I would like to now introduce our next speaker, doctor Emily Wong, but along is an associate professor in the Yale School of Madison and directs the health justice lab. The health dresses lab is a collaborative, innovative and introduce laneri team focused on improving the health of individuals and communities who have been affected by mass incarceration. Act along thank you for being. Thank you so much, Daniel, and thank you to the Dean for the invitation to speak on this web.
to share some of the work that our team is taking on in order to dress code at 19 and the criminal justice system.

Next slide. I start today with a photo of Cook County Jail in Chicago where is the side of the largest outbreak of COVID-19 in the US. according to the New York Times,

As we’re all witnessing, this pandemic is unearthing persistent structural inequities in our country. No more so obvious than those that exist in the criminal justice system there.

2.2 million people who are currently behind bars who are disproportionately
of racial and ethnic minority backgrounds poor and have high rates of chronic health conditions, including those which put people at risk for covert. Next slide.

Cover 19 is disproportionately represented in our jails and prisons, and many have taken on the task of measuring COVID-19 infection rates in the criminal justice system. I highlight here the work of doctors Lauren Brinkley, Rubenstein, Doctor Catherine Novotney and a graduate student, Aaron Macaulay, among others who have been working on the COVID-19 prison project.
This website provides a daily reporting of the number of cases in state prisons each day and compared it to the rates in the general population. So the blue bars here. Are the rate in the general population for 1000 people or residents and the orange bars represent the prison infection rate again for 1000 people incarcerated in the Red Arrow? I highlight that Connecticut has four times the number of infections in our Correctional facilities present an
ideal setting for infections to spread new individuals frequently. Many facilities don’t have access to alcohol based sanitizers or enough soap and social distancing measures are difficult or nearly impossible to implement. Further, the vast majority of correctional facilities aren’t built to handle large scale infectious outbreaks, or to deliver health care during respiratory pandemics. This is a photo taken prior to COVID-19 of a patient with chronic
obstructive pulmonary disease, requires oxygen and is being held in solitary confinement. The patient spends 23 hours a day in his cell with little to no human contact, and you’re going to note that the oxygen tank is outside of his door because of safety concerns forcing him to bang on his door each and every time the tubing is kinked. This picture is a reminder that while prisons and jails are currently managing outbreaks of COVID-19, they simply aren’t equipped to.
take on the strain that it presents to their health care systems,
and that, fundamentally, prisons and jails are places which prioritized safety over help.
Next slide.
So what can correctional systems do to mitigate these high rates of infection?
The CDC has recently provided basic guidance which highlights 7 different strategies to mitigate COVID-19 in correctional facilities. These include intensified cleaning, masks and infection control training, but the guidance really doesn’t provide a specific surround strategies.
that many correctional facilities are grappling with these days, so how do jails and prisons take on testing? Who should they test? When should they test? Do they test everyone I should they consider large scale population reduction or release? Or should they be releasing medically vulnerable patients next slide? In the past few weeks we saw a patient have been released from the Connecticut Department of Corrections in our transitions clinic network program here in New Haven.
one of about 40 programs that exist around that country for people just released from corrections. So this man had severe heart failure, an ejection fraction of 10%, and had been released back home to Connecticut under medical parole. I'm given his high risk of death where he to contract kovid while incarcerated. All over the country, facilities are deciding whether to release medically vulnerable patients an in some places, like in the federal system, the Bureau of Prisons Attorney has ordered home
combine Minton for elderly, medical vulnerable patients who are incarcerated in Connecticut and contrast each individual case is being considered and only a handful of people have been released like our patient and so the bottom line is that there isn’t official guidance nor data to guide the implementation of these policies. That protect medically vulnerable patients. I like the ones that we’re seeing in clinic and without this guidance, many people are being placed behind bars placed at at risk behind bars.
So we're working with Margaret Brando. She's a professor of engineering and medicine at Stanford University in
her graduate student Giovanni Malloy to develop a stochastic dynamic transmission model of the spread of COVID-19 in correctional facilities. This is a modified SCR model at Professor Pittser talked about this earlier, where we're able to estimate transmission among those that are susceptible than exposed asymptomatic. An infected symptomatic, infected, quarantined hospitalised. And recover,
our goal is to compare the relative effectiveness of these different strategies to mitigate COVID-19 in correctional facilities and ultimately to create models that allow us to simulate how individuals with chronic health conditions can best be protected in corrections and build an easy to use tool for correctional systems to make such decisions.

So to start, we’re creating partnerships with jails and prisons around the country to obtain anonymized data. An infection rates.
This has been an important but labor intensive task.

As you can imagine, prisons and jails aren’t always that down to share their data, but I share with you here data from one of the jails that we’re working with.

So on the Y axis, what you can see here are the percentage of individuals with koven infections here in the red or those who are detained in the green. The staff that her working there. And what you can see here is in the course of a large outbreak, The jail undertook many interventions in an attempt to spread to
mitigate the spread of Coke at 19, and this includes large scale release on day six, placing people in single cells on Day 14, testing asymptomatic people at Day 30. And so as a first step, we're measuring how these interventions have change transmission rates in jail. The basic statistic that we're measuring is the reproduction ratio, and this is how many people one person is likely to infect in this infographic here. They are not is 3.
and so it's important to note, as has been mentioned previously, Arnotts our context an location dependent so they change overtime. They differ from jail to jail, dependent so they change overtime. They differ from jail to jail, prison to prison, but the goal is to get the are not less than one, so new infections will decline and wait again. We wanted to do was to test how. Each of these interventions would change the basic reproduction ratio, so jails are present biting us demographic information. The location of who symptomatic
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00:07:51.305 --> 00:07:53.593 with COVID-19 or who test positive
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00:07:53.593 --> 00:07:55.617 hospitalization rates and deaths,
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00:07:55.620 --> 00:07:57.840 and in this first example we
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the literature of asymptomatic rates, incubation time, length of infection, and recovery rates in the model.

