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# California State Senate

## SENATE SELECT COMMITTEE ON CALIFORNIA-MEXICO COOPERATION

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## JOINT HEARING WITH THE SPECIAL COMMITTEE ON PANDEMIC EMERGENCY RESPONSE

### “The Impact of COVID-19 in California’s Border Region”

Tuesday, June 30, 2020 at 10:00am

State Capitol, Senate Chamber

## Background Paper

### BACKGROUND

California shares over 140 miles of our Southern border with Mexico and this close proximity has played a key role in the way that COVID-19 impacts the border region. Unfortunately, this virus preys on our interconnectedness and is not bound by human-made borders. The interconnectedness of the California-Mexico border region has undoubtedly played a role in the profusion of COVID-19. While the state is flattening the curve in the aggregate, this is not the case for communities along the border. Rate of infections and hospitalization have rapidly increased and hospitals have been overwhelmed. This has resulted in the transferring of COVID-19 patients to other hospitals in the region and across the state.

The COVID-19 pandemic has heightened the strain on our hospitals, local government, and drastically impacted our economies on both sides of the border. To that end, in order to ensure that California is doing everything it can to protect the health and safety of people on the border region and the rest of the state, the Senate Select Committee on California-Mexico Cooperation and the Senate Special Committee on Pandemic Emergency Response have convened a hearing on “The Impact of COVID-19 in California’s Border Region”. This hearing will provide the committees with an opportunity to understand how the state is communicating with our partners in Mexico, what efforts have been undertaken to coordinate with and support those partners, and to provide us with information as to how the state plans to address COVID-19 in California’s border region. This joint hearing seeks a comprehensive and robust discussion that includes hospital administrative staff and physicians who are working at the forefront of this pandemic in the border region. The focus of the joint hearing will be on the border region’s public health, impacts on non-profits, and the efforts and needs of local governments.

Special Committee on Pandemic Emergency Response

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## CORONAVIRUS (COVID-19)

The novel Coronavirus disease (COVID-19) is a highly infectious respiratory illness that is caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), a strain of coronavirus. The disease was first identified in December 2019 and has since spread around the world, resulting in millions of deaths and other health complications, as well as causing long-term public health, social, and economic harm. According to California's Public Health Department (CDPH) and the Center for Disease Control (CDC), symptoms of the disease include, but are not limited to: fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea and vomiting, and diarrhea. Symptoms range from mild or no symptoms to severe illness and can be expected to appear 2-14 days after exposure to the virus. The virus is spread through close contact (about 6 feet or two arms lengths) with a person who has COVID-19 and through exposure to respiratory droplets when the infected person coughs, sneezes or talks. The disease can also be contracted by touching a surface or object that has the virus on it and then by touching your mouth, nose, or eyes. Some people are at higher risk of contracting COVID-19, including: people over 65 years old, people with compromised immune systems, individuals with serious chronic medical conditions, and smokers.

According to the CDC, the first reported case of COVID-19 in the United States was around January 19, 2020. The first case of COVID-19 was reported on January 26, 2020. On March 11, 2020, the disease was characterized as a pandemic by the Worldwide Health Organization (WHO). In response to the high number of cases in California, Governor Newsom issued a state of emergency on March 4, 2020 and a mandatory stay-at-home order on March 19, 2020. According to CDPH's website, as of June 28, 2020, there a reported 211,243 total cases, 5,905 total deaths, and 3,955,952 tests.

### All Cases and Deaths associated with COVID-19 by Race and Ethnicity

Race/Ethnicity	No. Cases	Percent Cases	No. Deaths	Percent Deaths	Percent CA population
Latino	80,875	56.6	2,348	41.1	38.9
White	24,242	17.0	1,868	32.7	36.6
Asian	9,724	6.8	831	14.5	15.4
African American/Black	6,309	4.4	533	9.3	6.0
Multi-Race	1,019	0.7	34	0.6	2.2
American Indian or Alaska Native	266	0.2	18	0.3	0.5
Native Hawaiian and other Pacific Islander	900	0.6	22	0.4	0.3
Other	19,484	13.6	57	1.0	0.0
Total with data	142,819	100.0	5,711	100.0	100

Cases: 211,243 total; 68,424 (32%) missing race/ethnicity  
 Deaths: 5,810 total; 99 (2%) missing race/ethnicity  
 \*1,058 cases with missing age  
 \*\*Census data does not include 'other race' category  
 Data from California's Department of Public Health

## STATE RESPONSE TO COVID-19

On March 4, 2020, Governor Newsom issued a state of emergency proclamation. On March, 19, 2020, Governor Newsom issued a mandatory stay-at-home order. In response to the high number of cases in California, the Governor and the Legislature have activated numerous response mechanism including access to more funding and resources, increased legal protections, increased flexibility, additional medical capacity, among other things.

