
Withdrawal request from savings initiated by the client and signed as approved by the case manager and Savings Program Representative.

Grievance Policy:
Included in the Savings Program Policy or presented in a separate document. It details the specific grievance process from initial complaint to final resolution.

Grievance Form:
Used to guide the client in submitting a written complaint.

Transferred Savings:
Whenever a client transfers to another emergency housing or transitional housing facility, their savings must also be transferred within five (5) business days. Savings are transferred to transitional housing programs in accordance with each programs established standards. Clients must sign a statement acknowledging full receipt of their funds. A copy of the check and the signed receipt must be maintained in the client's financial file.

Unclaimed Savings:
Savings contributed by the client which were not claimed by the client when s/he left emergency housing.

Provider Bank Deposits:
Client monies must be maintained in a locked safe or other secure location at the shelter no more than three (3) days.

Reporting:
Failure to adhere to reporting requirements may result in a hold being placed on Provider contract payments.

Verified Income Disclosure Statements:
Shows the exact calculations for savings payments due based on the participants pay stubs, entitlement income, employment verification etc.

Office of
Homeless Services

GUIDELINES

Prevention and Control of Infectious Diseases in Emergency Housing

General Information

Introduction

The control of communicable diseases is a function of the State and City Departments of Health, governed by State laws and local Department of Public Health regulations. The City of Philadelphia Office of Homeless Services is a key partner in the control of communicable disease spread in residential emergency housing settings. Infectious disease prevention and control in emergency housing situations relies on three major activities:

- Vaccination, consistent with age-appropriate public health recommendations, to protect against vaccine-preventable diseases such as pertussis, measles, mumps, rubella, influenza, and hepatitis A.
- Hand washing and respiratory hygiene to break the chain of transmission of germs that are spread during close contact by respiratory droplets and through shedding in the stool (fecal-oral spread).
- Surveillance or recognition of diseases among **emergency housing residents or staff,** with prompt reporting to emergency housing and public health officials.

Hand Washing and Respiratory Hygiene Recommendations

Hand washing is one of the most effective ways to interrupt the spread of germs between people. It is an important way to reduce the spread of respiratory infections such as influenza ("the flu"), and enteric infections (stomach infections) that cause vomiting and diarrhea. Recommendations apply to **all residents and staff.**

- Hand washing must be done:
  - » After using the bathroom, changing diapers, and taking care of personal needs (e.g., combing hair)
  - » Before preparing or serving foods, and eating
  - » Before preparing bottles for babies, and before feeding babies
  - » After handling garbage or trash, even if using gloves
- Hot and cold running water must be available for hand washing in all bathroom areas, diaper changing areas, and in all food preparation and service areas
- Post signage in all bathrooms and kitchen/food preparation areas reminding people to wash hands
- Liquid soap in mounted dispensers (not bars of soap) should be available.
- Diaper pails should be available on each floor where diaper-age children reside or play, in close proximity to diaper changing areas.
- Steps to good hand washing:
  - » Soap and warm running water should be used.
  - » The entire surface of hands and fingers should be washed, rubbing hands together for at least 15 seconds.
  - » Alcohol-based hand sanitizers may be used for hand washing when access to hand washing facilities is limited.
  - » Rinse hands and dry with clean towels. Use towel to turn off water faucet, and discard after use.
- Encourage respiratory hygiene and cough etiquette among all staff and residents:
  - » Cover mouth and nose when coughing or sneezing
  - » Use tissues and dispose in no-touch waste containers
  - » Wash hands with soap and water or use hand sanitizer after soiling hands with respiratory secretions

Communicable Diseases Requiring Reporting

To prevent ongoing transmission of communicable disease (of resident or emergency housing staff) the following diseases are reportable to the PHMC Infection Control Coordinator (On-Call 215-341-1307) or 267-474-7613 and the Office of Homeless Services. The PHMC Infection Control Coordinator or the Office of Homeless Services will then report these conditions to the Division of Disease Control at the Philadelphia

Department of Public Health. Prompt reporting ensures the institution of an infection control plan in consultation with the Philadelphia Department of Public Health.

- **Amebiasis (Entamoeba histolytica)**
- **Chickenpox/Shingles**
- **Campylobacter**
- **Clostridium difficile**
- **Cryptosporidium E. coli 0157:H7**
- **Giardia Hepatitis A**
- **Measles**
- **Meningitis (due to any cause)**
- **Mumps**
- **Pertussis (whooping cough)**
- **Rubella Salmonella**
- **Shigella**
- **Tuberculosis**

Additional Reporting Requirements

The occurrence of **any of the following conditions in three or more emergency housing residents** should also be reported immediately to the **PHMC Infection Control Coordinator (On-Call 215-341-1307) or 267-474-7613 and the Office of Homeless Services.**

- **Diarrhea (any cause)**
- **Skin infections (strep, staph including MRSA)**

Bed Bugs

Any incidents of **bed bugs** at the emergency housing facility must be reported to the **Office of Homeless Services and the PHMC Infection Control Coordinator (On-Call 215-341-1307) or 267-474-7613.**

Office of Homeless Services Contact Persons:

Tojuana Conway, Emergency Housing Supervisor: Tojuana.Conway@phila.gov

Frederick Gigliotti, Director of Emergency and Transitional Housing: Frederick.Gigliotti@Phila.Gov

DISEASE SPECIFIC GUIDELINES

HEPATITIS A

Hepatitis A is a viral infection that causes nausea, vomiting and jaundice (yellow skin and dark urine). Hepatitis A is shed in the stool and is spread from person-to-person when someone with hepatitis A does not wash his or her hands properly after using the bathroom. Someone with hepatitis A can spread the disease from 2 weeks before he or she becomes sick, until 7 days after they become jaundiced. Hepatitis A can be prevented by hepatitis A vaccine, which is now offered routinely to young children. People who have not received vaccine and who are exposed to hepatitis A can receive either hepatitis A vaccine or a medication called immune globulin (IG) immediately following the exposure to prevent the infection. Both must be given within 2 weeks of the exposure to be effective. Someone is immune to hepatitis A if she or he has had the disease or two doses of hepatitis A vaccine. Hepatitis A vaccine is now given to all children age 12-23 months of age as part of the regular childhood immunization schedule. Hepatitis A vaccine is also recommended for the following adults:

- Men who have sex with men
- Travelers to foreign countries with high incidence of hepatitis A
- People who use street drugs
- People with chronic liver disease
- People with clotting problems

The key to controlling the spread of hepatitis A is through vaccination and through proper hygiene. Both staff and residents should understand the importance of hand washing after using the toilet or diaper changing facilities and before preparing or eating food.

The Division of Disease Control, Philadelphia Department of Public Health, (PDPH) should be notified for any case of hepatitis A **in an emergency housing resident or staff member.** The Division of Disease Control telephone number is 215-685-6742, Monday through Friday, 8:30 AM-5:00 PM; after hours, please call 215-686-1776 and ask for the person on call for Disease Control.

The PDPH Division of Disease Control staff will provide guidelines to interrupt the spread of disease in emergency housing and determine the need for the administration of IG (see Management of contacts, below). The emergency housing staff person reporting the disease, or a designated person should be available to communicate information about new cases and assist with efforts to control the spread of hepatitis A.

PDPH will provide educational materials, and if necessary, conduct training on infection control for emergency housing staff and residents.

General Recommendations to Prevent Spread of Hepatitis A

These general recommendations should be followed at all times, even when there are not cases of hepatitis A.

1. Hepatitis A vaccine should be given to all emergency housing residents > 12 months of age at intake, if they have not already received two doses of vaccine.
2. Bathrooms, diaper changing facilities, and any area where diapers are changed, as well as food preparation areas must have sings to remind staff and residents to wash their hands after using the bathroom, changing diapers and before food preparation or eating.
3. All emergency housing programs that admit diaper-age children should have diaper-changing facilities near sinks for handling washing after each diaper change. Cleaning of these facilities between each change is crucial to prevent the spread of the disease. Containers for diaper disposal should also be available.
4. Sinks used for hand washing after diaper changing should not be in or near food preparation or eating areas.

Management of Cases

Any resident with hepatitis A should be managed as follows:

1. Residents with hepatitis A must be referred to a health care provider for evaluation and diagnosis. Residents who do not have a primary health care provider can receive medical care at any PDPH District Health Care Center.
2. **Residents or staff** with hepatitis A should not prepare or serve food until one week after they become jaundiced.
3. If possible, residents with hepatitis A should use separate toilet facilities, which are not shared by residents who do not have hepatitis, until one week after the onset of jaundice.
4. If possible, residents with hepatitis A and their families should be housed together, sharing the same living space and bathrooms. This should continue until one week after the last person in the family has jaundice.

Management of Contacts Exposed to a Confirmed Case of Hepatitis A

Close contacts of someone with hepatitis A are at risk for getting the infection, if they have not previously received hepatitis A vaccine. Infection can be prevented by giving the exposed person either immune globulin or hepatitis A vaccine, provided it is given within 2 weeks. The PDPH will determine if any **residents or staff** are candidates for immune globulin or vaccine, and assist with the administration, if needed.

