Brie Williams, Cyrus Ahalt , David Cloud, Dallas Augustine, Leah Rorvig, David Sears

Correctional Facilities In The Shadow Of COVID-19: Unique Challenges And Proposed Solutions

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As the global COVID-19 pandemic accelerates, it is critical to note that incarcerated people in the U.S. have a constitutional right to healthcare services that meet community standards, and that older adults and those with chronic and/or serious medical conditions in prisons and jails are at grave risk of experiencing serious illness and death due to a COVID-19 infection – just as they would be in the community.

Given the rate and spread of infection in the U.S., direct impact in many if not most U.S. correctional systems is inevitable. Failure to mount an adequate response to potential COVID-19 outbreaks throughout the nation's jails and prisons has the potential to devastate the health and well-being of incarcerated Americans, the nation's correctional workforce, and people living in the thousands of communities in which our jails and prisons are located. As the epidemic rapidly worsens, the narrow window of opportunity to implement effective prevention and mitigation strategies on behalf of people living and working in U.S. jails and prisons is quickly closing. Last week, the World Health Organization (WHO) called upon correctional systems worldwide to take action, issuing interim guidelines for responding to the pandemic in jails, prisons, and other places of detetion, while protecting the health, safey and human rights of incarcerated people and correctional workforces.

While coordinated action over the coming days and weeks is critical, there are many reasons that responding to COVID-19 in U.S. jails and prisons is uniquely and extraordinarily challenging.

1. Testing and screening for COVID-19 infections in jails and prisons is absolutely critical, as contact tracing is a feasible means of mitigating the spread of disease in a closed institution. But, as is the case throughout the U.S., availability of COVID-19 tests has been delayed and/or limited for the nation's more than 2 million incarcerated people. Moreover, national guidelines have not been developed to ensure that all correctional residents and employees are screened for known symptoms (fever and cough). As state and local public health systems increase capacity for testing in communities, it remains uncertain whether jurisdictions are accounting for the urgent need for robust COVID-19 screening and testing in their correctional facilities.

2. Correctional facilities lack the medical supplies needed to treat people who get seriously ill from COVID-19 infection. Prisons and jails function like outpatient healthcare This means that most have access to extremely limited emergency medical equipment, such as oxygen tanks, nasal cannulae, and oxygen facemasks for treating a handful of patients in respiratory distress, similar to what an outpatient clinic in the community would have. Under such conditions, widespread community transmission of COVID-19 within a correctional institution is likely to result in a disproportionately high COVID-19 mortality rate.

3. CDC guidelines are not tailored to correctional settings. This means that community public health leaders must be attuned to the unique challenges of implementing CDC (or other) guidelines around isolation and quarantine for containing the spread of the virus in correctional facilities. For example:

During a pandemic, social distancing is uniquely challenging but critically important in correctional facilities. Jails and prisons are crowded places where people often live in large dormitories or shared cells and share spaces for eating, sleeping, and bathing. Patients almost always have a cellmate if housed in barred cells, and frequently are living in dorms of 40, 50, 100 or 200 people with no door at all. People lack individualized access to soap, sanitizer, and other materials that enable protection against infection. These conditions can quickly result in rapid spread of COVID-19.

Even the infirmaries and clinical spaces in jails and prisons are not built to contain the spread of the virus. While some facilities have a small number of rooms designed to isolate patients (for example, with tuberculosis), others do not. If a person becomes infected while incarcerated, then they will likely be moved to a clinical housing setting within the institution for enhanced oversight and nursing support. However, many such clinical settings also comprise medical beds organized in open dorms and house patients alongside other chronically ill patients. These conditions would enable the efficient spread of COVID-19 to vulnerable patients in close quarters.

Isolation is a complex and major concern in correctional facilities. In some prisons and jails, the only cells with solid doors for quarantine will be administrative segregation cells, which usually house people placed in solitary confinement. Moving people suspected of contracting COVID-19 – or those at high risk of suffering serious illness once infected - to segregation units may help quell the potentially devastating spread of illness. However, segregation cells bring their own physical and mental health risks. They are most commonly used to punish people and may cause substantial psychological trauma and distress. Therefore, policymakers should be aware that placing high-risk or laboratory-confirmed patients with COVID-19 in cells usually used for solitary confinement will

likely deter others from reporting symptoms or seeking medical attention, thus quickly hastening the spread of the disease. Additionally, these cells often lack intercoms or other means of communicating with a correctional officer or medical provider when patients are in need of help. This may further increase patients' concerns that they will suffer, not get the care they need in a timely manner, and die in such rooms. For these reasons, it is unrealistic to believe that an effective prevention, mitigation, and treatment response to COVID-19 in correctional facilities can rely upon conditions that incarcerated people are likely to experience as punitive. When such housing cells must be used for short-term quarantine and isolation patients should have full access to telephone or tablet communication with family and friends on the outside and access to personal property, personal hygiene supplies and access to canteen.