On April 14<sup>th</sup>, 2020, Governor Newsom announced six critical indicators that the state will consider before modifying the stay-at-home order and other COVID-19 related interventions. California's six indicators for modifying the stay-at-home order are:

- The ability to monitor and protect our communities through testing, contact tracing, isolating, and supporting those who are positive or exposed;
- The ability to prevent infection in people who are at risk for more severe COVID-19;
- The ability of the hospital and health systems to handle surges;
- The ability to develop therapeutics to meet the demand;
- The ability for businesses, schools, and child care facilities to support physical distancing; and
- The ability to determine when to reinstitute certain measures, such as the stay-at-home orders, if necessary.

On May 4<sup>th</sup>, the Governor signed an executive order informing local public health jurisdictions and industry sectors that they may gradually reopen under new modifications and guidance provided by the state. California's Pandemic Roadmap identified four stages as follows: safety and preparation (Stage 1), reopening of lower-risk workplaces and other spaces (Stage 2), reopening of higher-risk workplaces and other spaces (Stage 3), and finally an easing of final restrictions leading to the end of the stay at home order (Stage 4). On May 8<sup>th</sup>, the Governor outlined a process through which counties who met specified criteria could move more quickly than other parts of the state through Stage 2 (defined as requesting a variance). If Counties are able to demonstrate that they can protect that public and essential workers, they can move to Stage 2 by pursuing a variance through the filing of an attestation form with the California Department of Public Health. In order to file an attestation form, the local public health office must:

1. Notify the California Department of Public Health (CDPH).
2. Certify through submission of a written attestation to CDPH that the county has met the readiness criteria (outlined below), including guidance to be issued by the county and detailed plans, and that the county is designed to mitigate the spread of COVID-19.

County criteria to move further ahead in the Resilience Roadmap includes:

### 1. County Case Metrics:

- *Stable or down trending hospitalizations*
  - Stable hospitalizations of COVID individuals on a 7-day average of daily percent change of less than 5% OR no more than 20 COVID hospitalizations on any single day in the past 14 days
- *Cases per population count and test positivity rate*
  - Less than 25 new cases per 100,000 residents in the past 14 days OR less than 8% testing positive in the past 7 days

## 2. County Preparedness:

- *Testing capacity*
  - Minimum daily testing volume to test 1.5 per 1,000 residents, which can be met through a combination of testing of symptomatic individuals and targeted surveillance. The county's average daily testing volume for the past week must be provided. If the county does not believe a testing volume of 1.5 per 1,000 residents is merited, justification must be provided.
  - Testing availability for at least 75% of residents, as measured by a specimen collection site (including established health care providers) within 30 minutes driving time in urban areas, and 60 minutes in rural areas.
- *Contact tracing*
  - Sufficient contact tracing so public health staff work can work with a patient to help them recall everyone with whom they have had close contact during the timeframe while they may have been infectious. For counties that have no cases, there should be at least 15 staff per 100,000 county population trained and available for contact tracing; for counties with small populations, there must be at least one staff person trained and available.
- *Hospital surge*
  - County (or regional) hospital capacity to accommodate a minimum surge of 35% due to COVID-19 cases in addition to providing usual care for non-COVID-19 patients.
- *SNF disease outbreak prevention and containment*
  - Must have plans to prevent and mitigate infections in skilled nursing facilities (SNF)
  - Skilled nursing facilities must have more than a 14 day supply of PPE on hand for staff, with an established process for ongoing procurement from non-state supply chains.