Admission/Transfer Recommendations for Emergency Housing Programs with Confirmed Case of Hepatitis A

Residents with hepatitis A entering emergency housing should be sent to a facility where they can have their own room and toilet facilities. If this is not possible, and alternative housing can be arranged, the resident should not be admitted to emergency housing until one week after the onset of jaundice.

No resident with hepatitis A, or family who has a member with hepatitis A should be discharged or transferred to another group facility or emergency housing or private home, unless they will have separate living space and toilet facilities at that location. Residents with hepatitis A may be transferred one week after they had become jaundiced. Residents who do not have hepatitis A, and

leave emergency housing where there has been a case of hepatitis A in the preceding 45 days, should be advised to seek medical attention if they develop jaundice.

INFECTIOUS DIARRHEA

Infectious diarrhea (with nausea, vomiting and diarrhea) can be caused by a bacteria, viruses, or parasites. Infectious diarrhea is spread from person-to-person when someone who is sick does not wash his or her hands properly after using the bathroom. This section contains general prevention and control recommendations for all causes of infectious diarrhea. Specific recommendations regarding the control of Shigella and norovirus infections are contained in a separate section within this manual.

The Division of Disease Control, Philadelphia Department of Public Health, (PDPH) should be notified for any case of diarrhea in emergency housing caused by a specific type of bacteria or parasite, or if three or more residents have diarrhea, regardless of whether the cause is known. The Division of Disease Control telephone number is 685-6742, Monday through Friday, 8:30 AM-5:00 PM; after hours, please call 686-1776 and ask for the person on call for Disease Control.

One or more cases of diarrhea **in an emergency housing resident or staff member** caused by *Campylobacter, Clostridium difficile, Cryptosporidium, E. coli 0157:H7, Entamoeba histolytica (amebiasis), Giardia, Salmonella, or Shigella* should be reported to the Division of Disease Control. Division staff will provide specific recommendations for disease management based on the cause of illness, including guidance to interrupt the spread of disease in emergency housing and direct ill emergency housing residents to medical care. The emergency housing staff person reporting the disease, or a designated person should be available to communicate information about new cases and assist with efforts to control an outbreak.

General Recommendations to Prevent Spread of Infection

PDPH will provide educational materials, and if necessary, conduct training on infection control for emergency housing staff and residents.

The key to controlling the spread of infectious diarrhea is proper hygiene. **Both staff and residents** *should understand the importance of hand washing after using the toilet or diaper changing facilities and before preparing or eating food.* These general recommendations should be followed even when there is not an outbreak of diarrhea.

1. Bathrooms, diaper changing facilities, and any area where diapers are changed, as well as food preparation areas must have sings to remind staff and residents to wash their hands after using the bathroom, changing diapers and before food preparation or eating.
2. All emergency housing programs that admit diaper-age children should have diaper-changing facilities near sinks for handling washing after each diaper change. Cleaning of these facilities between each change is crucial to prevent the spread of the disease. Containers for diaper disposal should also be available.
3. Sinks used for hand washing after diaper changing should not be in or near food preparation or eating areas.

Management of Cases with Infectious Diarrhea

Any resident complaining of diarrhea (three or more loose stools/day) should be managed as follows:

1. Any resident with diarrhea for more than 72 hours must be referred for medical attention. If three or more residents have diarrhea, all residents with symptoms should have a medical evaluation within 24 hours. Residents who do not have a primary health care provider can receive medical care at any PDPH District Health Care Center.
2. If possible, residents with diarrhea should use toilet facilities that are not shared by residents who do not have diarrhea, until they no longer have symptoms.
3. If possible, residents with diarrhea, and their families, should be housed separately from other residents, including living space and bathrooms. This should continue until they no longer have diarrhea.

4. **Residents or staff** with diarrhea from any cause should not prepare or serve food until they no longer have symptoms. Residents with Shigella must have proof of negative stool cultures before they can return to handling food. Residents with other infections (e.g., Salmonella, Campylobacter, Giardia) must have negative stool cultures before being cleared to handle or serve food if there is evidence of disease spread within emergency housing. The Division of Disease Control, Philadelphia Department of Public Health should determine when a person with infectious diarrhea can return to high risk activities such as food handling.

Management of Contacts of Infectious Diarrhea

Close contacts (e.g., usually household contacts) of persons who have diarrhea due to bacteria such as Salmonella, Shigella and other types of bacteria may be presumed to be carriers of the bacteria, even if they have no symptoms of infection. Close contacts in an emergency housing situation will need to be identified on a case-by-case basis, in conjunction with DDC staff, but will likely include family members, others who share the same sleeping and living quarters, and bathrooms.

Because of the likelihood of spread to close contacts, these individuals should be presumed to be shedding the same bacteria as the index case. They must be excluded from any of the following situations until they show proof of negative stool cultures:

- Child care settings either as staff or participant
- Healthcare settings - if direct patient contact
- Food handling or service

Admission/Transfer Recommendations for Emergency Housing Programs with Infectious Diarrhea

1. If three or more residents have diarrhea, the emergency housing program should be closed to new admissions, until there are no symptomatic residents. If there are separate living and toilet facilities for symptomatic individuals, then the emergency housing can accept new admissions.
2. New residents entering the emergency housing system should be asked if they have diarrhea (defined as three or more loose stools/day). Residents with diarrhea should be referred for medical evaluation and if possible, admitted to a facility where they will have their own bathroom and their own room.
3. No resident with diarrhea, or family who has a member with diarrhea should be discharged or transferred to another group facility or emergency housing, unless they will have separate living space and toilet facilities at that location. Residents can be discharged to private homes. Residents who do not have diarrhea, and leave a emergency housing where there has been diarrhea, should be advised to seek medical attention if they develop diarrhea within two weeks of discharge.

INFLUENZA

Influenza is a respiratory virus that causes an acute respiratory illness characterized by fever, cough, sore throat, headache, and muscle aches. Symptoms generally resolve in 5-7 days, but may persist for several weeks. Bacterial complications (e.g., bronchitis, pneumonia, ear infections) are common following infection with influenza. Influenza viruses are highly contagious; close contacts to cases often develop infection. The infection is spread via respiratory droplets that are spread through coughing, sneezing, or contamination of objects and other frequently touched surfaces. The incubation period is generally 1-5 days. Adults with influenza will shed virus in respiratory secretions for up to 5 days after symptom onset; children will shed influenza virus for up to 10 days.

Influenza circulates seasonally, with annual outbreaks generally occurring during winter months. In any given year, up to 20% or more of a community can be affected by influenza. In closed settings such as nursing homes or schools, up to 50% of persons may become ill, especially when there are young children involved. Emergency housing settings are thus at high risk for influenza outbreaks. Influenza is preventable with a vaccine that is given each year. Beginning in the 2008-2009 season, influenza vaccination is recommended for the following groups:

- All children between 6 months and 18 years of age
- Adults with chronic medical conditions
- Adults > 50 years of age
- Adults who have contact with high risk susceptible persons (e.g., parents or caretakers of infants, healthcare workers).

Outbreaks of respiratory illnesses occur frequently during winter months, especially among children. The Division of Disease Control, Philadelphia Department of Public Health, (PDPH) should be notified for outbreaks of influenza (or suspected influenza) occurring in emergency housing programs, particularly emergency housing programs with young children, and/or immune compromised persons who might be at increased risk for influenza complications. Three or more cases of influenza-like illness (fever to 100˚ F, and cough or sore throat, without other explanation for illness) suggest an outbreak of influenza; symptomatic persons should be tested for influenza.

The Division of Disease Control telephone number is 685-6742, Monday through Friday, 8:30 AM-5 PM; after hours, please call 686-1776 and ask for the person on call for Disease Control. Division staff will provide specific recommendations for disease management, including vaccination if necessary, guidance to interrupt the spread of disease in the emergency housing, and access to diagnostic testing for influenza, if needed. The emergency housing staff person reporting the disease, or a designated person should be available to communicate information about new cases and assist with efforts to control an outbreak.

General Recommendations to Prevent Spread of Influenza

Influenza can be prevented with yearly vaccination and through promotion of respiratory hygiene and hand washing:

- DDC recommends that all staff and emergency housing residents receive a yearly flu shot as soon as it becomes available each fall. People who delay getting the shot can receive it throughout the winter or early spring. As long as influenza is circulating in the community, the vaccine may prevent disease. Individuals in the categories described above should be vaccinated early in the season, as a priority.

Respiratory hygiene and cough etiquette should be encouraged, and emergency housing programs should make supplies available:

- Everyone should be encouraged to cover the mouth and nose with tissues when coughing or sneezing
- Tissues should be available and disposed in no-touch waste containers
- Hands should be washed with soap and water or hand sanitizer after soiling hands with respiratory secretions

Handwashing in general should be promoted throughout the emergency housing program:

- Staff and residents should wash their hands with soap and water frequently.
- Children should be assisted in washing their hands with soap and water frequently.
- Alcohol hand gels are an effective addition to hand washing, and a reasonable temporary substitute when soap and clean water are not readily available.