4. Correctional healthcare systems are typically understaffed. Most prisons have a limited number of doctors and nurses on location to respond to routine medical issues, much less an infectious disease outbreak. There are few back-up healthcare professionals working at these facilities. Many correctional facilities are already understaffed, with little room for filling in for employees out on sick leave or handling a surge in clinical needs. This staffing shortage could pose grave danger to the ability to continue testing and treatment in correctional settings, particularly if healthcare professionals become ill themselves.

5. Security often overrules health in prisons. An effective response to COVID-19 will require a close, functional working relationship between medical and custody leadership, which is not always the case in jails and prisons. Without coordination, well-intended unilateral decisions made by non-medical personnel may fail to contain or even accelerate the virus' spread.

6. The patient-doctor relationship is unique in correctional settings. While some facilities have a culture of strong patient-provider relationships, others do not. Patients may lack trust in their medical providers or may not be accustomed to receiving complete medical information. They often have to pay for medical appointments. If incarcerated people do not trust their medical providers and/or worry about the costs of appointments, they may be less likely to seek help and follow medical guidance.

7. Jail and prisons are not actually closed environments. Hundreds of thousands of correctional officers nationwide, frequently untrained in how to respond to medical emergencies and how to protect themselves from infectious illness, will continue to enter and exit jails and prisons and return to their communities and families at the end of each shift. Facility administrators and health care personnel are also at risk of becoming ill themselves. All employees exiting prisons each day are at risk of becoming infected and transmitting COVID-19 to others.

What Can We do?

In this moment we must all remember that incarcerated people, and all those who work in prisons and jails, are part of our families and our communities. We have constitutional and ethical obligations to protect these populations and to take all appropriate actions needed to mitigate the effects of a potential outbreak in correctional facilities. Here are some practical ideas for where to start:

1. Release some people from prisons and jails. Wherever possible, and in close coordination with public health officials in corresponding jurisdictions, we must decrease the number of people in jails and prisons immediately. Releasing or paroling patients who have residential placement in the community and are within 1-2 years of their release, or who have served the vast majority of their sentence, will create critical opportunities (space, personnel, equipment and others) to slow the spread of COVID-19 in U.S. jails and prisons and mitigate its worst outcomes. It is a particularly critical time to release or parole those with life-limiting illness and/or serious illness who have a place to go after release. In most correctional systems, patients meeting public safety and medical eligibility for early release could be quickly identified using available administrative data and prioritized for rapid reentry planning using case management, education, and other staff resources made available by a temporary suspension of congregate (group) activities (see below).

2. Give correctional medical leaders the authority to determine how best to house the remaining population, and aim to reorganize patients into small cohorts, or “mini-communities”. To prevent the spread of COVID-19 without imposing inhumane or punitive conditions, correctional administrators should organize residents into the smallest, most stable possible cohorts for recreation, pill call, and canteen. All other congregate activities should be discontinued for at least 4 weeks pending an assessment of COVID-19’s prevalence in the facility. (Group mental health treatment should continue as indicated by clinicians but should be conducted following the strictest possible social distancing guidelines.)

Cohorts should be developed based on where residents currently reside (rather than undertaking any significant population movements at this time). Cohorts must practice absolute social distancing from other cohorts. This approach aims to verify cohorts of residents without exposure to COVID-19 within 4 weeks and to contain identified cases of COVID-19 in order to slow the spread of the virus as much as possible. The restriction of all non-essential movement within facilities using the non-punitive “shelter-in-place” protocols described here will buy time to develop policies and procedures for effectively testing, contact-tracing, triaging, and housing patients as the epidemic continues beyond this initial response phase.

The following additional protocols are critical to the implementation of this approach, which seeks to promote health while conserving the dignity of incarcerated people and limiting risk of exposure to staff:

Medical leadership at the facility should provide all residents with immediate education regarding COVID-19 and its spread as well as a thorough and clearly articulated rationale for why they are being cohorted into mini-communities and what effective social distancing between cohorts requires.

All residents should receive clear instructions for safely socializing within their cohort and when moving between their housing units and congregate spaces (for recreation, pill call, canteen, and/or medical and mental health treatment as needed). Emergency response officials from public health agencies should visit correctional facilities to hold informational sessions and provide patient education to mitigate some of the trust problems that may exist between residents and staff in many correctional facilities.

It is likely that patients will be an important resource for ideas, and will perform the critical service of informing staff and leadership when a policy or its implementation is having unintended consequences (such as patients hiding symptoms), so opportunities for partnership between healthcare staff and patients (such as the use of resident councils) will be crucial during this time.

Meals should be served in-cell if possible. If not feasible, meals should be served in such a way that social distancing between cohorts is achieved during transit and in dining spaces and all dining spaces should be disinfected between cohorts.