## 3. County Response

- *Counties must produce plans for the following related to county-wide containment:*
  - Availability of temporary housing units to shelter at least 15% of county residents experiencing homelessness in case of an outbreak among this population requiring isolation and quarantine of affected individuals. The county's plans to support individuals, including those experiencing homelessness, who are not able to properly isolate in a home setting by providing them with temporary housing (including access to a private bathroom), for the duration of the necessary isolation or quarantine period must be described.
- County (or regional) hospital facilities have a robust plan to protect the hospital workforce, both clinical and nonclinical, with PPE.
- Guidance for employers and essential critical infrastructure workplaces on how to structure the physical environment to protect essential workers.
- Availability of supplies (disinfectant, essential protective gear) to protect essential workers.
- Each county must provide details on their plans to move further ahead in the Resilience Roadmap including which sectors and spaces will be opened, in what sequence, on what timeline. Please specifically indicate where the plan differs from the state's order. Please note that this variance should not include sectors that are part of Stage 3.
- County metrics that would serve as triggers for either slowing the pace through Stage 2 or tightening modifications, including the frequency of measurement, the specific actions triggered by metric changes must be described, and how the county will inform the state of emerging concerns and how it will implement early containment measures.

- The county must provide details on the plan to move through opening sectors and spaces that are part of the State’s plan for Stage 2. A reminder, that this variance only covers those areas that are part of Stage 2, up to, but not including Stage 3.

The List of business activities and sectors that fall within and outside State 2 are as follows:

- Early Stage 2:
  - Curb-side retail
  - Manufacturers
  - Logistics
  - Childcare for those outside of the essential workforce
  - Office-based businesses (telework remains strongly encouraged)
  - Select services: car washes, pet grooming and landscape gardening
  - Outdoor museums, open gallery spaces and other public spaces with modifications
- Expanded Stage 2 with Attestation: Upcoming changes in the Stay-at-Home Order will move the entire state methodically through opening further. Those counties with variation attestation may progress to open these sectors more rapidly, according to their county-specific plan for modification.
  - Destination retail (retail stores), including shopping malls and swap meets
  - Dine-in restaurants (other amenities, like bars or gaming areas, are not permitted in Stage 2)
  - Schools with modifications
  - Limited-capacity religious services and cultural ceremonies
  - Day camps
  - Campgrounds, RV Parks, and Outdoor Recreation
  - Hotels
  - Cardrooms, Satellite Wagering Facilities and Racetracks
  - Family Entertainment Centers and Movie Theaters
  - Restaurants, Bars, and Wineries
  - Fitness Facilities
  - Museums, Galleries, Zoos, and Aquariums
  - Music, TV and film production
  - Professional Sports without Live Audiences

## **CALIFORNIA-MEXICO BORDER REGION**

Established in 1983, the La Paz Agreement defined this binationally agreed upon border region as the area within 62 miles (100 km) on either side of the border, an area that encompasses approximately 250,000 square miles. Of the 1,952-mile boundary between the United States and Mexico, California’s border region spans 140-miles. It is home to over 7.1 million people and is one of the most highly populated border region in the United States. It includes the California counties next to the border (San Diego and Imperial Counties) and five municipalities in Baja California. Imperial County is located in the Imperial Valley, in the far southeast of the state, bordering Arizona.

According to the Imperial Valley County Website, the county is “home to approximately 180,000 residents which live and work within its seven cities (Brawley, Calexico, Calipatria, El Centro, Holtville, Imperial and Westmorland) and eight unincorporated communities (Bombay Beach, Heber, Niland, Ocotillo, Palo Verde, Salton City, Seeley and Winterhaven). The county was the last to be established in California in 1907; however it is the ninth largest California County encompassing 4,284 square miles.” It is a small rural community whose major industries include agriculture, producing over half the nation’s winter vegetables, and an extensive amount of renewable resources.

San Diego County is the second most populous county in California and the fifth largest county in the United States. It is home to over 3.1 million residents with 18 cities (Carlsbad, Chula Vista, Coronado, Del Mar, El Cajon, Encinitas, Escondido, Imperial Beach, La Mesa, Lemon Grove, National City, Oceanside, Poway, San Diego, San Marcos, Santee, Solana Beach, and Vista) and is an extremely ethnically diverse community. San Diego County has more than 70 miles of coastline and encompasses a broad range of industries, including military, tourism, and technology, among others. South San Diego County is the area closest to the border. It includes the communities of Imperial Beach, Otay Mesa, and San Ysidro, as well as Chula Vista and National City.