Encourage good personal hygiene practices including the following:

Management of Cases with Influenza

Residents with respiratory illness that appears to be influenza should be managed as follows:

1. Any resident with influenza or suspected influenza who is at high risk for complications (e.g., persons with chronic medical problems, immune suppression, advanced age) should be referred for medical evaluation early in the course of illness, ideally within 48 hours of symptom onset. Antiviral medications may shorten illness and prevent severe complications if given early.

2. If possible, residents with influenza and their families, should be housed separately from other residents, with dedicated living space and even bathrooms if possible. Resident with influenza should try to remain in the emergency housing, and not participate in work, school or childcare until completely well. Adults with influenza who work in healthcare settings should remain out of work for 5 days after the onset of symptoms.
3. **If three or more residents have influenza-like illness,** the emergency housing may be experiencing an outbreak of influenza. Patients should be referred to healthcare providers for diagnostic testing. DDC should be contacted to assist with access correct diagnostic tests, and to provide outbreak control recommendations. Patients who have no primary health care provider can receive medical care at any PDPH District Health Care Center. Emergency housing staff should **report the Office of Homeless Services and the PHMC Infection Control Coordinator (On-Call 215-341-1307) or 267-474-7613**

Management of Contacts of Influenza

Because influenza is likely to be spread to close, susceptible contacts, unvaccinated persons living in emergency housing situations who are exposed to influenza are at high risk of getting this infection. While it might be desirable to prevent influenza in all persons in a emergency housing situation, the priority should be to prevent illness in those most susceptible to complications of influenza, including persons who are immunosuppressed (e.g., living with HIV infection, undergoing treatment for cancer), very young children and the elderly.

1. Close contacts in an emergency housing situation will need to be identified on a case-by-case basis, in conjunction with DDC staff, but will likely include family members, others who share the same sleeping and living quarters, and bathrooms. In emergency housing programs where everyone shares communal eating areas, all residents and staff may be considered to be at risk for influenza.
2. DDC will ensure that the emergency housing has access to influenza vaccine to provide to unvaccinated emergency housing residents.
3. In selected situations (e.g., emergency housing programs with immunosuppressed residents, or others at high risk for influenza-related complications), DDC may recommend that all residents take antiviral medication as long as there is influenza in the emergency housing program, until one week after the outbreak is over.

Admission/Transfer Recommendations for Emergency Housing Programs with Influenza

1. If there is an outbreak of influenza in emergency housing, unvaccinated persons who are at high risk for influenza-related complications (e.g., children < 6 months of age, immunosuppressed persons) should not be admitted to emergency housing. This restriction should continue until there are no symptomatic residents.
2. During periods of widespread influenza transmission in the community, new residents entering the emergency housing system should be asked if they have influenza-like illness. Residents with influenza should be referred for medical evaluation, especially if they are at high-risk for medical complications and were not vaccinated. If possible, they should be admitted to an emergency housing program where they may have their own living space and bathroom facilities.

LICE

Lice (pediculosis) are parasites that live on or under the skin of people. Any setting where overcrowding and close person-to-person contact occurs may be an ideal place for transmission.

There are 3 different types of lice that may infest humans: the human body louse, the human head louse, and the pubic or crab louse. All lice live on the skin and feed on the blood of its host. Head lice are the most common form of lice among children.

Head and body lice are spread through direct or indirect contact with an infected person, or through shared objects used by infected persons such as headgear and combs, clothing, bedding and other personal items like towels. Head and body lice may survive for only

one week without a food source. Pubic lice (crabs) are most frequently transmitted through sexual contact. Overcrowding may increase the likelihood of spread. Crabs can only live 2 days without a host. The incubation period between exposure and symptoms is generally between 7-10 days but can extend up to 3 weeks.

Management of Cases of Lice

Head lice may be hard to see, but persons who are infected may have continuous scratching of the head, back of neck. People with other forms of lice will have itching on the infested part of the body or genital area.

Recommended Therapy

Head lice may be treated with 1% permethrin cream rinse (Nix), a pyrethrin-based product such as RID, or 1% lindane (Kwell). All are available as shampoos or hair treatments; Kwell should be considered a second-line treatment, and is not recommended for infants, pregnant or nursing women, persons with inflamed or traumatized skin, or persons with seizure disorders.

Pubic lice can be treated with the same medications that are effective for head lice. Retreatment is recommended 7-10 days later. All sexual contacts should be treated. If eyelashes are infested by pubic lice, they should be treated with petrolatum ointment, and not one of the recommended parasite medications.

Body lice lay eggs (nits) and reside in the seams of clothing rather than on the skin of human hosts. Nits can persist in clothing for up to one month. Treatment for body lice consists of improving hygiene and cleaning clothes and bedding. Clothing and bedding must be laundered and dried at hot temperatures to kill lice. The topical treatments recommended for head and pubic lice should not be necessary for body lice if materials are laundered at least weekly. Consult with the Philadelphia Department of Public Health Division of Disease Control for cases or outbreaks that are difficult to manage.

Management of Contacts of Lice and Other Control Measures

Emergency housing residents who are infested with lice need contact precautions. Close contacts of persons with head lice should be examined and treated if infested. Sexual contacts of persons with pubic lice should be treated whether or not they have signs of infection. Bedmates and immediate family members and others with intimate contact should also be treated prophylactically.

All medical treatments should be used in conjunction with other measures such as disinfesting headgear, pillowcases, and towels.

- Clothing and bedding of all affected families and residents should be washed in hot water in an automatic washer and dried in a dryer.
- Clothing that cannot be washed but can be dried should be placed in a hot dryer for at least 20 minutes (dryer should be turned on). Stuffed animals, coats, and blankets should also be put into a hot dryer for 20 minutes.
- Items that cannot be washed or dried should be dry cleaned or put into a sealed plastic bag and placed in a cool, dry place for 2 weeks. Floors, furniture, other upholstery can be vacuumed.
- Soak combs, hairbrushes thoroughly in hot water (130˚ F) or in lice treatment shampoo for at least 5 minutes.

Admission/Transfer Recommendations for Emergency Housing Programs with Lice

There are no restrictions on emergency housing admission or transfer of residents with lice. Efforts should be made to recognize and treat residents with lice as quickly as possible.

MEASLES

Measles is a very contagious vaccine preventable disease that is spread from person-to-person through the spread of airborne respiratory droplets that are produced by coughing, sneezing. Measles causes fever, rash, red eyes and a runny nose. A person is immune to measles if she or he has had the disease or has received two doses of measles vaccine.

When a confirmed case of measles occurs in a residential setting, everyone is considered exposed. Determining whether or not residents and staff are immune to measles should occur as soon as possible.

This is especially important for children under one year old and immune compromised persons who are most likely to get a serious illness if exposed to measles.

All staff and residents of homeless emergency housing programs in Philadelphia should be immune to measles. Proof of immunity includes:

1. Documentation of immunization for measles, with type of vaccine and dates received. Immunization requires two doses of measles-containing vaccine (usually MMR) received on or after the first birthday;
2. A copy of a laboratory report of a blood test indicating immunity to measles; or
3. Proof of birth before January 1, 1957.

New emergency housing residents who were born after 1956, are >12 months of age, and have no proof of immunity should be referred to a health care provider for immunization for measles, mumps and rubella. Children 18 years of age and under should be provided with any routine childhood immunizations at intake, as appropriate. Older persons without health care providers can be referred to any Philadelphia Department of Public Health (PDPH) District Health Center for immunizations at no cost.

Management of Suspected Cases of Measles

Emergency housing staff must report confirmed or suspected cases of measles to the Division of Disease Control, PDPH at 685-6742, Monday through Friday, 8:30 AM-5:00 PM. After hours, call 686-1776 and ask for the person on call for Disease Control.

Measles is contagious 3-5 days before and until 5 days after the rash appears. **Any emergency housing staff or resident** with suspected measles should be evaluated immediately at a health care facility, and have a blood test to confirm or rule out the diagnosis. All suspected or confirmed cases of measles and their families must be provided with a separate living space within the emergency housing. Emergency housing residents with measles should not return to work or school until 5 days after the onset of their rash. **Emergency housing staff** with confirmed measles must not return to work until after 5 days after the onset of their rash.

Management of Contacts Exposed to a Confirmed or Suspected Case of Measles

After receiving a report of suspected or confirmed case of measles, DDC Immunization Program staff will provide assistance in determining the immune status of residents and staff of the emergency housing. DDC will also work with emergency housing staff to **monitor emergency housing residents and staff** for new cases of rash illness that should be evaluated for measles.

Measles vaccine, given within 72 hours of exposure, will provide protection from measles in most cases. Emergency housing residents 12 month of age or older and staff who received only one dose of measles vaccine before exposure should receive a second dose within 72 hours of exposure; resident children 6-11 months of age should receive a single dose of measles vaccine.

