

SUBJECT TO RESOLUTION COMMITTEE REVIEW

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 415
(November 2020)

Introduced by: Medical Student Section

Subject: Support Public Health Approaches for the Prevention and Management of Contagious Diseases in Correctional Facilities

Referred to: Reference Committee D

1 Whereas, COVID-19 is an infectious disease caused by SARS-CoV-2 that spreads rapidly
2 between individuals in close contact, presents more severely in people above age 60 with
3 chronic health conditions, and disproportionately impacts racial and ethnic minorities^{1,2,3,4}; and
4

5 Whereas, Many opportunities exist for COVID-19 to be introduced into correctional facilities, in
6 which individuals facing incarceration live in crowded environments, are not permitted to leave,
7 and are exposed to others who have transferred between facilities^{5,6}; and
8

9 Whereas, In 2013, over 130,000 people experiencing incarceration were older than 55, and in
10 2011-2012, over 40% of those incarcerated in state and federal institutions reported having
11 chronic health problems^{5,7,8,9}; and
12

13 Whereas, The incarceration rate of Native American and Black individuals is two times and five
14 times that of white individuals, respectively, and approximately three out of five individuals in
15 prison are Black or Latinx--nearly double their proportion of the country's population^{10,11}; and
16

17 Whereas, Adjusted for age, Black, Latinx, and Native American individuals are more than three
18 times more likely to die of COVID-19 than their white counterparts, and Black Americans make
19 up the largest racial group in 10 out of 20 US counties with the highest COVID-19 deaths per
20 capita^{12,13}; and
21

22 Whereas, Identification, isolation, and treatment of cases in incarcerated individuals is often
23 delayed due to inadequate healthcare funding and high patient medical copays⁶; and
24

25 Whereas, More than 120,000 people that are incarcerated in state and federal prisons have
26 tested positive for COVID-19 and over 1,000 have died from the disease, with new cases per
27 week continuing to increase since late June¹⁴; and
28

29 Whereas, Of the top 20 largest disease clusters in the country, 19 are in prisons or jails, with a
30 growth rate that doubly outpaces the general population¹⁵; and
31

32 Whereas, The COVID-19 outbreak at San Quentin prison is expected to spread past the prison
33 walls and overwhelm the local health care system, suggesting that these outbreaks threaten
34 public health efforts in the general population as well¹⁵; and
35

36 Whereas, Testing rates differ substantially between prisons, with some conducting mass testing
37 and others testing only symptomatic individuals who are incarcerated, suggesting that current
38 estimates of COVID-19 prevalence in prisons may fall short of actual numbers¹⁶; and

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1 Whereas, Most states have released incomplete or no demographic information on COVID-19
2 cases and deaths within the incarcerated population, limiting the understanding and
3 development of efforts to address racial disparities^{8,17,18}; and
4

5 Whereas, Public health experts have advocated for the release, or “decarceration”, of elderly
6 and medically vulnerable individuals, as well as those least likely to commit additional crimes, to
7 prevent the spread of COVID-19^{19,20,21}; and
8

9 Whereas, Since March 2020, states across the country have begun releasing non-violent,
10 medically vulnerable individuals experiencing incarceration, resulting in an 11% reduction in the
11 California state prison census and a 25% reduction in the North Dakota state prison
12 population²²; and
13

14 Whereas, Illinois, California, Colorado, and Oklahoma have aimed to reduce prison admissions
15 by halting new admissions or arrests for low level parole violations in order to reduce the risk of
16 viral transmission into the prison population²³; and
17

18 Whereas, A 17% reduction in California’s prison population to reduce overcrowding from 2011
19 to 2012 had no effect on crime rates after three years, suggesting that decarceration of
20 nonviolent offenders poses minimal threat to public safety²⁴; and
21

22 Whereas, Of 29 county jail systems studied, 28 had all reduced their jail population between the
23 months of February and April 2020, yet less crime occurred over the subsequent months as
24 compared to monthly trends over the past two years²⁵; and
25

26 Whereas, Strategies to minimize COVID-19 spread among staff and those that remain
27 incarcerated include universally available COVID-19 screening, testing, and care, access to
28 sanitation, space to maintain social distancing, and appropriate personal protective equipment²¹;
29 and
30

31 Whereas, In Ireland, prison-led contact tracing programs detected 45 COVID-19 cases in staff
32 members but no cases in tested people who are incarcerated and were under investigation for
33 possible exposure, supporting the use of contact tracing to mitigate the spread of disease in
34 such closed institutions²⁶; and
35

36 Whereas, The National Commission on Correctional Health Care and the CDC have released
37 specific guidance for controlling the spread of COVID-19 in correctional and detention facilities,
38 including hand washing, employee PPE training, and establishment of disease outbreak
39 protocols in the event of an outbreak to ensure adequate preparation and open lines of
40 communication with local health officials²⁷; and
41

42 Whereas, Despite a Prison Policy Initiative Report that found that all but 3 states had reported
43 providing masks to all staff, there have also been several accounts of non-adherence to PPE
44 requirements by staff as well as “a lack of transparency around policies for... PPE and testing”
45 for staff in correctional and detention facilities^{28,29,30}; and
46