The California-Mexico border region boasts some of the busiest land ports of entry in the world. In 2017, the region experienced 73.7 million northbound crossings (vehicle passengers and pedestrians) and 1.4 million northbound truck crossings. According to the San Diego Regional Planning Agency (SANDAG), the border region has seven operating land ports of entry (POEs). These include:

- In the San Diego region these include: San Ysidro-Puerta México/Ped West-El Chaparral, Otay Mesa-Mesa de Otay, Tecate-Tecate, and the Cross Border Xpress (CBX) which is a privately operated paid-use facility for travelers accessing the Tijuana International Airport.
  - An eighth POE, Otay Mesa East-Mesa de Otay II, will be constructed two miles east of the existing Otay Mesa port and will accommodate passenger and cargo vehicles.
- In Imperial County these include: Calexico West-Mexicali I, Calexico East-Mexicali II, and Andrade-Los Algodones.

To put this into context, SANDAG shares the following, “crossings of people through the California-Baja California border accounted for 32 percent of all crossings into the U.S. via land POEs along the U.S.-Mexico and U.S.-Canada border in 2019. The 31.4 million POVs that crossed northbound through the region in 2019 was 20 percent higher than the estimated total number of automobiles registered in the state. Truck crossings through the state’s commercial POEs broke a new record in 2019, processing more than 1.4 million northbound trucks. The Otay Mesa - Mesa de Otay and Calexico East - Mexicali II POEs are the second and fifth busiest ports in terms truck crossings along the U.S.-Mexico border – respectively. of California.”

All this cross-border activity results in impacts to the region. According to the Washington Post, the San Ysidro border crossing, south of San Diego, is the busiest ambulance pickup point in the United States. As a result, air quality is a huge concern. The Imperial Valley has one of California’s worst rates of childhood asthma hospitalizations and emergency visits and the prevalence of asthma is higher (15%) than the state average. These issues arise from traffic of idling cars along the border, as well as industrial and agricultural pollutants, unpaved roads, and drying sea beds (such as the Salton Sea) and other environmental issues specific to the border region. Infectious diseases, such as TB, STIs, HIV/AIDS and vaccine-preventable diseases, continue to be a significant challenge in the California border region. These and other health inequities undoubtedly play a role in the profusion of COVID-19 on the region.

Along with this, it is important to consider the economic and social conditions that impact the availability and access to healthcare for communities along the border. For example, the Imperial County is a designated Health Professional Shortage Area (HPSA). Imperial County only has one Pulmonary Care physician and one Infectious Disease physician. The area has one of the highest unemployment rates in the country. According to the Employment Development Department, “The unemployment rate in Imperial County was 27.8 percent in May 2020, down from a revised 28.1 percent in April 2020, and above the year-ago estimate of 16.5 percent. at 20.5% on March 2020.” Just across the border is Mexicali, the capital of the Mexico state of Baja California, with an estimated population of 689,775. Their healthcare system includes dozens of hospitals and hundreds of medical offices. Many people cross back and forth to access healthcare, among other things. This is similar to San Diego County and Tijuana.

The South Bay, the southern part of San Diego County, is where most of the cities in the border region are concentrated. The area has a large Black and Latino population and has been largely hit by unemployment. A new SANDAG report found “Black and Hispanic populations are more than four times as likely to live in areas that have been impacted by COVID-19 and unemployment. More than two-thirds of the region’s Black (67%) and Hispanic (70%) populations reside in ZIP Codes with higher than average unemployment rates. Approximately half of Black (52%) and Hispanic (49%) residents live in ZIP Codes with higher than average COVID-19 cases.” As stated earlier, many of these communities are concentrated along the border and these socioeconomic impacts result in health inequities in the region.

Understanding the unique needs of the region, California established the Office of Binational Border Health. According to their website, “The mission of the Office of Binational Border Health (OBBH) is to facilitate communication, coordination, and collaboration among California and Mexico health officials, health professionals, and communities in order to optimize binational and border health.” The office is statutorily required to submit an annual border health status Report to the Legislature that seeks to provide a general overview of the health status of border communities in the California-Mexico border region. The last report, the 2017-2018 Border Status, is available on their website.

