

LOUISIANA COVID-19 HEALTH EQUITY TASK FORCE



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LOUISIANA COVID-19 HEALTH EQUITY TASK FORCE

Charge

To provide recommendations relative to health inequities which are affecting communities that are most impacted by the coronavirus. The task force will examine opportunities which provide greater access to high quality medical care and improve health outcomes.

Goals/Outcomes

· Provide reliable and data driven information on COVID-19 safety and prevention;

· Provide the medical community with best practices and protocols for treating communities with underlying medical conditions and health disparities; and

· Ensure testing availability and ease of access for all communities.

Timeline

Louisiana's COVID-19 Health Equity Task Force will begin its work immediately and continue as needed. Its actions and research will ultimately result in improved health equity in Louisiana, serve as a foundation and resource for addressing healthcare disparities in vulnerable populations, and contribute to the progression and improvement of Louisiana's healthcare rankings. To measure progress, a statewide Dashboard on Health Equity will be created.

This task force is funded by the Governor's COVID-19 Response Fund, which is made possible by the Irene W & C.B. Pennington Family Foundation, the Baton Rouge Area Foundation and the Huey and Angelina Wilson Foundation.

LOUISIANA COVID-19 HEALTH EQUITY TASK FORCE

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Office of the Governor
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LOUISIANA COVID-19 HEALTH EQUITY TASK FORCE

SUBCOMMITTEE REPORTS

COVID-19 Testing for Vulnerable and At-Risk Communities

COVID-19 Data and Analysis

COVID-19 in Special Populations – LA Prisons

COVID-19 in Special Populations – Nursing Homes

COVID-19 Policy and Regulatory Affairs

COVID-19 Community Outreach and Stakeholders Engagement (COSE)

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SUBCOMMITTEE REPORTS

COVID-19 Communication and Messaging

COVID-19 Health Equity Dashboard

COVID-19 Racial Disparities in Healthcare

LOUISIANA COVID-19 HEALTH EQUITY TASK FORCE

SUBCOMMITTEE REPORT

Subcommittee Name: Testing for Vulnerable and At-Risk Communities

Subcommittee Members: Meg Brown, PhD, RN (Co-Chair), Raynando Banks, MD (Co-Chair), Gary Wiltz, MD, Rani Whitfield, MD, Senator Regina Barrow, Tiffany Netters, Carol Smith, Terry Davis, PhD, and Rebekah Gee, MD

Priorities/Goals: Review the State-wide Testing Plan for COVID-19, antibody testing and quarantine. Review statewide protocols for testing, geomapping of testing, barriers to testing, testing site locations, COVID-19 mobile testing efforts, local government's role in testing, and contact tracing efforts. A comprehensive recommendation to facilitate COVID-19 testing for vulnerable and at-risk communities (symptomatic and asymptomatic) will be produced.

Statement of the Problem:	The spread of disease over several countries and continents has increased with access to travel, contact with different populations, and living in densely populated areas. Coronavirus 2019 was identified in December 2019 in Wuhan, China and spread across 216 countries and territories. The World Health Organization (WHO) reported more than eight million cases worldwide with greater than 440,000 deaths. The Center for Disease Control and Prevention (CDC) reported that the United States had more than two million cases and more than 116,000 deaths with Louisiana ranking 13th in the United States for confirmed cases. Residents of Louisiana showed symptoms of infection in early March, however infections were underreported due to lack of available tests, restrictions on who received testing, and delayed reporting of testing results. The cost of delayed testing resulted in the rapid spread of the virus, residual impairment to survivors, possibly death, and a burden on the healthcare capacity in Louisiana. The implementation of a comprehensive statewide testing plan will facilitate COVID-19 testing for vulnerable and at risk communities. This plan will produce early identification and treatment initiation of positive cases, improvement of contact tracing efforts, containment of virus transmission, and the reduction in the loss of life. The COVID-19 pandemic spread rapidly across countries and continents since its identification in December 2019. Since the pandemic's identification and spread, Louisiana has experienced challenges with testing, obtaining

	results, and slowing the spread of the virus. The implementation of a comprehensive testing plan for COVID-19 will facilitate the testing for vulnerable and at-risk communities to improve the health outcomes of those who test positive and locate others who may be infected due to contact with someone who tested positive.
Background:	The first presumptive case of COVID-19 in Louisiana was reported on March 9, 2020. There have been confirmed cases in all 64 parishes with the majority of the cases in the New Orleans metro area. In efforts to slow the spread of the virus, Governor John Bel Edwards closed schools on March 16, 2020 and enacted a stay at home order on March 23, 2020. The spread of COVID-19 is associated with the Mardi Gras festivities held during February 2020. The rapid spread of the virus and alarming number of deaths resulted in President Trump declaring Louisiana a major disaster area. On June 17, 2020, The Louisiana Department of Health (LDH) reported 48,634 confirmed cases with 37,017 presumed recovered and 2,950 deaths due to COVID-19. The Louisiana Dashboard from the LDH documented 28,415 tests performed by the State Lab and 516,806 commercial tests as of June 17, 2020.
Supporting Data/Evidence:	The review of the Statewide Testing Plan included: • A baseline of 100,000 tests in the month of April • Initial testing focused on areas of high positivity • Testing per capita varied across all parishes in the state, ranging from 0.1% to 9.52% per capita • A goal to increase testing by 100,000 tests per month **by**: • A Multi-pronged approach to test vulnerable populations • Leveraging in-state laboratory resources with coordinated regional mapping to reduce transport time for specimens • Staff and personnel training in congregate settings to provide comprehensive education in the use of personal protective equipment, infection control strategies, and guidance on cohorting positive patients • Incorporation of multiple specimen collection types • Utilization of a flexible model in testing to accommodate the needs in different settings and varying resources in partner communities • Increased access to minority populations, rural communities with reduced access to testing, and populations with special needs • Testing of congregate populations (nursing homes, incarceration facilities, developmentally disabled group homes and assisted living facilities) and Community populations (community based fixed and mobile testing sites) • A multi-sector Testing Action Collaborative (TAC) formed to increase coordination of testing efforts and design a collaborative statewide testing model • Three categories of SARS-COV-2 testing (intrinsic testing, state reference laboratories, and out of state commercial laboratories) • Additional testing at mobile units and drive up testing