Measles vaccine should not be given to anyone who is pregnant or immune compromised - they must be referred to a health care provider if exposed.

Staff

Staff who are not immune to measles must be vaccinated within 72 hours of exposure or cannot return to work until 14 days after rash onset in the last confirmed case of measles at the emergency housing program. *Nonimmune pregnant or immunocompromised staff should not be vaccinated but referred for evaluation by a health care provider to determine appropriate post-exposure management.*

Residents

Residents who are not immune to measles must be vaccinated within 72 hours of exposure, including children 6-11 months of age. *Nonimmune pregnant or immunocompromised staff should not be vaccinated but referred for evaluation by a health care provider to determine appropriate post-exposure management.*

Immune globulin

Exposed, non-immune **residents or staff** who are pregnant, immune compromised, or less than 12 months of age, are candidates for immune globulin (IG). If given

within 6 days of exposure, IG may prevent measles. All efforts should be made to vaccinate children 6-11 months of age within 72 hours of exposure, in place of giving IG. Children less than 6 months of age, non-immune pregnant or immune-compromised **residents or staff** should be referred for evaluation by a health care provider to determine if they should receive IG.

Admission/Transfer Recommendations for Emergency Housing Programs with Measles

If a confirmed case of measles occurs in a emergency housing:

1. No children less than 12 months of age, or residents who lack proof of measles immunity should be admitted to the emergency housing until 14 days after the onset of rash in the last confirmed case at the emergency housing. Residents with measles entering an emergency housing program should be sent to a facility where they can have their own room and avoid contact with residents who are not immune; if this is not possible, and temporary housing can be arranged, admission to the emergency housing should be delayed until the fifth day after onset of rash. Persons with measles who are already residents should have their own room and avoid contact with residents who are not immune.
2. No exposed resident without proof of immunity or resident child 6 months of age should be transferred out of the emergency housing unless they received measles vaccine within 72 hours of exposure. Residents with measles should not be transferred to another emergency housing or discharged to a private home where any residents are not immune to measles until the fifth day after onset of their rash.

NOROVIRUS

Norovirus is a common cause of nausea and vomiting, especially during the winter and spring. It is also very contagious. The typical symptoms are nausea, vomiting, fever, abdominal cramps, and watery non-bloody diarrhea. The usual incubation period is 1-2 days, but can be as short as 12 hours. Illness typically lasts 12-60 hours and is self-limiting. Virus is present in vomitus and stool, and can be shed in stool for up to two weeks. Norovirus can be a problem for facilities because the infectious dose is very low: very few virus particles are necessary to cause illness. In addition, the virus can persist on surfaces in the environment for weeks, and is relatively resistant to many disinfecting agents. Contamination of food and drink may occur when infected individuals handle food or beverage, leading to spread of infection to those who consume those products. Reinfection may occur multiple times during a lifetime. There is no specific therapy for norovirus infection; treatment is supportive and centered on fluid replacement.

An outbreak of norovirus infection is likely when there are **at least 3 residents and/or staff in emergency housing** who are experiencing symptoms of nausea and vomiting within a 48-hour period. Any outbreak should be promptly reported to emergency housing managers and **to the PHMC Infection Control Coordinator** who should report the outbreak to PDPH (215-685-6742).

Management of Cases of Norovirus

1. Residents with symptoms of norovirus should be restricted to their own living space as much as possible. This will help prevent contamination of the shared living space.
2. If possible, place residents with norovirus in private rooms. If several residents have the same illness, they can co-reside.
3. Bathroom facilities should be cleaned frequently with a chlorine-based or other appropriate disinfectant (see below).
4. Symptomatic individuals should not prepare or serve food for others until 72 hours after resolution of symptoms.
5. Cases should be referred for medical attention if the illness is unusually severe (e.g., refractory vomiting) or if the case is at risk of dehydration (e.g., infant, elderly, or medically unstable).
6. Report outbreak of suspected norovirus (3 or more cases occurring within 48 hours) to the Division of Disease Control PDPH at 215-685-6742.

7. The Pennsylvania Department of Health Bureau of Laboratories (BOL) can identify norovirus in stool and vomitus using a PCR-based assay. PDPH must be consulted before clinical specimens can be submitted to the lab for testing.

    - Stool or vomit should be collected during the acute phase of illness, and put into a dry, sterile container. Liquid stool obtained during the acute phase of illness will have a higher yield than semi-formed stool obtained later in the illness.
    - Each specimen container should be labeled with patient name, date of collection, and name of the facility from which the specimen is obtained.
    - Specimens can be stored in a working refrigerator (4C) until ready for shipment or pick-up. Specimens should be kept away from food, double-bagged (and/or wrapped in plastic) and clearly labelled if stored in the same refrigerator as food.
    - Ideally, specimens from at least 4 or 5 individuals should be obtained during outbreaks.
    - PDPH can assist with specimen transport to the lab.

Infection Control Measures

Strict hand hygiene and other infection control practices are necessary to control norovirus spread.

Hands should be washed vigorously with soap and water:

AFTER:
Toilet visits
Cleaning up vomitus or diarrhea
Changing diapers
Handling soiled clothing or linens
Contact with a symptomatic person

BEFORE:
Eating
Food preparation
Serving food
Playing with young children
Providing any type of direct care for activities of daily living

- Patients with symptoms of norovirus infection should be managed with careful attention to hand hygiene practices. If water and soap are not available, use an alcohol-based hand sanitizer with 62% ethanol-based hand sanitizer, preferably in gel form.
- Staff must clean up vomit and fecal spillages promptly and carefully so that virus aerosolization is minimized. Dispose of vomit or feces in a toilet and disinfect the surrounding area with a bleach-based cleaner (as detailed below).
- Immediately wash clothing or linens that may be contaminated with the virus, especially after an episode of vomiting or diarrhea. Staff should handle soiled linens as little as possible, with minimal agitation so that aerosols are prevented. Launder with hot water and detergent on the maximum cycle length and machine dry.

Recommendations for staff

- **Any staff member,** including kitchen staff, with symptoms of norovirus infection should be sent home. Symptomatic staff must not return to work for 48 – 72 hours after symptoms resolve.
- Infected food handlers must not prepare or serve food for others under any circumstances
- Educate all staff, patients and visitors about norovirus and the risk of infection. During community-wide outbreaks, instruct staff with diarrhea or vomiting not to come to work until they have recovered.

Cleaning and Disinfection of Environmental Surfaces

During an outbreak, routine bathroom and toilet cleaning should occur with increased frequency, especially common-use bathrooms. "High touch" surfaces such as faucets, toilets, commodes,

bath rails, toilet rails, counters, phones, tables, chairs, handrails, doorknobs, elevator buttons, light switches and ice machines, require frequent cleaning.

- Disinfection with either chlorine bleach or a U.S. Environmental Protection Agency (EPA) approved disinfectant can be used to control norovirus outbreaks.

- Chlorine bleach should be applied to hard, non-porous, environmental surfaces at a minimum concentration of 1000 ppm (generally a dilution of 1 part household bleach solution to 50 parts water – e.g., 1/3 cup bleach mixed in 1 gallon of water). In areas of high levels of soiling and resistant surfaces, a concentration of 5000 ppm may be used (a dilution of 1 part bleach to 10 parts water, or 1 2/3 cup (25 tablespoons) of bleach mixed with 1 gallon water). Chlorine-based solutions should be freshly prepared to disinfect.
- Phenolic-based disinfectants (e.g., Pinesol or Lysol) are effective but may require concentrations of 2-4 times the manufacturer's recommendations for routine use.
- Heat disinfection (to 60C or 140F) has been suggested for items that cannot be subjected to chemical disinfectants such as chlorine bleach.
- Quaternary ammonium compounds, often used for sanitizing food preparation surfaces and disinfecting large surfaces such as countertops or floors, are not effective against noroviruses.

Admission/Transfer Recommendations for Emergency Housing Programs with an Outbreak of Norovirus

Limit new admissions until the outbreak is over. Educate staff, residents and visitors about norovirus and the risk of infection.

PERTUSSIS (WHOOPING COUGH)

Pertussis, also known as whooping cough, is a bacterial disease spread through the respiratory system. The cough that accompanies pertussis releases the bacteria into the air. Other symptoms of pertussis include runny nose and cough. Fever is usually absent. As the disease progresses, the characteristic cough comes in continuous bouts called paroxysms and may be followed by vomiting. Young children develop a high-pitched whooping sound. Infants may develop apnea (no breathing) during the bouts of coughing; pertussis is most severe when it occurs during the first 6 months of life, when infection can be fatal.