47 Whereas, Further accounts have alleged that incarcerated individuals are being punished for
48 wearing face coverings and are banned from using sanitation materials like hand sanitizer^{28,29};
49 and
50

51 Whereas, Our AMA prescribes specific plans and supports collaboration between medical,
52 public health, and criminal justice systems to prevent and control the spread of HIV/AIDS,

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1 tuberculosis, and hepatitis C but does not identify other infectious respiratory diseases in its
2 policies (H-430.985, H-430.988, H-430.989, H-440.931); and

3
4 Whereas, Our AMA believes that correctional and detention facilities should provide medical,
5 psychiatric, and substance misuse care that meets prevailing community standards, including
6 appropriate referrals for ongoing care upon release from the correctional facility in order to
7 prevent recidivism (H-430.997); therefore be it

8
9 RESOLVED, That our American Medical Association collaborate with state medical societies to
10 advocate for evidence-based public health measures to curb the spread of highly contagious
11 pathogens in the setting of prisons and jails, including, but not limited to:

- 12 (a) Universally available screening, testing, contact tracing, and medical care to staff and
13 individuals that are incarcerated,
14 (b) Access to sanitizing equipment including, but not limited to, soap, hand sanitizer, and
15 cleaning supplies,
16 (c) Humane and safe quarantine protocol for individuals that test positive for or are exposed
17 to highly contagious respiratory pathogens,
18 (d) Adherence to use of personal protective equipment for incarcerated individuals and staff,
19 and
20 (e) Expanded data reporting, including testing rates and demographic breakdown of highly
21 contagious infectious disease cases and deaths (Directive to Take Action); and be it
22 further

23
24 RESOLVED, That our AMA support efforts to decarcerate non-violent elderly and medically
25 vulnerable individuals to mitigate the spread of highly contagious pathogens within correctional
26 facilities and communities (New HOD Policy); and be it further

27
28 RESOLVED, That our AMA support prioritizing COVID vaccine access for justice-involved
29 populations (New HOD Policy); and be it further

30
31 RESOLVED, That our AMA will amend policy H-430.989 by insertion as follows:

32
33 H-430.989, Disease Prevention and Health Promotion in Correctional
34 Institutions

35
36 Our AMA urges state and local health departments to develop plans that would foster closer
37 working relations between the criminal justice, medical, and public health systems toward the
38 prevention and control of HIV/AIDS, substance abuse, tuberculosis, and hepatitis, and highly
39 contagious infectious diseases. Some of these plans should have as their objectives: (a) an
40 increase in collaborative efforts between parole officers and drug treatment center staff in case
41 management aimed at helping patients to continue in treatment and to remain drug free; (b) an
42 increase in direct referral by correctional systems of parolees with a recent, active history of
43 intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of
44 assigning individuals to drug treatment programs as a sentence or in connection with
45 sentencing. (Modify Current HOD Policy)

Fiscal Note: Not yet determined

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RELEVANT AMA POLICY

Support for Standardized Diagnosis and Treatment of Hepatitis C Virus in the Population of Incarcerated Persons H-430.985

Our AMA: (1) supports the implementation of routine screening for Hepatitis C virus (HCV) in prisons; (2) will advocate for the initiation of treatment for HCV when determined to be appropriate by the treating physician in incarcerated patients with the infection who are seeking treatment; and (3) supports negotiation for affordable pricing for therapies to treat and cure HCV among correctional facility health care providers, correctional facility health care payors, and drug companies to maximize access to these disease-altering medications.

(Res. 404, A-17)

Health Care While Incarcerated H-430.986

1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
 2. Our AMA supports partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.
 3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
 4. That our AMA encourage state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
 5. Our AMA encourages states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal justice system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
 6. Our AMA urges Congress, the Centers for Medicare & Medicaid Services (CMS), and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from adult and juvenile correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism.
 6. Our AMA urges Congress, the Centers for Medicare & Medicaid Services (CMS), and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from adult and juvenile correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism.
 7. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females, including gynecological care and obstetrics care for pregnant and postpartum women.
 8. Our AMA will collaborate with state medical societies and federal regulators to emphasize the importance of hygiene and health literacy information sessions for both inmates and staff in correctional facilities.
 9. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance abuse disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; and (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community.
- (CMS Rep. 02, I-16; Appended: Res. 417, A-19; Appended: Res. 420, A-19; Modified: Res. 216, I-19)

Prevention and Control of HIV/AIDS and Tuberculosis in Correctional Facilities H-430.988