	• Additional sites for testing including Rural Health centers, churches, local CVS, Walmart and Walgreens pharmacies, and LA Fresenius dialysis centers • The process for activating the Contact Tracing System is present • The establishment of a Contact Tracing Action Coalition (CTAC) to address infrastructure needs for the implementation of the statewide contact tracing program • Sentinel surveillance system with diagnostic and monthly serologic testing including testing at two school based clinics in each of the nine health regions of the state
Summary of Findings:	• Existing outline of priority testing • Provision of detailed testing for who, when, and where • There is NO gold standard for testing and the LDH wants to collect both virus and serology test data. They also need to collect data on <u>what platform is being used</u> for each test. They are not all interchangeable • Presentation of protocol for positive COVID-19 cases • The plan addressed contact tracing efforts • The plan did not have a compliance, enforcement or evaluation component • The plan noted the creation of a hub and Spoke model to provide each regional leadership a support framework • The plan lacked a mechanism for members of the Community Populations to locate available test sites, criteria for testing, and fee schedule
Recommendations (based on priorities):	1. Collect data on <u>identical platform being used</u> for each test. They are not all interchangeable. Some PCR tests look at 2 genes, some 3. The real-world sensitivity is quite variable. Some antibody tests look at spike protein, others at nucleocapsid. The best anyone has is an EUA (Emergency Use Agreement) which is a provisional FDA approval. 2. Clarify the compliance, enforcement and evaluation component in the plan. 3. Clarify how home testing kits will be delivered, returned, and results reported back to patients and state lab. 4. Describe how members of the Community Populations may locate and access available testing sites, criteria for testing, and fee schedule. 5. Include a process for testing students, faculty, and staff returning to educational settings.
Responsible Parties and Timeline for Completion (if applicable)	N/A
Committee Contact(s):	Raynando Banks, MD or Meg Brown, PhD, RN

LOUISIANA COVID-19 HEALTH EQUITY TASK FORCE

SUBCOMMITTEE REPORT

Subcommittee Name: COVID-19 Data and Analysis

Subcommittee Members: Simone Rambotti, PhD, Chair; Peter Katzmarzyk, PhD; Jacqueline Harris, PhD; Daniel Sarpong, Ph.D.

Priorities/Goals:

- **A comprehensive statewide report on COVID-19 data based on age, gender, and race with geospatial analysis of mortality will be developed.**
- **Obtain COVID 19 data to include deaths by age/race/zip codes; hospitalizations by age and race; cases and deaths in nursing homes and prisons by age and race; # of people tested by age and race; obesity data; cross tabulation of data with comorbidities; Various nationalities, including Latino community numbers, will be included.**

Statement of the Problem:	"Pandemics and economic recessions exacerbate disparities that ultimately hurt us all. Therefore, state and local leaders cannot design equitable response and recovery strategies without monitoring COVID's impacts among socially and economically marginalized groups."[1] Thus, an important consideration in establishing a public health surveillance system related to COVID-19 is to be able to "Collect, analyze, and report data disaggregated by age, race, ethnicity, gender, disability, neighborhood, and other sociodemographic characteristics."[1] [1]The Robert Wood Johnson Foundation (2020). *Health Equity Principles for State and Local Leaders in Responding to, Reopening, and Recovering from COVID-19*. Available at: https://www.rwjf.org/.
Background:	To adequately address health inequities, it is important to be able to identify these inequities in the population using valid data. The *COVID-19 Data and Analysis Subcommittee* was tasked with obtaining COVID-19 data for the state of Louisiana, and to present these data by age/race/zip codes, etc. These data are housed by the Louisiana Department of Health and partially presented on their dashboard: http://ldh.la.gov/coronavirus/. Additional data are available for prisons and nursing homes; however, these sources provide only overall totals, and they do not disaggregate the data by age, sex, race or ethnicity. This is a major limitation of the existing data. Prisons: https://doc.louisiana.gov/doc-covid-19-testing/ Nursing Homes: http://ldh.la.gov/index.cfm/page/3965/

Supporting Data/Evidence:	Please see the Appendix for a summary of data on COVID-19 in the Louisiana population. Data on tests, positive cases, and hospital admissions were provided to the Subcommittee by the Louisiana Department of Health. Data on deaths were collected by the Subcommittee from the Louisiana Department of Health online Coronavirus dashboard (address: http://ldh.la.gov/coronavirus) for the purpose of preparing this report.
Summary of Findings:	Based on data found in the Appendix, the following trends are evident: <u>Race</u> • The Black population has been disproportionally affected by COVID-19. • In the state of Louisiana, 32.7% of the population is Black. Excluding individuals whose race was recorded as "unknown," the data below show that 60.4% of positive cases, 63.3% of hospital admissions, and 53.9% of deaths occurred among Blacks. • Whites comprise 62.9% of the population of Louisiana. Net of unknown cases, whites comprise 32.1% of positive cases, 30.8% of hospital admissions, and 44.5% of deaths. • Race is unknown in a large portion of tests (21.9%) and positive cases (21.5%). • Information on other races is very limited. This is a cause of concern because it may mean that other races are not being properly counted. <u>Ethnicity</u> • Hispanics comprise 5.2% of the population of Louisiana. According to the data below, once individuals with unknown ethnicity are excluded, it would appear that Hispanics comprise 3.9% of tests, 5.1% of positive cases, 3.9% of hospital admissions, and 2.3% of deaths. • Non-Hispanics comprise 94.8% of the Louisiana population. If we exclude individuals with missing information about ethnicity, non-Hispanics represent 96.1% of the tests, 94.9% of the positive cases, 96.1% of the hospital admissions, and 97.7% of the deaths. • We are particularly concerned with the large share of data reporting unknown ethnicity. Ethnicity is unknown in 41.3% of tests, 36.9% of positive cases, 15.7% of hospital admissions, and 12.2% of deaths. With such a large amount of missing data, any estimate of disparity by ethnicity is very unstable and should not be trusted. • These estimates, in fact, seem to be inconsistent with data being reported elsewhere. Recent reports of analyses conducted by Louisiana State University, LCMC Health, and Ochsner on data from testing sites in New Orleans, show that the "Hispanic community is being disproportionately infected with the coronavirus"[2]. We believe that Louisiana Department of Health data may be undercounting the infection rate among the Hispanic population. <u>Gender</u> • Women are more likely than men to be tested, have a positive result, and be admitted.