Pertussis can infect children under 1 year who are too young to have completed their primary immunizations. It can also infect children over 1 year who are incompletely immunized. Teenagers and adults can be infected due to declining immunity from immunizations received in childhood. Emergency housing dwelling concentrates vulnerable children and adults in small spaces potentially exposing them to this airborne communicable disease. When a resident or staff member is diagnosed with pertussis, everyone is considered exposed. Timely implementation of an infection control plan will help to minimize illness among residents and staff. When a diagnosis of pertussis has been made, emergency housing staff must report this immediately to the **Office of Homeless Services and the PHMC Infection Control Coordinator (On-Call 215-341-1307) or 267-474-7613.**

Management of Cases of Pertussis

Residents with confirmed pertussis should be confined to their designated living area until they have completed 5 days of appropriate antibiotic treatment. Respiratory hygiene, such as use of tissues and covering coughs, should be encouraged.

The PHMC Infection Control Coordinator will verify all reported suspects or cases through the Philadelphia Department of Health, Division of Disease Control. Once a case has been verified, the PHMC Infection Control Coordinator will notify the OHS Emergency Housing Supervisor. The OHS Emergency Housing Supervisor will issue a Health Alert bulletin.

The PHMC Infection Control Coordinator will implement symptom screening, obtain specimens as necessary, provide vaccine and coordinate provision of preventive medication in accordance with current CDC recommendations. In addition, the coordinator will monitor residents and staff compliance with preventive medication and work with emergency housing staff to monitor the emergency housing's residents and staff for secondary cases.

Exclusion of Cases from Childcare, School, or Work

Children with pertussis will be excluded from childcare or school until they have completed 5 days of antibiotic treatment. Adults, including emergency housing staff,

with pertussis disease will be excluded from work until they have completed 5 days of treatment

Management of Contacts to Pertussis

All contacts of a case of pertussis must receive preventive antibiotic prophylaxis regardless of vaccination status. Contacts should receive chemoprophylaxis with any of the recommended treatment courses described below.

Current treatment and prophylaxis guidelines

The same treatment and treatment course is recommended for both the treatment of persons with pertussis, and for prevention of pertussis in their close contacts. Appropriate regimens are:

- Erythromycin 40-50 mg/kg/day in 4 divided doses daily for 14 days. (Adolescents and adults should receive 500 mg 4 times daily)
- Clarithromycin 15-20 mg/kg/day in 2 divided doses daily for 7 days. (Adolescents and adults should receive 500 mg twice daily)
- Azithromycin 10-12 mg/kg/day/ in a single dose on day #1; followed by 5 mg/kg/day for a total of 5 days. (Adolescents and adults should receive 500 mg as a single dose on day 1, then 250 mg daily on days 2-5).
- Trimethoprim-sulfamethoxazole (TMP-SMX) TMP, 8 mg/kg per day; SMX 40 mg/kg per day in 2 divided doses for 14 days. (Alternative medication for people with allergy to macrolides; contraindicated at <2 months of age)

All school-age children in Philadelphia should have documentation of 5 pertussis-containing vaccines prior to school entry at ages 5-6. Pertussis vaccine should be updated for children under the age of 7 years if:

a. The child has had fewer than 4 total doses of pertussis vaccine OR
b. The child received their 3rd dose of vaccine more than 6 months ago OR
c. The child received a 4th dose of vaccine more than 3 years previously.

Admission/Transfer Recommendations for Emergency Housing Programs with Pertussis

All admissions and transfers to emergency housing with a suspect or confirmed case of pertussis will be suspended until all residents are screened for symptoms and prophylactic treatment is completed for those determined to be at risk for infection. Emergency housing restrictions will be imposed for a minimum of 5 days after initiation of treatment or prophylaxis.

After consultation with the PHMC Infection Control Coordinator, the Philadelphia Department of Health will determine when the emergency housing placement restrictions may be ended. The PHMC Infection Control Coordinator will notify the OHS Emergency Housing Supervisor and a Health Alert bulletin will be issued, lifting placement and transfer restrictions.

RUBELLA

Rubella is a very contagious vaccine-preventable disease that is spread from person-to-person by coughing, sneezing, or direct contact. Rubella causes slight fever and rash, but can cause severe malformations in unborn children if their mother is infected while pregnant. A person is immune to rubella if she or he has had the disease or has received rubella vaccine. When a confirmed case of rubella occurs in a residential setting, everyone is considered exposed. Determining whether or not residents and staff are immune to rubella should occur as soon as possible. This is especially important for pregnant women who are not immune to rubella.

All staff and residents of homeless emergency housing programs in Philadelphia should be immune to rubella. Proof of immunity includes:

1. Documentation of immunization for rubella, with type of vaccine and dates received. Immunization requires one dose of rubella-containing vaccine (usually measles, mumps or rubella MMR) received on or after the first birthday; or
2. A copy of a laboratory report of a blood test indicating immunity to rubella.

3. New emergency housing residents who are 12 or more months of age and have no proof of immunity should be referred to a health care provider for immunization for MMR vaccine. Persons without health care providers can be referred to any Philadelphia Department of Public Health (PDPH) District Health Center for immunizations at no cost.

Management of Suspected Cases of Rubella

Emergency housing staff must report confirmed or suspected cases of rubella to the Division of Disease Control, PDPH at 215-685-6742, Monday through Friday, 8:30 AM-5:00 PM. After hours, call 215-686-1776 and ask for the person on call for Disease Control.

Rubella is contagious 7 days before until 7 days after the rash appears. Any emergency housing staff or resident with suspected rubella should be evaluated immediately at a health care facility, and have a blood test to confirm or rule out the diagnosis. All efforts should be made to provide a separate living space within the emergency housing for suspected or confirmed cases of rubella and their families. Emergency housing residents with rubella should not return to work or school until 8 days after the onset of their rash.

Emergency housing staff with confirmed rubella must not return to work until after 8 days after the onset of their rash.

Management of Contacts Exposed to a Confirmed or Suspected Case of Rubella

After receiving a report of suspected or confirmed case of rubella, PDPH Immunization Program staff will provide assistance in determining the immune status of residents and staff of the emergency housing and advise on the management of susceptible contacts.

Rubella vaccine will not provide protection following exposure to rubella. However, efforts should be made to immunize non-immune staff and residents 12 month of age or older. Rubella vaccine should not be given to anyone who is pregnant or immune compromised - they must be referred to a health care provider if exposed.

Admission/Transfer Recommendations for Emergency Housing Programs with a Case of Rubella

Residents with rubella entering an emergency housing program should be sent to a facility where they can have their own room and avoid contact with residents who are not immune; if this is not possible, and temporary housing can be arranged, admission to the emergency housing should be delayed until the eighth day after onset of rash. Persons with rubella who are already residents should have their own room and avoid contact with residents who are not immune.

Residents with rubella should not be transferred to another emergency housing program or discharged to a private home where any residents are not immune to rubella until the eighth day after onset of their rash.

If a confirmed case of rubella occurs in a emergency housing:

- No children less than 12 months of age, or residents who lack proof of rubella immunity, should be admitted to a emergency housing with a suspected case of rubella. Twenty-one days must pass after the onset of rash in the last confirmed case before infants and non-immune persons can be admitted.
- No exposed resident without proof of immunity or resident child less than 12 months of age should be transferred out of emergency housing until 21 days after the onset or rash in the last case of rubella.

SCABIES

Scabies is a condition caused by a parasite (Sarcoptes scabiei, or the "itch mite") that burrows into the skin of human beings, causing an intensely itchy, red and sometimes raised rash that tends to occur at areas of clothing-to-skin or skin-to-skin contact. The burrows may be seen around finger webs, folds of the anterior wrists and elbows, under arms, beltline, thighs, external genitals, and lower portion of the buttocks in adults. In infants, the head, neck, palms and soles may be involved. Itching is often more severe at night.

Scabies is transmitted by intimate personal contact. The mite can burrow under the skin in minutes after contact. Sharing intimate clothing or items, or sharing a bed immediately after an infested individual can also lead to spread. Unlike lice, scabies is not spread by contaminated items. The incubation period for people who have not been exposed to scabies previously is between 4-6 weeks.

Management of Cases

Infected children and adults should apply a topical medication over the entire body, below the head. In infants and young children, treatment of the head and neck area is recommended. Because the scabies rash results from a reaction to the mite, itching may not subside for several weeks despite successful treatment.

- The drug of choice is 5% permethrin cream, approved for all but infants < 2 months of age. Permethrin should be removed by bathing after 8-14 hours.
- Kwell (1% Lindane) lotion is recommended as an alternative treatment. Lindane should not be used in people with known seizure disorders, young infants, women who are pregnant or breastfeeding.
- Medication should be reapplied after washing hands each time, since hands are common sites of infestation. The nails should be cut before applying lotion.

Children should be excluded from school or childcare until treatment has been completed.

Management of Contacts and Prevention Measures

- Close contacts who have had prolonged skin-to-skin contact with cases should be treated prophylactically, like family members and other intimate contacts.
- All close contacts should be treated at the same time to prevent re-infestation.
- Bedding and clothing worn next to the skin during the 3 days before initiation of therapy should be laundered in a washer with hot water and dried on the hot cycle. Mites do not survive more than 3 days without skin contact.
- Clothing that cannot be laundered should be removed from the patient and stored for several days to a week to avoid re-infestation.
- Environmental disinfestation is not necessary.