(1) Medical Testing and Care of Prisoners a) Federal and state correctional systems should provide comprehensive medical management for all entrants, which includes mandatory testing for HIV infection and tuberculosis followed by appropriate treatment for those infected; b) During incarceration, prisoners should be tested for HIV infection as medically indicated or on their request; c) All inmates and staff should be screened for tuberculosis infection and retested at least annually. If an increase in cases of tuberculosis or HIV infection is noted, more frequent retesting may be indicated; d) Testing for HIV infection and tuberculosis should be mandatory for all prisoners within 60 days of their release from prison; e) Physicians who practice in correctional institutions should evaluate all tuberculin-positive inmates for HIV infection and all HIV-positive patients for tuberculosis, since HIV status may affect subsequent management of tuberculosis infection or disease and tuberculosis may accompany HIV infection; f) Correctional institutions should assure that informed consent, counseling, and confidentiality procedures are in place to protect the patient, when HIV testing is appropriate; g) During their post-test counseling procedures, prison medical directors should encourage HIV-infected inmates to confidentially notify their sexual or needle-sharing partners; and h) Correctional medical care must, as a minimum, meet the prevailing standards of care for HIV-infected persons in the outside community at large. Prisoners should have access to all approved therapeutic drugs and generally employed treatment strategies.

(2) HIV/AIDS Education and Prevention Our AMA: a) Encourages the inclusion of HIV-prevention information as a regular part of correctional staff and inmate education. AIDS education in state and federal prisons should stress abstinence from drug use and high-risk sexual practices, as well as the proper use of condoms as one way of decreasing the spread of HIV; b) Will pursue legislation that encourages state, local, and federal correctional institutions to make condoms available to inmates; and c) Urges medical personnel in correctional institutions to work closely with state and local health department personnel to control the spread of HIV/AIDS, tuberculosis, and other serious infectious diseases within and outside these facilities.

(3) Prison-based HIV Partner Notification Program Our AMA: a) Urges state health departments to take steps to initiate with state departments of correctional services the development of prison-based HIV Partner Notification Programs for inmates convicted of drug-related crimes and their regular sexual partners; and b) Believes that all parties should recognize that maximum effectiveness in an HIV Partner Notification Program will depend on the truly voluntary participation of inmates and the strict observance of confidentiality at all levels.

(CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13)

Disease Prevention and Health Promotion in Correctional Institutions H-430.989

Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward the prevention and control of HIV/AIDS, substance abuse, tuberculosis, and hepatitis. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers and drug treatment center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a recent, active history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs as a sentence or in connection with sentencing.

(CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13)

Standards of Care for Inmates of Correctional Facilities H-430.997

Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance misuse care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism.

(Res. 60, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Amended: Res. 416, I-99; Reaffirmed: CEJA Rep. 8, A-09; Reaffirmation I-09; Modified in lieu of Res. 502, A-12; Reaffirmation: I-12)

Update on Tuberculosis H-440.931

It is the policy of the AMA that: (1) All prison inmates should be tuberculin skin-tested upon arrival and annually thereafter. Those who are positive should be managed as medically appropriate, contact tracing performed, and provisions made for the continued treatment and follow-up of those who are released prior to the completion of their therapy. (2) Staff of both prisons and jails should be tuberculin-tested upon employment and annually thereafter. Those who are positive should be managed as medically

appropriate and contact tracing performed. (3) Both public and health care worker education about TB, its transmission, and the necessity for preventive as well as therapeutic treatment should be increased. (4) Current CDC guidelines for the prevention of tuberculosis in congregate settings should be fully implemented. The protection of persons who are immunocompromised needs to be addressed especially by treatment centers housing such persons. (5) While powered air-purification respirators may be useful for the protection of HIV-infected and other immunocompromised health care workers who care for patients with infectious TB, their routine use for the prevention of the nosocomial transmission of TB is uncalled for in health care facilities where CDC guidelines are fully implemented. (6) States should review their TB control laws using current CDC recommendations and recent legal and ethical publications as guidelines. Where necessary to further protect the public health from the disease, existing laws should be modified and/or new ones added.

(BOT Rep. JJ, A-93; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)

Support for Health Care Services to Incarcerated Persons D-430.997

Our AMA will:

- (1) express its support of the National Commission on Correctional Health Care Standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities;
- (2) encourage all correctional systems to support NCCHC accreditation;
- (3) encourage the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding;
- (4) continue support for the programs and goals of the NCCHC through continued support for the travel expenses of the AMA representative to the NCCHC, with this decision to be reconsidered every two years in light of other AMA financial commitments, organizational memberships, and programmatic priorities;
- (5) work with an accrediting organization, such as National Commission on Correctional Health Care (NCCHC) in developing a strategy to accredit all correctional, detention and juvenile facilities and will advocate that all correctional, detention and juvenile facilities be accredited by the NCCHC no later than 2025 and will support funding for correctional facilities to assist in this effort; and
- (6) support an incarcerated person's right to: (a) accessible, comprehensive, evidence-based contraception education; (b) access to reversible contraceptive methods; and (c) autonomy over the decision-making process without coercion.

(Res. 440, A-04; Amended: BOT Action in response to referred for decision Res. 602, A-00; Reaffirmation I-09; Reaffirmation A-11; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: CMS Rep, 02, I-16; Appended: Res. 421, A-19; Appended: Res. 426, A-19)