	• Men are more likely to die of COVID-19: 53% of those who died were men while 47% of those who died were women. <u>Age</u> • There is a very strong age gradient in those affected by COVID-19, with the greatest risk of being positive or admitted to hospital being among those aged 60+ years. • Further, the risk of death increases sharply after age 70 years, with 67.5% of the deaths being in this age bracket. • It should also be noted that the percentage of those admitted who are in the middle-aged groups (e.g., 10.1% in age 40-49 and 16.5% in age 50-59) is not trivial. <u>Geographical Variation</u> • LDH provided this subcommittee with data disaggregated by 9 regions. • These data largely confirm the state-wide pattern regarding disparities between Black and White population. • These data report no specific information on other races. • These data report a large share of unknown race and ethnicity. • We had no access to data on hospital admissions and deaths by ethnicity. • We had no access to data on tests, hospital admissions, and deaths by gender. • We had no access to data on tests, hospital admissions, and deaths by age. • These data present sizeable variation in terms of reporting across regions. For instance, 16.6% of tests and 17.6% of positive cases are recorded as unknown races in region 1 (which include New Orleans). These numbers increase to 33.8% and 36.5% in region 2 (which include Baton Rouge). <u>Comorbidities</u> • We had no access to data on comorbidities. [2]Santana Rebecca (2020). *New Orleans: Concern over coronavirus in Hispanic community*. Available at: https://apnews.com/54c42dcb030cdc8f34ce384d7ad9f86c.
Data Limitations:	The results presented above are based on the data made available to the committee. However, it should be noted that there are several limitations with these data: 1) The LDH dashboard (as of June 7, 2020) reports 434,065 COVID-19 tests performed at state and commercial labs. However, the data available to the subcommittee only included a sample of 193,429 tests. The subcommittee is unsure how representative the sample is of the overall population. 2) In the data on testing that was received by the subcommittee, 22% were missing information on race, and 41% were missing data on ethnicity. It is unclear if and how such missing data will bias our estimates, as it is unknown if these data are missing at random or in some systematic way.

	3) The data available from prisons and nursing homes is not disaggregated by age, race and gender; therefore, it is impossible to understand heath disparities in these two high-risk populations. 4) Data on comorbidities was not provided to the subcommittee, so it is not possible to explore the role of comorbidities on explaining race, gender and ethnic disparities in the development of COVID-19 complications. 5) Data by zip code were not provided. The lowest geographical level of data was the LDH region (for tested and positive). 6) Data from various testing sites present large amounts and varying degree of missing information.
Recommendations (based on priorities):	We advance the following recommendations: 1) Standardized protocols should be established to ensure that information is consistently collected across the multiple testing sites, especially those pertaining to racial and ethnic identity. 2) Outreach initiatives should be taken to increase the representation of the Hispanic community. Members of this community may avoid being tested and getting care because of concerns regarding their immigration status (even when documented), fear of deportation[3], and language barriers[4]. We recommend that data collectors work with organizations trusted by the Latino community and that bilingual testing sites are established. 3) Outreach initiatives should also be taken to ensure that other races, e.g. Asians and Native Americans, are properly counted. In this case also we recommend that data collection occurs in collaboration with trusted organizations, e.g. tribal organizations and faith-based organizations or nonprofits within the Asian community. 4) Information on common comorbidities should be made available for tests, positive cases, hospital admissions, and deaths. It should be possible to cross-tabulate this information with sociodemographic information, such as race, ethnicity, gender, and age. 5) Geographical information on tests, positive cases, hospital admissions, and deaths by all the relevant sociodemographic data should be available at a lower level than LDH regions. Provided that measures are taken to prevent identification of specific individuals, these data should ideally be available at the level of ZIP codes. 6) Disaggregated data on COVID-19 in nursing homes should be collected and publicly available. 7) The Louisiana Department of Health should work in collaboration with the Louisiana Department of Public Safety & Corrections to collect and share disaggregated data on COVID-19 in prisons. 8) The ultimate goal should be to create a data warehouse where harmonized data can be easily extracted for analysis. 9) Finally, and most importantly, it is crucial that proper resources are allocated to the Louisiana Department of Health to accomplish these goals. [3]Williams Jessica (2020). *Seeing surge in Hispanic coronavirus cases, New Orleans leaders urge outreach to Latino community*. Available at: https://www.nola.com/news/coronavirus/article_41851300-9aef-11ea-addf-eb6520332411.html.

	[4]WWL-TV (2020). *New bilingual COVID-19 testing site aims to curb spread within Hispanic community*. Available at: https://www.wwltv.com/video/news/health/coronavirus/new-bilingual-covid-19-testing-site-aims-to-curb-spread-within-hispanic-community/289-f35b444b-8c31-44ea-b665-6b480569ab5e.
Committee Contact(s):	Simone Rambotti, PhD, Chair

Appendix

Louisiana COVID-19 Data: Tables

Table 1: Race (Combined Other Races)

Race	% Population	% Tested	Count Tested	% Positive	Count Positive	% Admitted	Count Admitted	% Deaths	Count Deaths
Black	32.70	32.72	63,292	47.45	15,518	60.35	3,291	53.20	1,543
White	62.90	39.59	76,582	25.20	8,241	29.32	1,599	43.94	1,275
Other (Combined)	4.40	5.74	11,112	5.86	1,915	5.63	307	1.57	46
Unknown	0.00	21.94	42,443	21.49	7,027	4.69	256	1.20	35
Total	100.00	100.00	193,429	100.00	32,701	100.00	5,453	99.91	2,898

Table 2: Race (Disaggregated Other Races)