Admission/Transfer Recommendations for Emergency Housing Programs with Scabies

There are no restrictions on emergency housing admission or transfer of residents with scabies. Efforts should be made to recognize and treat residents with scabies as quickly as possible.

SHIGELLA

Shigella is a bacterial disease of the intestine resulting in watery diarrhea. Shigella associated diarrhea is frequently accompanied by mucous and blood. Fever, nausea, vomiting and abdominal cramps may accompany the diarrhea.

Shigella is generally spread by hand-to-hand contact and/or contact with contaminated surfaces. People who have the infection shed the germ in the stool, often even after people's symptoms have improved. Inadequate hand washing after using the toilet facilities or changing diapers allows the bacteria to remain on the hands. Preparing food or providing physical care for children with contaminated hands allows the bacteria to be passed from person to person. It is highly contagious (easy to spread) because very few germs are needed to cause infection. (See the general recommendations in the infectious diarrhea policy for hygiene guidelines and the guidelines for effective hand washing.)

Symptoms of the disease can be seen within one to three days after exposure. Prompt recognition of symptoms and institution of antibiotic therapy helps to reduce transmission of this disease. Emergency housing staff who learn of a case of Shigella in a resident or staff member should report it immediately to the **PHMC Infection Control Coordinator (On-Call 215-341-1307) or 267-474-7613 and the Office of Homeless Services.** The PHMC coordinator will then report these conditions to the Division of Disease Control at the Philadelphia Department of Public Health.

Management of Shigella Cases

Emergency housing staff and residents, with symptoms of diarrhea **lasting longer than 72 hours,** must be evaluated by a medical care provider. Residents who do not have a medical care provider can receive care at any PDPH District Health Care Center or the Mary Howard Health Center (adults only) at 125 South 9th St. (phone# 215-592 4500).

The Division of Disease Control Philadelphia Department of Public Health will verify all reported cases of Shigella associated with the emergency housing, and work with the OHS Emergency Housing Supervisor and PHMC Infection Control Coordinator to develop an infection control plan. The Emergency Housing Supervisor will issue a Health Alert bulletin based on the recommendations of the Division of Disease Control.

Residents or staff with Shigella should be treated with appropriate antibiotic therapy. Antibiotics will reduce the time an individual is contagious. The PHMC Infection Control Coordinator should follow cases until completion of therapy. Because antibiotic resistance is common with Shigella, treatment should be determined by a healthcare professional, and guided by culture results. DDC staff may be consulted to ensure appropriate therapy has been prescribed.

The following infection control measures should be instituted:

- Separate bathrooms for symptomatic residents. Emergency housing providers will set aside bathroom facilities for the use of confirmed cases and symptomatic residents. All confirmed cases of Shigella will continue to use these set-aside facilities until completion of therapy and 2 negative follow-up cultures
- Job reassignment for symptomatic residents and staff. Symptomatic kitchen staff and childcare workers will be reassigned to other duties that do not pose a risk for spreading Shigella to others. Food handlers with Shigella who cannot be re-assigned should be excluded from work until they have proof of two negative stool cultures collected 48 hours (or more) after antibiotics have been completed, and no less than 24 hours apart.
- Thorough hand washing (all residents and staff). The PHMC Infection Control Coordinator and emergency housing staff will instruct residents in hand washing technique. Emergency housing providers will ensure the availability of hand soap and paper towels in all bathrooms.

The PHMC Infection Control Coordinator will implement symptom screening, obtain stool cultures and arrange appropriate antibiotic therapy. Residents and staff will be interviewed daily to identify new symptomatic residents and establish the extent of transmission to close contacts within the emergency housing.

Exclusion From Daycare

Staff and residents providing daycare, or children attending daycare, who are suspected of having infection with Shigella, may not work or attend daycare until:

a. Symptomatic individuals are determined to not have Shigella by a medical provider.
b. Confirmed cases have completed treatment and have 2 negative stool cultures collected 24 hours apart and at least 48 hours after the last dose of any antimicrobial therapy.

Work Restrictions

Staff and residents who are suspected of having infection with Shigella may not work in food preparation or service or healthcare with direct patient contact until:

a. Symptomatic individuals are determined not to have Shigella by a medical provider.
b. Confirmed cases have completed treatment and have 2 negative stool cultures collected 24 hours apart and at least 48 hours after the last dose of any antimicrobial therapy.

Management of Shigella Contacts

If there is a child, adult or staff member with confirmed Shigella infection in the emergency housing, other residents with diarrhea and other symptoms suggestive of Shigella should have a stool culture obtained, ideally by their own healthcare professional, or through the Philadelphia Department of Public Health.

Close contacts of cases of Shigella should be presumed to be carrying the bacteria, whether or not they are symptomatic. Because close contacts are probable carriers, they must also be excluded from the following high-risk situations until they have proof of two negative stool cultures:

- Child care – either as staff or participant
- Health care – if direct patient contact
- Food handling or service

Close contacts are typically defined as household contacts, and in an emergency housing situation may be determined to be all of the persons who share a common bathroom, common kitchen, or other living quarters. DDC staff should be consulted to define close contacts at risk for asymptomatic infection in a specific emergency housing situation.

Admission/Transfer Recommendations for Emergency Housing Programs with Shigella

1. The PHMC Infection Control Coordinator will confer with the Division of Disease Control regarding new admissions. If there is wide spread disease throughout the emergency housing, the emergency housing should be closed to new admissions until the outbreak is over, as determined by the Division of Disease Control.
2. Symptomatic residents or confirmed cases may not be transferred to another emergency housing until cleared by the PHMC Infection Control Coordinator. They may be required to demonstrate proof of two negative stool cultures before transfer, unless they are transferred to a facility where they will have private, dedicated bathroom and diaper changing facilities.
3. Residents who do not have Shigella and are transferred to another emergency housing or leave emergency housing should be advised to seek medical attention if they develop symptoms.

After consultation with the PHMC Infection Control Coordinator, the Philadelphia Department of Health will determine when the emergency housing restrictions may be ended. The PHMC Infection Control Coordinator will notify the OHS Emergency Housing Supervisor and a Health Alert bulletin will be issued lifting any placement or transfer restrictions.

STAPH (MRSA) SKIN INFECTIONS

Staphylococcus aureus (staph) bacteria are a common cause of skin infections, particularly boils and abscesses that have pus or drainage. MRSA ("methicillin-resistant Staph aureus") is a type of staph that is resistant to certain antibiotics, including methicillin and related medications. Although infections from MRSA may be more difficult to treat than infections from regular staph, they are otherwise similar. In the past, MRSA occurred mainly in hospitals and nursing homes, where it caused serious infections like pneumonia, bloodstream infections and surgical wound infections. But now, it is more common in community settings such as schools and among groups of people who have frequent close contact (e.g., families, athletic teams, inmates in jails). Community associated MRSA infections most commonly present as skin pustules or boils.

MRSA, like all staph infections, is spread from person to person through direct contact with infected skin or contaminated items that are shared. Good personal hygiene is the best way to prevent and control the spread of MRSA.

Management of Staph (including MRSA) Skin Infections

Most MRSA infections that occur in the community are skin infections that appear as pustules or boils, which often are red, swollen, painful, and have pus or other drainage. These skin infections often occur at sites of visible skin trauma, such as cuts and abrasions, and areas of the body covered by hair (e.g., back of neck, groin, buttock, armpit, beard area of men).

Emergency housing staff who observe residents with open skin wounds or boils should refer them to the PHMC coordinator. Not all skin infections are due to MRSA. A skin lesion that is one centimeter or larger in size should be referred to a medical care provider for diagnosis and treatment. All persons with lesions that appear to be open, uncovered, and/or draining pus, should also be referred to a medical provider for evaluation.

Skin infections that are due to Staph or MRSA may respond to simple drainage of the wound or boil. Antibiotic treatment may also be necessary. People with bacterial infections of the skin that are caused by Staph should:

- Cover skin lesions or skin trauma such as cuts and abrasions with a clean and dry bandage that is taped on all four sides, until healed.
- Avoid sharing personal items (towels, razors) that come into contact with bare skin. Use a barrier (clothing, towel) between skin and equipment that is shared between people (e.g., gym equipment such as weight-training benches).

Emergency housing healthcare staff should wear disposable gloves when examining skin lesions or providing wound care. Gloves should be used when changing bandages and soiled bandages should be disposed of in infectious waste containers or placed inside a plastic zip lock bag before being discarded.

In general, single cases of MRSA infection do not need to be reported to PDPH.

Management of Two or More Cases of Staph/MRSA in a Emergency housing

MRSA infections are extremely common in the community: more than one case in emergency housing at any given time does not necessarily mean that transmission occurred within the emergency housing. However, transmission is extremely common among families, and others who have direct skin contact or who share common personal items (e.g., towels, linens, clothing).