Next generation method to estimate the basic reproduction ratio under each intervention as a function of the change in transmission rates.

Next slide.

So here I show preliminary results of the basic difference in reproduction ratio as a function of time under each intervention as both the transmission rate and the size of the susceptible population is changing overtime.
What you can see here is that transmission rate first drop by about 60% after the period marking the beginning of large scale release when compared to the beginning of the outbreak, it dropped again by 60% after the jail began. An effort to start single selling individuals. And then again by another 30% after the testing of asymptomatic individuals. Simultaneously were creating a visual model at COVID-19 for correctional policymakers and so, essentially, correctional
leaders could enter a simple information about their facility. So the number of people in single cells, double cells living in the gymnasium, identify how many people need to be released or move to single cells to reduce their reproduction ratio using data, hopefully by creating a visual model. This will move our research findings much more quickly. into action next slide. Next steps here are two account for data on testing and the transmission model will incorporate individual data on COVID-19 into our model and specifically look at race.
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00:10:31.970 --> 00:10:34.100 Next slide.
NOTE Confidence: 0.898608163992564
00:10:34.100 --> 00:10:36.564 And so even though our early results
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a larger scale release in reducing COVID-19 transmission, the risks the health risks of release are not inconsequential from more than a decade of research. We know that in times prior to COVID-19 release from correctional facilities is associated with significantly high risks of hospitalizations and deaths in the immediate post release period. This op Ed piece came out a few days ago in the Washington Post. Where the author wrote that early release of incarcerated people may look like clemency, but it can endanger lives.
And she details the story of her uncle who had an alcohol use disorder, was released to homelessness without the supports that he needed to be successful in the community.

Individuals just released from correctional facilities face unique barriers to coming home in the time of Covad. They’re more likely to be living in densely populated neighborhoods, homes, or congregate settings, including homeless shelters. In halfway houses, they can’t work from home, they can afford to take
private transportation,

they don’t have phones for Talla,

Medison, and many distrust

messaging coming from public health.

Officials, doctors and health systems.

Next slide.

Next slide.

So. Great. Sorry it’s the previous slide,

so while we continue to push forward

with the science of who and how

we ought to release people from

Correctional Systems in the time of

Correctional Systems in the time of

Cove it we’ve adapted our national

model of primary care transitions clinic

for individuals just released from

correctional facilities here at Yale.
This is being led by our community health workers here in the pictures, Jerry, Smart Doctor Lisa Puglisi, who is the director of our transitions clinic network programs in Connecticut and a patient, we’ve adapted this such that. Primary care is adaptable and low barrier, which means providing Beeper Northing over tell a Medison meeting patients on the green, whatever they need. We’ve also started a statewide COVID-19 hotline so that parole halfway houses and apartments of.
Corrections has a single number to call to create a medical discharge plan. This includes getting 90 days of medications for patients, medical records, and the appropriate referrals to primary care and specialist. We’ve also been working with community agencies in New Haven and throughout the state to get basic needs. Met telephones with video capabilities. Rapid ho telling through the states. I am RP and the Connecticut coalition to end homelessness and we’re hiring community leaders with their
own histories of incarceration to disseminate public health guidance and tackle counter narratives about COVID-19. About public health guidance that are indeed health harming. Hopefully I’ve convinced you that there are real injustices in the criminal justice system. Certainly at large. And now in the time of COVID-19 and for many through the years of notice that this can maybe feel remote from the work that you’re doing.
That is the work that’s ongoing happening in our communities or New Haven at large. And so I end with this, which is that not long ago, the New Haven independent published an important story highlighting the work of so many at this school of Madison across the University. Focused on exposing the persistent racial and ethnic disparities in Cove at 19th and hear the headline is black and Brown. New Haven ours are disproportionately impacted. The story featured this beautiful quote from our Department chair Gary.
Desear shining light on racial and ethnic disparities in our communities, and what was notable about this story was that nearly every patient all but one in that article was a patient of arson. In other words, people that had recent histories of incarceration, highlighting this important fact that we will not be able to address an attend to racial ethnic disparities in our community without addressing the criminal justice system. Next slide.
So I get asked often. How can a person get involved either locally and nationally? And here I share with you some resources to learn more about COVID-19 infections within the criminal justice system, but I want to end also by highlighting that there so many across the University that have are doing profound work in this domain. Here, Judith Resnik, and Hope Metcalf, have filed an even one big court cases to insist on the release of medically vulnerable people who are incarcerated. Jamie Myron Gregans. All this have shined a light on.
Injustice is behind bars writing Apfa David’s letters to the governor successfully getting people out one by one and organizing in partnership with community organizations across the state against the unjust treatment behind bars.

There’s so much to be done, infinitely grateful to be doing this work with my lab, and with those across the University.

Thank you for the time. Thank you very much.