Race	% Population	% Positive	Count Positive	% Admitted	Count Admitted	% Deaths	Count Deaths
Black or African American	32.70	47.45	15,518	60.35	3,291	53.20	1,543
White	62.90	25.20	8,241	29.32	1,599	43.94	1,275
American Indian and Alaska Native	0.80	0.21	70	0.26	14	0.07	2
Asian	1.80	0.68	224	0.59	32	0.78	23
Native Hawaiian and Other Pacific Islander	0.10	0.06	20	0.04	2	0.08	2
Other	1.70	4.90	1,601	4.75	259	0.64	19
Unknown	0.00	21.49	7,027	4.69	256	1.20	35
Total	100.00	100.00	32,701	100.00	5,453	99.91	2,898

Table 3: Ethnicity

Ethnicity	% Population	% Tested	Count Tested	% Positive	Count Positive	% Admitted	Count Admitted	% Deaths	Count Deaths
Hispanic	5.20	2.32	4,488	3.24	1,061	3.26	178	2.00	58
Non-Hispanic	94.80	56.42	109,133	59.88	19,581	81.07	4,421	85.80	2,489
Unknown	0.00	41.26	79,808	36.88	12,059	15.66	854	12.20	354
Total	100.00	100.00	193,429	100.00	32,701	100.00	5,453	100.00	2,901

Table 4: Gender

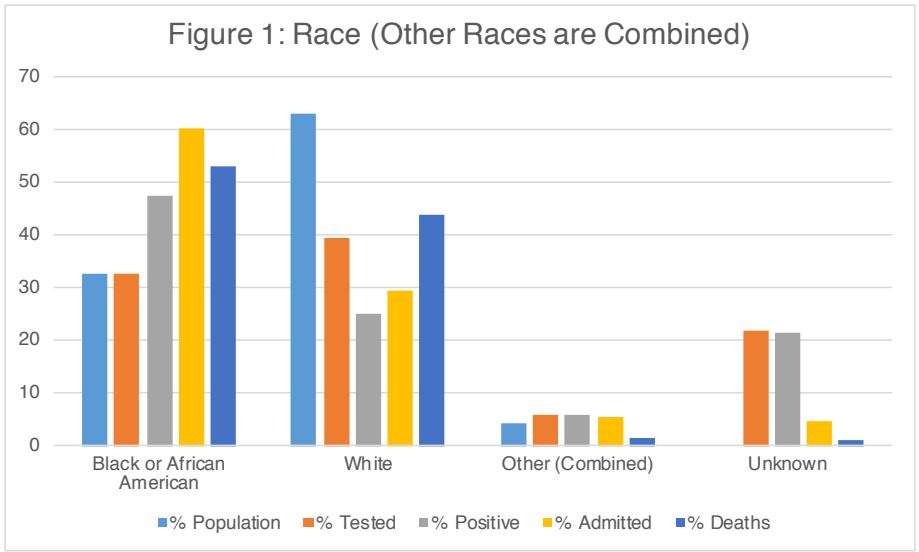
Gender	% Population	% Tested	Count Tested	% Positive	Count Positive	% Admitted	Count Admitted	% Deaths	Count Deaths
Male	48.80	40.33	78,019	40.24	13,158	46.16	2,517	53.00	1,538
Female	51.20	57.22	110,681	55.84	18,259	52.63	2,870	47.00	1,363
Unknown	0.00	2.44	4,729	3.93	1,284	1.21	66	0.00	0
Total	100.00	100.00	193,429	100.00	32,701	100.00	5,453	100.00	2,901

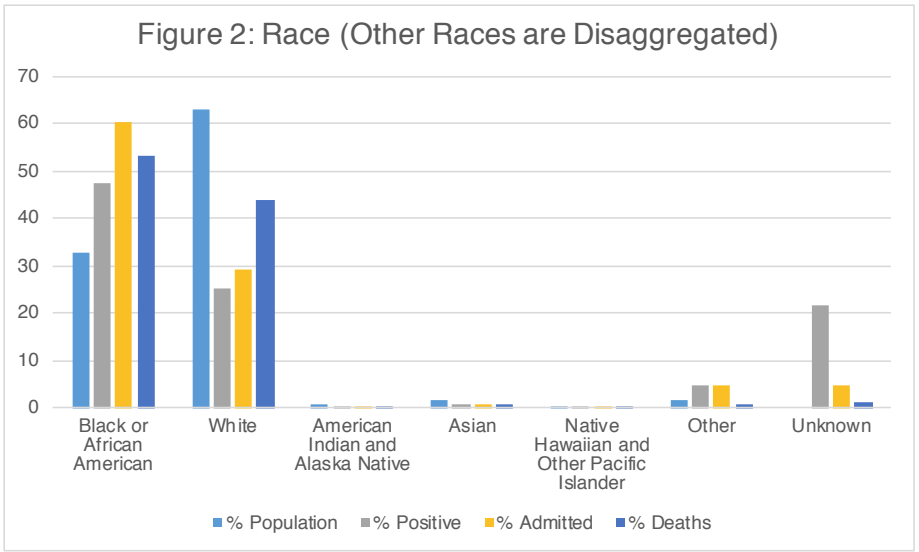
Table 5: Age

Age	% Positive	Count Positive	% Admitted	Count Admitted	Age	% Deaths	Count Deaths
Age 0-19	3.16	1,034	0.79	43	< 18	0.07	2
Age 20-29	12.05	3,939	2.99	163	18 - 29	0.38	11
Age 30-39	15.88	5,192	5.98	326	30 - 39	1.69	49
Age 40-49	16.55	5,413	10.10	551	40 - 49	3.65	106
Age 50-59	18.31	5,986	16.47	898	50 - 59	8.76	254
Age 60+	33.70	11,019	63.67	3,472	60 - 69	17.99	522
Unknown	0.36	118	0.00	0	70+	67.46	1957
Total	100.00	32,701	100.00	5,453	Total	100.00	2901

Notes: Population data are from the 2019 U.S. Census estimates. Tested, positive, and admitted data are from the Louisiana Department of Health (partial data through May 18, 2020). Deaths data are from the Louisiana Department of Health online Coronavirus dashboard (address: http://ldh.la.gov/Coronavirus/; data collected on June 14, 2020). Please, notice that the Louisiana Department of Health online Coronavirus dashboard reports 2,901 deaths, but the percentages of deaths by race do not sum up to 100, and that age groups for deaths are slightly different from age groups for positive, admitted, and tested.