All residents should be given the option to remain in-cell if they choose. Accommodations for those who choose to remain in-cell must not be punitive, and patients should retain the option of accessing amenities with their mini-community as desired.

All adults age 55 or older and/or with chronic medical conditions should receive verbal daily screening for symptoms of fever, cough, and respiratory distress.

Rather than remove recreation or yard privileges, recreation spaces should be sub-divided and residents should be allowed outside in their cohorts at least daily.

Access to safe but reliable means of communication with family and friends outside of the prison should be enhanced during this crisis (see item below regarding cell phones and tablets).

3. The response to suspected cases of COVID-19 should be consistent, orderly, optimized for harm reduction, and patient-centered. Residents showing symptoms or otherwise suspected of infection with COVID-19 should be promptly removed from the mini-community in which they have been residing and temporarily placed in individual housing pending results of laboratory testing or the onset of health conditions that require transfer to an outside medical facility. These individuals should continue to receive access to regular amenities, such as communication with family and friends outside of the prison, access to canteen, and to personal hygiene supplies as well as personal property. Members of the mini-community from which individuals suspected of infection have been removed should remain in their cells and practice social distancing from others in their cohort to the greatest extent possible pending the results of the removed individual's COVID-19 testing. Patients who test positive for COVID-19 should be safely transported to an appropriate treatment unit and the spaces in which they have been living disinfected. Following a positive test from within a mini-community, facilities must devise consistent, patient-centered policies for how to best monitor remaining members of that mini-community. Approaches may vary considerably based on housing scheme (e.g. dorm, single-cell, double-cell, etc) and available resources.

Facilities should also consider including a peer companion (with appropriate Personal Protective Equipment) for patients removed from a mini-community who will then retain visiting rights should the patient test positive and be placed in a treatment unit subject to clinical approval. This is a critical point as many patients hide symptoms in the correctional setting for fear that they will be brought to a new place and no one will know where they have gone or be able to stay in touch with them.

4. As testing capacity expands, testing and contact tracing in correctional facilities should be prioritized. For the many reasons described above, correctional facilities are uniquely susceptible to the rapid spread of COVID-19 and disproportionately poor outcomes, including death, among those infected. In addition, slow identification and/or poor management of COVID-19 outbreaks in correctional facilities are extremely likely to spread to staff and then into local communities. Political leaders and policymakers must recognize the import of making testing available to correctional systems in their jurisdictions; and correctional system leaders must prioritize targeted and efficient administration of testing and contact tracing as indicated by medical staff.

5. Restrict all non-essential movement of patients between facilities, including limiting transfers between prisons and from jails to prisons, and prohibit technical probation or parole violations from sending people into jails and prisons. The goal during a pandemic must be to decrease the population of patients living in an institutionalized outpatient setting.

6. Enhance patient communication with friends and family outside of prison while temporarily eliminating in-person contacts. Patient compliance with prevention and mitigation efforts will be supported by enhanced access to emotional support from friends and family. In addition, as COVID-19 cases inside correctional facilities are reported in the media, community members with loved ones inside are likely to experience profound anxiety and elevated risk for associated adverse health outcomes absent such access. Yet in-person visits potentially undermine prevention and mitigation efforts in both correctional facilities and the community. Thus, correctional facilities should immediately prioritize the following interventions:

1. Restrict all non-essential staff, visitors and volunteers from prison entry (including, unfortunately, friends and family) until policies and procedures are put in place to optimize screening and containment.

2. Issue non-internet enabled cell phones and/or tablets pre-programmed for access to approved phone numbers and/or email addresses (i.e. numbers/emails whose owners have provided affirmative consent) for the duration of the pandemic. This may seem hard for many correctional facilities, but patients need access to outside friends and family during this uncertain and terrifying time. In most facilities, patients share a small number of public telephones (often at a ratio of one phone for every ten people, or worse). This represents a clear risk for viral transmission. While it generally goes against facility policies, the reality is that cell phones and tablets already exist in all prisons, sometimes in large numbers, and are passed between residents frequently; it is likely that this cellphone/tablet sharing will only increase as more patients feel unwell or afraid and wish to reach their families, thereby further elevating the risk of viral transmission. Providing patients with basic cell phones that have no internet capacity (and can be activated during limited hours of each day), or tablets with email capacity, would allow correctional facilities to essentially eliminate these devices as a potential major driver of COVID-19 transmission and simultaneously grant patients the dignity and humanity all patients deserve when faced with a frightening and unknown danger to their health.

7. Community hospitals must be compelled to include nearby prisons and jails in their disaster planning process. Correctional facilities are outpatient facilities that cannot manage profoundly ill patients without hospitalization. If necessary, state governors should compel area hospitals to accept patient transfers when needed.