Two or more cases of MRSA from the same emergency housing program (who are not from the same household) should be reported to the Department of Public Health. PDPH will work with emergency housing staff to verify that the cases are actually staph infections, and to investigate whether the cases may have resulted from spread within the emergency housing. Staff in the Division of Disease Control will assist in providing additional guidance with respect to prevention and control as needed.

Management of Contacts - Prevention of Staph/MRSA Infections in Emergency Housing Programs

Contacts to MRSA infections require no special treatment, although a close contact who develops a skin lesion that appears to be an infection should be evaluated by a medical provider. The spread of Staph infections, including MRSA, can be prevented by the following measures:

- Practicing good hygiene (washing hands with soap and water or using an alcohol-based sanitizer, showering after exercise or group physical activities).
- Covering skin lesions or skin trauma such as cuts and abrasions with a clean and dry bandage until healed.
- Avoiding sharing personal items (towels, razors) that come into contact with bare skin. Use a barrier (clothing, towel) between skin and equipment that is shared between people (e.g., gym equipment such as weight-training benches).

Recommendations for Facility Cleaning

Because staph bacteria are primarily carried on people, there are no routine disinfection measures that are recommended for emergency housing programs to eliminate staph from the environment. The spread of MRSA is mainly controlled through personal hygiene measures such as good hand hygiene and the covering of infections.

- In general, common-use personal items (e.g., towels) should not be shared by residents, particularly by a resident with a skin infection.
- Cleaning of shared surfaces/equipment is recommended in settings where a risk for direct skin contact is identified (e.g. gym equipment, athletic gear, etc.), particularly when there is possible MRSA spread among users of the shared facility or equipment. DDC staff should be consulted to determine if the emergency housing requires any special cleaning or disinfection procedures.
- If there is evidence of MRSA transmission in the emergency housing that appears to be related to contamination of shared items or facilities, the following disinfection procedures are advised:

a. Contaminated surfaces that are non-porous should be cleaned using an EPA-registered disinfectant or dilute bleach solution (1:100 dilution or 500-615 ppm).
b. Wood and other porous surfaces that require disinfection should be cleaned with a 1:10 dilution of household chlorine bleach. If commercial products are used for disinfection, the label should be checked to make sure the product is suitable for the type of surface being treated, and that the product label specifies Staphylococcus aureus and other bacteria.
c. Gloves should be worn when cleaning. For additional information regarding cleaning and disinfection recommendations please contact the Division of Disease Control. A list of EPA-registered products effective against MRSA can be found at http://epa.gov/oppad001/chemregindex.htm.

In general, disease control measures for MRSA should focus on hygiene and eliminating opportunities for contact with infected skin and environmental disinfection of shared equipment that appears to be responsible for disease spread. Consult the Division of Disease Control, PDPH for recommendations regarding cleaning measures that are appropriate.

Admission/Transfer Recommendations for Emergency Housing Programs with Staph/MRSA Infections

There are no specific recommendations for limiting admissions or transfers to or from emergency housing with Staph or MRSA infections. Efforts should be made to recognize skin infections in both residents and staff to ensure that wounds are covered appropriately and that all emergency housing residents observe good hygiene practices.

VARICELLA (CHICKENPOX and SHINGLES)

Chickenpox and shingles are caused by the varicella zoster virus. Chicken pox is a vaccine-preventable, generalized vesicular (blistering) rash illness that is spread by coughing, sneezing, or direct contact. Chickenpox can be spread 1-2 days before the rash appears until all skin lesions have crusted over. A person is immune to chickenpox if she or he has had the disease or received at least 2 doses of the varicella (chickenpox) vaccine.

Shingles ("varicella zoster") is a localized vesicular rash that occurs in a person who has already had chickenpox. It is caused by a re-activation of the varicella virus that remains inside the body's nerve cells after someone has recovered from chickenpox. People who have never had chickenpox can develop chickenpox after exposure to a person with shingles. Shingles can be spread through direct contact with the shingles rash, and occasionally through the air. The rash is contagious until it has crusted over.

When a confirmed case of chickenpox or shingles occurs in a residential setting, everyone is considered exposed. Timely implementation of an infection control plan will help to minimize illness among residents and staff. Emergency housing staff must report confirmed or suspected cases of varicella or shingles (resident or staff member) to the Office of Homeless Services and the PHMC Infection Control Coordinator (On-Call 215-341-1307) or 267-474-7613, who will report the case(s) to the Division of Disease Control, Philadelphia Department of Public Health.

Routine Vaccination

- Emergency housing staff – The Philadelphia Department of Public Health (PDPH) recommends varicella vaccine (Varivax) for all emergency housing staff who do not meet the immunity criteria (see below) and are not pregnant or immunocompromised.
- Homeless families seeking emergency housing placement will see the Immunization Nurse during the intake process at OHS. All children from the age of 1 to 18 years of age will be immunized with Varivax if they do not have documentation of age-appropriate varicella immunization. Varivax will be offered to all parents who also do not meet the evidence of immunity criteria.

These actions will decrease the possibility of transmission should a case occur in a residential site.

Management of Cases of Varicella (Chickenpox or Shingles)

Residents with a rash illness must be evaluated by a medical care provider and return to emergency housing with a written diagnosis for the rash. Residents without a medical care provider can be referred to the Philadelphia Department of Public Health District Health Centers or the Mary Howard Health Center (adults only) at 125 S. 9th Street (phone 215-952-4500). Prompt administration of antiviral medication (i.e., begun within 48 hours of rash onset) can decrease shedding of virus, and is recommended.

All confirmed or suspected cases will be verified by the PHMC Infection Control Coordinator through the PDPH Division of Disease Control. The Division of Disease Control can be reached by telephone at 215-685-6742, Monday through Friday, 8:30 am – 5:00 pm; after hours division staff can be reached through the City Hall operator at 215-686-1776. When a case has been

verified, the Emergency Housing Supervisor will issue a Health Alert bulletin to the emergency housing, based on the recommendations of the Division of Disease Control staff.

Families with suspected or confirmed cases of chickenpox or shingles will be isolated in their own room. Meals will be eaten in the family's room. When there is no attached bathroom to the family's room, a shower stall should be set aside for use by the index case. Isolation will be observed until all chickenpox or shingles lesions have crusted. Emergency housing residents and emergency housing staff with confirmed chickenpox or shingles should not return to work or school until all lesions have crusted. Resident with shingles should be instructed to keep their rash covered, and use separate bathing facilities, if possible, until all lesions have crusted.

The Infection Control Nurse will provide active surveillance for secondary cases until 42 days after the last case of chickenpox. After consultation with the Philadelphia Department of Public Health, the PHMC Infection Control Coordinator will notify the OHS Emergency Housing Supervisor and another Health Alert bulletin will be issued to the emergency housing, lifting admission and transfer restrictions.

Management of Contacts to Varicella (Exposure Management)

If a confirmed case of varicella or shingles occurs, emergency housing staff and residents will be questioned by the Infection Control Nurse regarding evidence of immunity. People who are not immune and are pregnant or immune compromised must be identified and referred to a health care provider. Vaccination will be considered for residents and staff who are not immune, provided they are not pregnant or immune compromised. Evidence of immunity will be determined by the following:

- Documentation of age-appropriate vaccination with a varicella containing vaccine (2 doses one month apart)
- Prior diagnosis of chickenpox or shingles, verified by a physician or other healthcare provider
- Laboratory confirmation of immunity

Vaccine

Varicella vaccine, if given within 5 days of exposure, may provide protection for non-immune residents and staff who have been exposed to a person with varicella.

- Emergency housing residents and staff not meeting the immunity criteria or who haven't received 2 doses of varicella vaccine before exposure should receive vaccine.
- Emergency housing residents or staff unsure of their vaccine history before exposure should receive varicella vaccine
- Varicella vaccine should not be given to anyone who is pregnant or immune compromised (i.e., CD4 count < 200 in the setting of HIV infection)

Immune Globulin

Exposed, non-immune residents or staff who are immune compromised or pregnant may be candidates to receive "Varizig," an immune globulin product containing antibody to varicella virus. This product must be administered within 96 hours of exposure to prevent or reduce the seriousness of varicella infection.

Requests for Varizig must be made to the PDPH Varicella Active Surveillance Program within the Division of Disease Control, who will determine if it is indicated. The product must be requested from the Centers for Disease Control and Prevention, in Atlanta, Georgia.

Additional recommendations for exposed staff or residents

- Emergency housing staff, OHS employees, and emergency housing-based employees of other agencies who are pregnant or immune compromised and haven't received Varizig may be evaluated by antibody titer. Until titer results are known, these employees may not return to the affected emergency housing until admission restrictions are lifted.
- Non-immune residents who do not receive the indicated protection (i.e., vaccination or immune globulin when indicated) should be isolated until 42 days after the onset of the last case.