Louisiana COVID-19 Data: Figures





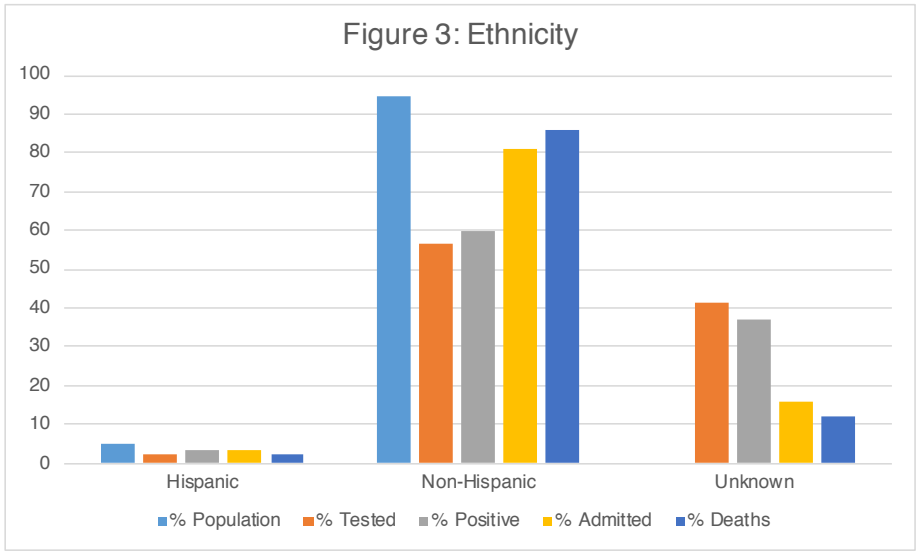


Figure 3: Ethnicity
100
90
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Hispanic
Non-Hispanic
Unknown
% Population
% Tested
% Positive
% Admitted
% Deaths

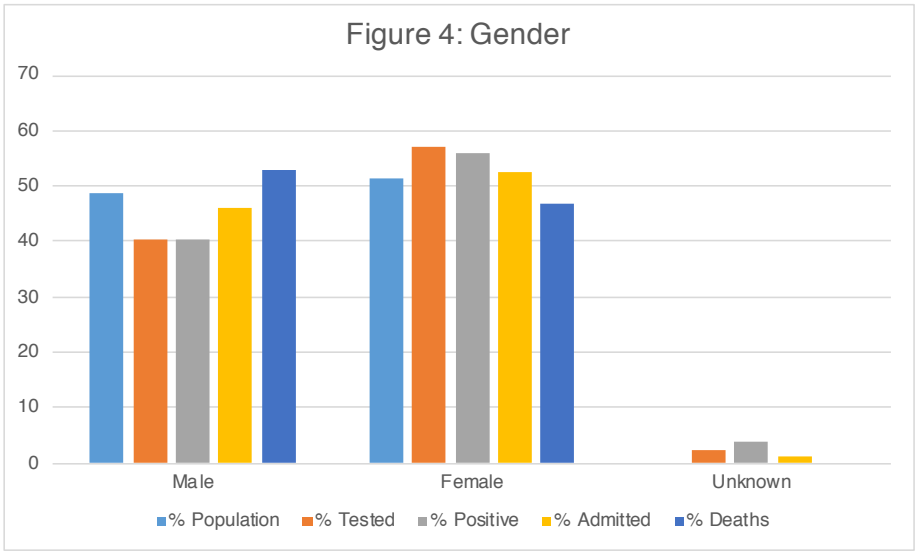
Figure 4: Gender
70
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Male
Female
Unknown
% Population
% Tested
% Positive
% Admitted
% Deaths

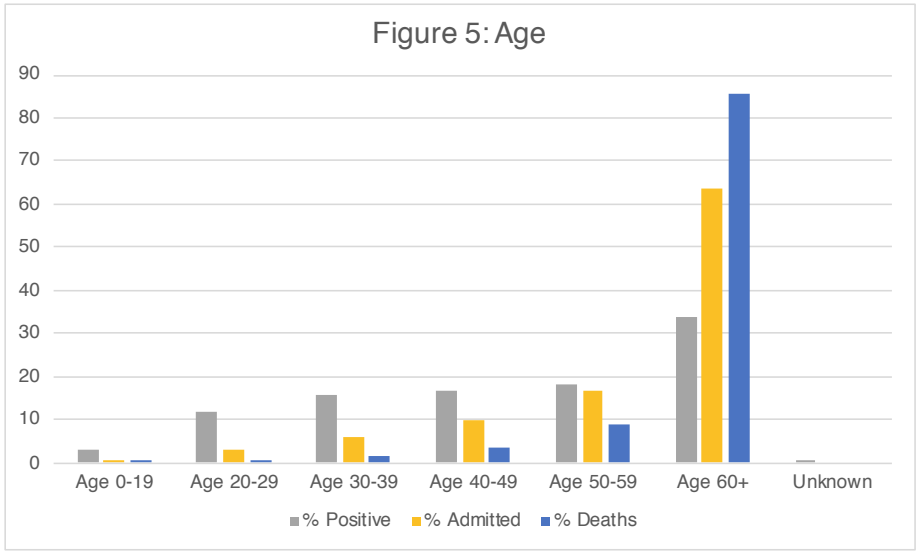
Figure 5: Age
90
80
70
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50
40
30
20
10
0
Age 0-19
Age 20-29
Age 30-39
Age 40-49
Age 50-59
Age 60+
Unknown
% Positive
% Admitted
% Deaths