### **IMMIGRATION, COVID-19, AND THE BORDER**

Concerns regarding the impact of COVID-19 on the immigrant community, specifically immigrants in detention facilities, are amongst some of the biggest concerns expressed to both committees in preparation for this hearing. Background provided to the committee is as follows:

“Civil detention facilities used to house migrants at the border present a unique challenge to the state of California within the context of COVID-19 and public health. Currently the border region is home to two privately operated civil detention facilities with sizable populations. They include the following facilities and immigrant populations:

- **Otay Mesa Detention Facility** - Population capacity- 1,500 (Operated by CoreCivic Inc.)
- **Imperial Regional Detention Facility** - Population capacity- 700 (Operated by the Management and Training Corp)

As it stands, the Otay Mesa facility is the site of one of the largest outbreaks of COVID-19 in immigration detention in the entire country, with more than 160 individuals having tested positive. While the facility is a federal facility, it is operated by the for-profit CoreCivic, which has been accused of coercing detainees to sign legal waivers in order to obtain protective gear, and has been sued by its own employees for unsafe conditions.

The operation of both facilities by for-profit operators raises serious questions as to how decisions involving public health are made. The inevitable consequence of mass infections at these sites is the mass hospitalization of detainees at local hospitals, which can quickly overwhelm medical resources in these regions, endangering public health in a mass and unanticipated scale.

Recent models predict that intensive care units (ICUs) in more than half of hospitals within 10 miles of an ICE detention facility would be overwhelmed by day 90 in the event of a COVID-19 outbreak. Expanding that radius to 50 miles lessens the risks, but 8% of hospitals would still be unable to meet the need for ICU beds.

In addition to the threat to medical resources, these detention facilities can facilitate the spread of COVID-19 to the local community through facility staff, as well as other locations in the state, as ICE often transfers individuals from border facilities to other facilities in the state.

Thus, it is clear that these facilities present high risk sites that have been overlooked by state planners despite the potentially disastrous impacts they can have on public health. The fact that decisions involving operations, testing and medical care are left in the hands of for-profit corporations who have every incentive to limit testing further compounds the urgency of the matter.

*Migrant Protection Protocol*

As it stands the adjudication of individual cases at the border under the “Migrant Protection Protocol” (MPP) have been postponed until after July 17, 2020. Once MPP proceedings begin, asylum seeking individuals and families who have been forcibly returned to Mexico under MPP, will be required to present at the San Ysidro Port of Entry on the date of their court hearing. Individuals and families will be transported from the Port of Entry to the San Diego Immigration Court while in DHS custody. From there, Immigration Judges will determine the outcome of their case which could include continuance and return to Mexico, case termination where ICE could detain or release individuals inside the U.S., bond, or adjudication on the merits of the case.

Once this program restarts proper planning will be required in order to coordinate services and support for individuals placed in immigrant detention, or being released into the state, including those who will be placed in shelters.

*Shelter*

The Jewish Family Services Migrant Family Shelter provides humanitarian services to asylum-seeking families at our border. The shelter is coordinated with the San Diego Rapid Response Network (SDRRN), a coalition of more than 40 human rights and service organizations, attorneys, and community leaders dedicated to aiding immigrants and their families in the San Diego border region.

The shelter was created to fill a critical gap in government assistance created in late 2018 when Immigration and Custom Enforcement (ICE) abruptly ended a program known as “Safe Release,” which helped asylum-seekers connect with friends and family in the U.S. as they waited for their court date.

The JFS Migrant Family Shelter provides medical screenings, hot meals, travel assistance, legal counsel, and a safe place to sleep. Most migrants are women with two young children, and the average length of time spent at the shelter is 12 to 48 hours. After addressing a family’s urgent needs, shelter staff provide transportation assistance to ensure asylum-seekers can safely reunite with loved ones in cities across the U.S. More than 95% of families at the shelter leave San Diego for other destinations as they continue through the legal process to claim asylum.”

**Total Number of Asylum Seekers Served Since October 2018:**

<b>Family Units</b>	<b>Individuals</b>
<b>9,249</b>	<b>23,289</b>