Admission/Transfer Recommendations for Emergency Housing Programs with a Confirmed Case of Varicella

If a confirmed case of chickenpox or shingles occurs in a emergency housing, the following persons should not be admitted to the emergency housing:

- Pregnant women without documentation of 2 doses of previous vaccine
- Clients who are immune compromised and who have no proof of immunity
- Children less than 1 year of age born to mothers without documented immunity

New admissions to the affected emergency housing program will need to meet evidence of the immunity criteria as listed above, or receive varicella vaccine at OHS prior to placement. Children under the age of 1 year can be admitted to emergency housing if the birth mother meets the evidence of immunity criteria. Limited admissions will be in place while the Infection Control Nurse monitors the emergency housing program for additional cases and vaccinates susceptible residents and staff. Admissions will be limited for 42 days after rash onset in the last case of chickenpox.

Homeless clients WITH chickenpox entering emergency housing should be sent to a facility where they can have their own room and avoid contact with residents who are not immune. If this is not possible, and temporary housing can be arranged, admission to the emergency housing program should be delayed until all lesions have crusted over.

Transfer policy from affected emergency housing program to another emergency housing program

- Residents meeting evidence of immunity criteria may be transferred. Previously non-immune residents who have received vaccine within 5 days of rash onset of the case may also be transferred.
- Families or single adults WITH chickenpox or shingles should not be transferred until all lesions have crusted over.
- The following persons are not eligible for transfer until 42 days after the last case of chickenpox:
  - » Any exposed, non-immune person not vaccinated within 5 days after the onset of rash in the case
  - » Any resident receiving Varizig.

Transfer policy to affected emergency housing program from another emergency housing program

- Residents meeting the evidence of immunity may be transferred to the affected emergency housing.
- Previously non-immune residents who have received 2 doses of varicella vaccine may be transferred to the affected emergency housing.

Discharges

- Residents with chickenpox or shingles may be discharged at any time to a self-contained independent living environment (e.g., house, apartment, etc.)

Delayed Recognition or Reporting of Cases

For all cases reported beyond 5 days after the rash first appears, the following will apply:

1. Admission criteria are the same as for timely reporting of cases
2. All susceptible residents and staff will be vaccinated and counseled that the vaccine may not prevent disease
3. Residents who have evidence of immunity and previously non-immune residents who have received the vaccine are eligible for transfer.

NOVEL INFLUENZA A (H1N1)

Novel influenza A (H1N1), also called "swine flu," is a new strain of influenza that emerged in the United States in the spring of 2009. This new strain of influenza causes the same illness that is seen with the usual, seasonal flu strains. Symptoms are fever, cough, sore throat, headache, and muscle aches. The illness usually lasts 5-7 days but bacterial complications (e.g., bronchitis, pneumonia, ear infections) are common following infection with influenza. Influenza viruses are highly contagious; close contacts to cases often develop infection. The infection is spread via respiratory droplets that are spread through coughing, sneezing, or contamination of objects and other frequently touched surfaces. The incubation period is generally 1-5 days. Adults with influenza will shed virus in respiratory secretions for up to 5 days after symptom onset; children will shed influenza virus for up to 10 days.

In a typical winter season, up to 20% or more of a community can be affected by influenza. In closed settings such as nursing homes or schools, up to 50% of persons may become ill, especially when there are young children involved. Emergency housing settings are thus at high risk for influenza outbreaks. This new strain of flu is expected to cause even more illness because there is no vaccine at this point, and there is no immunity in the population. A prior flu shot or previous infection with the flu will not protect against this strain.

The Division of Disease Control, Philadelphia Department of Public Health (PDPH) should be notified for outbreaks of influenza (or suspected influenza) occurring in emergency housing programs, particularly emergency housing programs with young children, and/or immunocompromised persons who might be at increased risk for influenza complications. Three or more cases of influenza-like illness (fever to 100˚ F, and cough or sore throat, without other explanation for illness) suggest an outbreak of influenza; symptomatic persons should be tested for influenza.

The Division of Disease Control (DDC) telephone number is 215-685-6742, Monday through Friday, 8:30 AM-5 PM; after hours, please call 215-686-1776 and ask for the person on call for Disease Control. Division staff will provide specific recommendations for disease management and guidance to interrupt the spread of disease in the emergency housing, and access to diagnostic testing for influenza, if needed. The emergency housing staff person reporting the disease or a designated person should be available to communicate information about new cases and assist with efforts to control an outbreak.

General Recommendations to Prevent Spread of Novel Influenza

Seasonal influenza can be prevented with yearly vaccination and through promotion of respiratory hygiene and hand washing. In the absence of a vaccine for novel H1N1, disease prevention will rely on the following infection control measures:

Persons who are ill with influenza-like symptoms should be considered contagious, and they should be confined to their rooms, with limited interaction with the general emergency housing population for up to 1 week after the onset of their symptoms.

Respiratory hygiene and cough etiquette should be encouraged, and emergency housing programs should make supplies available:

- Everyone should be encouraged to cover the mouth and nose with tissues when coughing or sneezing
- Tissues should be available and disposed in no-touch waste containers
- Hands should be washed with soap and water or hand sanitizer after soiling hands with respiratory secretions

Handwashing in general should be promoted throughout the emergency housing:

- Staff and residents should wash their hands with soap and water frequently.
- Children should be assisted in washing their hands with soap and water frequently.
- Alcohol hand gels are an effective addition to hand washing, and a reasonable temporary substitute when soap and clean water are not readily available.

Management of Cases with Novel Influenza

Residents with respiratory illness that appears to be influenza should be managed as follows:

1. Any resident with influenza or suspected influenza who is at high risk for complications (e.g., persons with chronic medical problems, pregnancy, immune suppression, advanced age, and children under the age of 5 years) should be referred for medical evaluation early in the course of illness, ideally within 48 hours of symptom onset. Antiviral medications may shorten illness and prevent severe complications if given early.
2. If possible, residents with influenza and their families should be housed separately from other residents, with dedicated living space (and bathrooms if possible) and meals eaten in room, or separated from the general population. Resident with influenza should try to remain in the emergency housing, and not participate in work, school or childcare until 7 days after the onset of symptoms.
3. If three or more residents (unrelated to each other) have influenza-like illness, the emergency housing program may be experiencing an outbreak of influenza. The initial patients should be referred to healthcare providers for diagnostic testing, although once the presence of an outbreak in the emergency housing is established, others with influenza-like illness can be presumed to have influenza and will probably not require testing unless there are special circumstances. Emergency housing staff should report this to the Office of Homeless Services and the PHMC Infection Control Coordinator (On-Call 215-341-1307) or 267-474-7613.
4. Limit congregate activities when there are multiple cases of influenza in a emergency housing, including use of playrooms. Structure mealtimes so that ill persons and their close family contacts eat together, at a time separate from the general emergency housing population.
5. DDC should be contacted to assist with access correct diagnostic tests, and to provide outbreak control recommendations. Patients who have no primary health care provider can receive medical care at any PDPH District Health Care Center.

Management of Contacts of Novel Influenza

When there are cases of influenza (confirmed or suspected) among emergency housing residents, the emergency housing staff should work with the PHMC Infection Control Coordinator to identify new cases through active symptom screening, if possible. Newly identified persons who are at high risk for complications should be managed as outlined above. The priority should be to prevent illness in those most susceptible to complications of influenza, including persons who are immunosuppressed (e.g., living with HIV infection, undergoing treatment for cancer), very young children and the elderly. 3

1. Close contacts in an emergency housing situation will need to be identified on a case-by-case basis, in conjunction with DDC staff, but will likely include family members, others who share the same sleeping and living quarters, and bathrooms. In emergency housing programs where everyone shares communal eating areas, all residents and staff may be considered to be at risk for influenza.
2. High risk contacts are candidates for prophylaxis with antiviral medications, and should be referred to medical providers for that purpose. In selected situations (e.g., emergency housing programs with immunosuppressed residents, or others at high risk for influenza-related complications), DDC may recommend that some or all residents take antiviral medication as long as there is influenza in the emergency housing, until one week after the outbreak is over.

Admission/Transfer Recommendations for Emergency Housing Programs with Novel Influenza

1. If there is a case of influenza in emergency housing, persons who are at high risk for influenza-related complications (e.g., pregnant women, persons with underlying medical problems, children < 1 year old who are too young for antiviral therapy) should not be admitted to the emergency housing, if at all possible. This restriction should continue for 7 days after the onset of symptoms in the last case.

2. If an outbreak is recognized in emergency housing, there should be no new admissions to the emergency housing program or transfers from the emergency housing program to another emergency housing program until at least one week has elapsed with no new cases and after the onset of symptoms in the most recent case.

3. During periods of widespread influenza transmission in the community, new residents entering the emergency housing system should be asked if they have influenza-like illness, and referred for medical evaluation if they are at high-risk for medical complications. If possible, they should be admitted to a emergency housing where they may have their own living space and bathroom facilities.

4. Families/residents with active flu symptoms should not transfer to other emergency housing programs until at least 1 week after symptoms have resolved. Family members who have shared sleeping quarters are at high risk for infection themselves, and ideally should not transfer to other emergency housing programs while they might be incubating influenza