Table 6: Race by LDH Region

Race	% Pop	% Tested	Count Tested	% Positive	Count Positive	% Deaths	Count Deaths
Region 1							
Black	40.79	42.18	25,913	52.60	7,283	63.54	629
White	50.73	34.58	21,239	23.13	3,203	33.64	333
Other	8.48	6.63	4,070	6.73	932	2.73	27
Unknown	0.00	16.61	10,206	17.54	2,428	0.10	1
Total	100.00	100.00	61,428	100.00	13,846	100.00	990
Region 2							
Black	41.10	32.78	8,189	41.39	2,383	56.91	243
White	53.18	28.24	7,056	17.14	987	41.22	176
Other	5.72	5.19	1,297	4.98	287	1.87	8
Unknown	0.00	33.79	8,443	36.49	2,101	0.00	0
Total	100.00	100.00	24,985	100.00	5,758	100.00	427
Region 3							
Black	26.42	28.19	5,522	52.48	1,695	48.54	150
White	66.51	36.67	7,183	27.62	892	50.49	156
Other	7.07	4.15	812	3.44	111	0.97	3
Unknown	0.00	30.99	6,070	16.47	532	0.00	0
Total	100.00	100.00	19,587	100.00	3,230	100.00	309
Region 4							
Black	27.14	23.76	3,664	34.55	588	29.59	50
White	68.51	42.32	6,525	30.20	514	70.41	119
Other	4.35	7.83	1,207	6.70	114	0.00	0
Unknown	0.00	26.10	4,024	28.55	486	0.00	0
Total	100.00	100.00	15,420	100.00	1,702	100.00	169
Region 5							
Black	21.55	15.89	1,224	35.19	202	38.24	26
White	73.60	44.03	3,392	34.15	196	57.35	39
Other	4.85	4.15	320	3.83	22	4.41	3
Unknown	0.00	35.92	2,767	26.83	154	0.00	0
Total	100.00	100.00	7,703	100.00	574	100.00	68

Race	% Pop	% Tested	Count Tested	% Positive	Count Positive	% Deaths	Count Deaths
Region 6							
Black	27.09	23.17	1,570	32.74	239	56.00	28
White	68.00	37.14	2,516	17.95	131	42.00	21
Other	4.91	8.01	543	9.04	66	2.00	1
Unknown	0.00	31.68	2,146	40.27	294	0.00	0
Total	100.00	100.00	6,775	100.00	730	100.00	50
Region 7							
Black	38.73	40.79	9,013	63.11	1,533	68.73	200
White	56.21	40.50	8,950	22.60	549	30.58	89
Other	5.06	3.55	785	2.80	68	0.34	1
Unknown	0.00	15.16	3,350	11.49	279	0.34	1
Total	100.00	100.00	22,098	100.00	2,429	100.00	291
Region 8							
Black	37.77	29.47	4,153	40.60	652	57.43	58
White	59.46	39.27	5,534	21.30	342	40.59	41
Other	2.78	8.33	1,174	11.33	182	1.98	2
Unknown	0.00	22.92	3,230	26.77	430	0.00	0
Total	100.00	100.00	14,091	100.00	1,606	100.00	101
Region 9							
Black	16.68	18.93	4,030	33.43	943	24.62	64
White	79.32	66.55	14,168	50.58	1,427	74.62	194
Other	4.00	4.21	896	4.68	132	0.38	1
Unknown	0.00	10.31	2,196	11.31	319	0.38	1
Total	100.00	100.00	21,290	100.00	2,821	100.00	260

Notes: Population data are from the U.S. Census. Tested and positive data are from the Louisiana Department of Health (partial data through May 18, 2020). Deaths data are from the Louisiana Department of Health online Coronavirus dashboard (address: http://ldh.la.gov/Coronavirus/; data collected on June 7, 2020).

Table 7: Ethnicity by LDH Region

Ethnicity	% Pop	% Tested	Count Tested	% Positive	Count Positive
Region 1					
Hispanic	10.08	4.88	2,999	5.72	792
Non-Hispanic	89.92	69.38	42,616	69.53	9,627
Unknown	0.00	25.74	15,813	24.75	3,427
Total	100.00	100.00	61,428	100.00	13,846
Region 2					
Hispanic	4.00	1.00	249	1.16	67
Non-Hispanic	96.00	41.02	10,250	40.52	2,333
Unknown	0.00	57.98	14,486	58.32	3,358
Total	100.00	100.00	24,985	100.00	5,758
Region 3					
Hispanic	5.05	1.51	295	1.98	64
Non-Hispanic	94.95	51.74	10,135	66.35	2,143
Unknown	0.00	46.75	9,157	31.67	1,023
Total	100.00	100.00	19,587	100.00	3,230
Region 4					
Hispanic	3.67	0.88	135	1.06	18
Non-Hispanic	96.33	52.96	8,167	54.82	933
Unknown	0.00	46.16	7,118	44.12	751
Total	100.00	100.00	15,420	100.00	1,702
Region 5					
Hispanic	3.58	0.35	27	0.00	0
Non-Hispanic	96.42	14.12	1,088	14.98	86
Unknown	0.00	85.53	6,588	85.02	488
Total	100.00	100.00	7,703	100.00	574
Region 6					
Hispanic	3.90	0.61	41	0.41	3
Non-Hispanic	96.10	22.11	1,498	17.12	125
Unknown	0.00	77.28	5,236	82.47	602
Total	100.00	100.00	6,775	100.00	730

Ethnicity	% Pop	% Tested	Count Tested	% Positive	Count Positive
Region 7					
Hispanic	3.50	1.50	331	1.44	35
Non-Hispanic	96.50	65.61	14,498	74.80	1,817
Unknown	0.00	32.89	7,269	23.75	577
Total	100.00	100.00	22,098	100.00	2,429
Region 8					
Hispanic	2.24	0.57	81	0.87	14
Non-Hispanic	97.76	49.35	6,954	47.88	769
Unknown	0.00	50.07	7,056	51.25	823
Total	100.00	100.00	14,091	100.00	1,606
Region 9					
Hispanic	4.39	1.52	324	2.34	66
Non-Hispanic	95.61	65.27	13,896	61.96	1,748
Unknown	0.00	33.21	7,070	35.70	1,007
Total	100.00	100.00	21,290	100.00	2,821

Notes: Population data are from the U.S. Census. Tested and positive data are from the Louisiana Department of Health (partial data through May 18, 2020).