8. Correctional healthcare administration should allow emergency credentialing of nearby hospital healthcare professionals so that shifts can be covered if needed when prison and jail healthcare workers fall ill.

9. State and local public health systems should deploy an infectious disease and/or public health professional to each correctional facility to offer support to medical leadership in the development of emergency planning particular to the unique constraints of each facility.

10. Develop a national forum for dissemination and sharing of knowledge. Many correctional facilities already have pandemic protocols, but those that do not would benefit from a national forum for sharing such policies. National professional organizations that support healthcare professionals and correctional healthcare professionals should develop and publicize such platforms immediately.

11. Acknowledge and provide support to correctional officers and prison healthcare professionals who are on the frontlines of this pandemic. Our communities must give correctional staff both the emergency training and supplies they need to protect themselves as well as the national recognition they deserve for putting themselves in harm's way as a part of their job, each and every day of this pandemic.

As our nation mobilizes to address the emerging and potentially longstanding public health crisis represented by COVID-19, mounting a robust– and effectively tailored – response to the virus' spread in U.S. jails and prisons is essential to safeguarding the health of more than 2 million incarcerated Americans, hundreds of thousands of correctional staff and their families, and thousands of surrounding communities – many located in already medically underserved communities. Many correctional reform advocates in the U.S. are calling for rapid decarceration in response to the crisis and are warning against using the risks posed by COVID-19 to justify punitive measures, including long-term isolation. We strongly agree that safely reducing jail and prison populations is an important first-line strategy that ill enable correctional and medical leaders to implement effective prevention, mitigation and treatment in U.S. correctional facilities. We also recommend against the use of isolation as a prevention strategy given that such measures are (a) inconsistent with international consensus on the need to dramatically reduce the use of isolation under all circumstances, (b) very likely to undermine vital detection, testing, and contact tracing efforts, and (c) impractical, given the sheer numbers of chronically ill and/or older patients living in these settings.

But decarceration alone will fall profoundly short of what is needed to effectively safeguard the health and well-being of those living and working in correctional facilities over the months ahead. The rapid emergence and community transmission of COVID-19 constitutes an exceedingly complex public health challenge that will likely prove uniquely difficult to manage in our nation's correctional facilities. In response, jails and prisons must be brought into broader community

mobilization efforts and must themselves undertake measures commensurate to a worst-case scenario. As is currently being argued in a growing number of states and cities under shelter-in-place restrictions, the potential devastation likely to follow an under-reaction to the risks to America's jails and prison posed by COVID-19 far outweighs the foreseeable risks of leveraging all resources and solutions at our disposal today.

Purpose: The Coronavirus (COVID-19) outbreak is rapidly emerging as a global health threat. With no proven vaccination or treatment, infection control measures are paramount. In this article, we aim to describe the impact of COVID-19 on our practice and share our strategies and guidelines to maintain a sustainable ophthalmology practice.Â Our guidelines during this outbreak are discussed. Results: Challenges in different care settings in our ophthalmology practice have been identified and analyzed with practical solutions and guidelines implemented in anticipation of these challenges. First, to minimize cross-infection of COVID-19, stringent infection control measures were set up. Experts have warned that, â€œwidespread community transmission of Covid-19 within a correctional institution is likely to result in a disproportionately high Covid-19Â i World Prison Population List, 2018, Institute for Criminal Policy Research https://www.prisonstudies.org/sites/default/files/resources/downloads/wppl_12.pdf ii â€œCOVID-19 in Correctional Settings: Unique Challenges and Proposed Responsesâ€, AMEND (March 23, 2020), https://amend.us/wp-content/uploads/2020/03/COVID-in-Corrections-Challenges-and-Solutions-1.pdf; see also â€œCorrectional Facilities In The Shadow. Of COVID-19: Unique Challenges And Proposed Solutions," Health Affairs Blog, March... 2. Combating COVID-19 on the Second Front: New Challenges, Old Problems. The tasks that face us as a society, at present, are posing extraordinary ethical challenges of a kind that many of us have never before experienced. On the frontlines of the pandemic, our health care professionals are confronted with a merciless convergence of limited resources and surging illness.Â In the data science and AI community, such second-front efforts are already well under way. Machine learning and data-driven technologies are already augmenting human capacities to better tackle the challenges of the pandemic (Bullock et al., 2020). As many of our countries are facing unprecedented challenges from COVID-19 the strain on our governments is extreme, and the impact on people all over the world continues to grow. At OGP our first steps have been to take proactive measures to protect our own team, and to adjust the timelines and expectations around OGP participation â€“ such as postponing Open Gov Week events to later in the year and replacing the activities planned for May 3-10 with a series of online community events (more details coming soon).Â We also know that many of us in the open government community are looking for ways to help and to apply the principles of transparency, accountability, and participation to the COVID-19 response.