Table 8: Gender by LDH Region

Gender	% Positive	Count Positive	Gender	% Positive	Count Positive
Region 1			**Region 6**		
Male	39.61	5,484	Male	50.27	367
Female	55.58	7,696	Female	49.59	362
Unknown	4.81	666	Unknown	0.14	1
Total	100.00	13,846	Total	100.00	730
Region 2			**Region 7**		
Male	38.56	2,220	Male	38.78	942
Female	53.42	3,076	Female	60.89	1,479
Unknown	8.02	462	Unknown	0.33	8
Total	100.00	5,758	Total	100.00	2,429
Region 3			**Region 8**		
Male	40.59	1,311	Male	48.07	772
Female	57.37	1,853	Female	51.62	829
Unknown	2.04	66	Unknown	0.31	5
Total	100.00	3,230	Total	100.00	1,606
Region 4			**Region 9**		
Male	38.90	662	Male	41.30	1,165
Female	59.99	1,021	Female	56.79	1,602
Unknown	1.12	19	Unknown	1.91	54
Total	100.00	1,702	Total	100.00	2,821
Region 5					
Male	40.42	232			
Female	59.06	339			
Unknown	0.52	3			
Total	100.00	574			

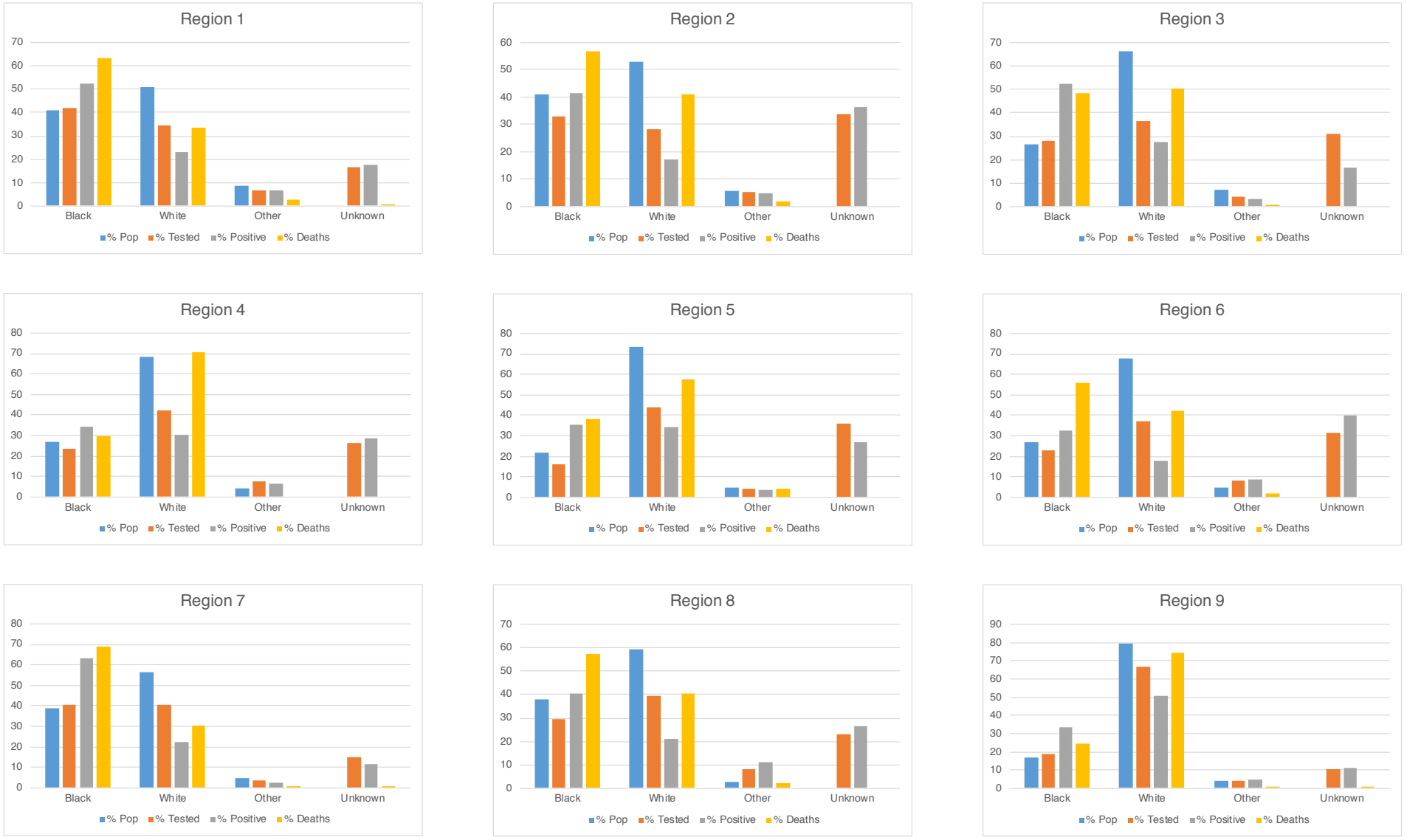
Notes: Data are from the Louisiana Department of Health (partial data through May 18, 2020).

Table 9: Age by LDH Region

Age	% Positive	Count Positive	Age	% Positive	Count Positive	Age	% Positive	Count Positive
Region 1			**Region 4**			**Region 7**		
Age 0-19	2.14	296	Age 0-19	3.76	64	Age 0-19	5.27	128
Age 20-29	11.17	1,546	Age 20-29	12.51	213	Age 20-29	13.26	322
Age 30-39	16.84	2,332	Age 30-39	14.10	240	Age 30-39	14.41	350
Age 40-49	17.36	2,403	Age 40-49	13.04	222	Age 40-49	16.10	391
Age 50-59	19.44	2,691	Age 50-59	18.27	311	Age 50-59	17.62	428
Age 60+	32.97	4,565	Age 60+	38.31	652	Age 60+	33.31	809
Unknown	0.09	13	Unknown	0.00	0	Unknown	0.04	1
Total	100.00	13,846	Total	100.00	1,702	Total	100.00	2,429
Region 2			**Region 5**			**Region 8**		
Age 0-19	3.30	190	Age 0-19	2.96	17	Age 0-19	8.66	139
Age 20-29	12.14	699	Age 20-29	14.46	83	Age 20-29	16.50	265
Age 30-39	15.63	900	Age 30-39	12.37	71	Age 30-39	16.25	261
Age 40-49	16.45	947	Age 40-49	17.07	98	Age 40-49	16.38	263
Age 50-59	17.58	1,012	Age 50-59	17.07	98	Age 50-59	13.95	224
Age 60+	33.61	1,935	Age 60+	35.71	205	Age 60+	28.27	454
Unknown	1.30	75	Unknown	0.35	2	Unknown	0.00	0
Total	100.00	5,758	Total	100.00	574	Total	100.00	1,606
Region 3			**Region 6**			**Region 9**		
Age 0-19	2.88	93	Age 0-19	3.84	28	Age 0-19	2.76	78
Age 20-29	10.31	333	Age 20-29	22.33	163	Age 20-29	11.17	315
Age 30-39	14.58	471	Age 30-39	17.53	128	Age 30-39	15.49	437
Age 40-49	15.54	502	Age 40-49	16.71	122	Age 40-49	16.45	464
Age 50-59	18.54	599	Age 50-59	17.53	128	Age 50-59	17.55	495
Age 60+	37.89	1,224	Age 60+	21.92	160	Age 60+	35.94	1,014
Unknown	0.25	8	Unknown	0.14	1	Unknown	0.64	18
Total	100.00	3,230	Total	100.00	730	Total	100.00	2,821

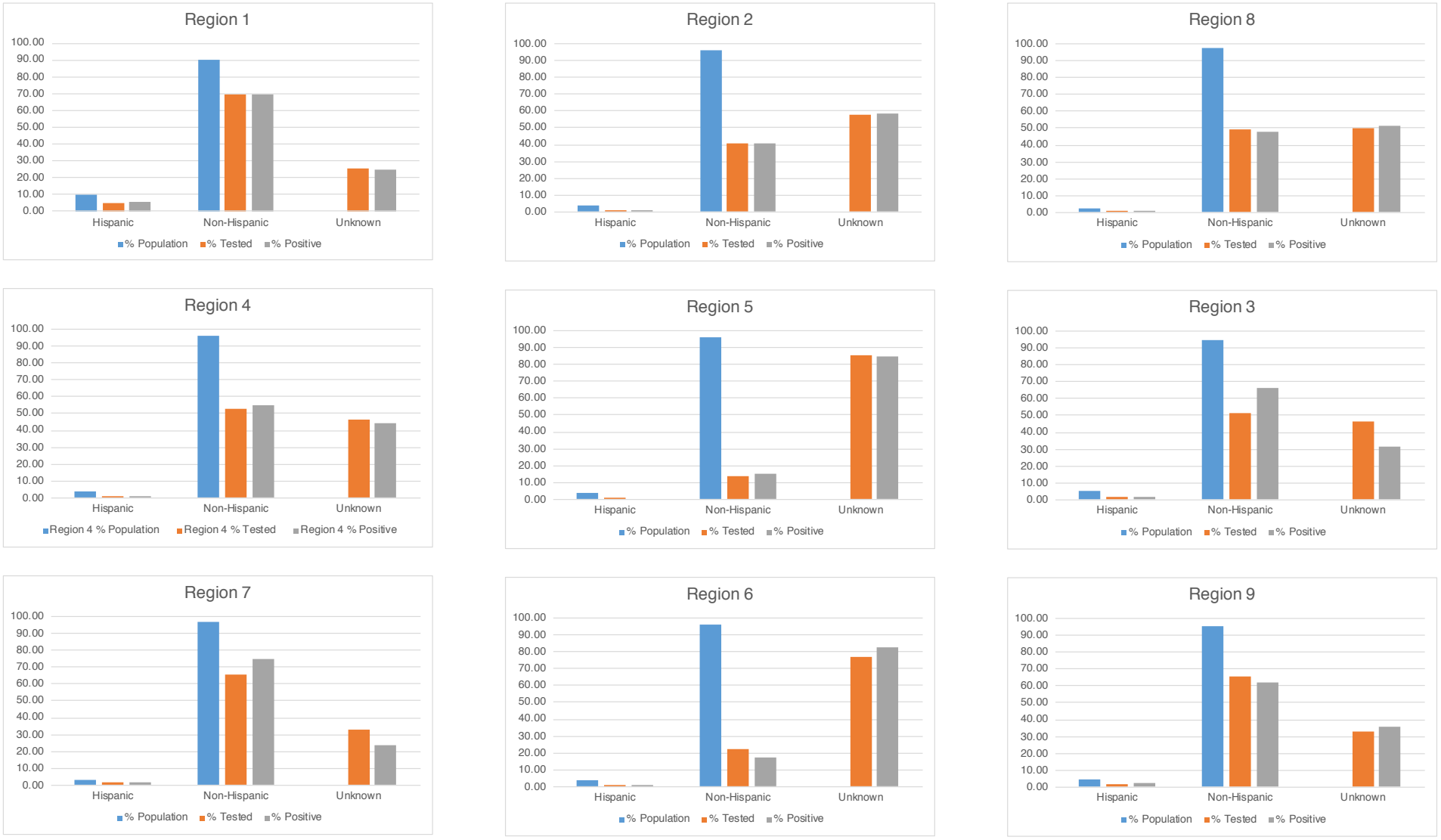
Notes: Data are from the Louisiana Department of Health (partial data through May 18, 2020).

Figure 6: Race by LDH Region



Notes: Population data are from the U.S. Census. Tested and positive data are from the Louisiana Department of Health (partial data through May 18, 2020). Deaths data are from the Louisiana Department of Health online Coronavirus dashboard (address: http://ldh.la.gov/Coronavirus/; data collected on June 7, 2020).

Figure 7: Ethnicity by LDH Region



Notes: Population data are from the U.S. Census. Tested and positive data are from the Louisiana Department of Health (partial data through May 18, 2020).

LOUISIANA COVID-19 HEALTH EQUITY TASK FORCE

SUBCOMMITTEE FINAL REPORT JUNE 15.2020

Subcommittee Name: COVID-19 Special Populations – LA Prisons

Subcommittee Members: Shelina Davis, MPH, MSW – Co-Chair, Michael McClanahan – Co-Chair, Frederick L. Thomas, MSCJ, Erica Rogers, RN, Faye Grimsley, Ph.D., CIH, MSPH, Connie Arnold, Ph.D.

Subject Matter Expert Contributors: Andrea Armstrong, JD, MPA, Ashley Wennerstrom, PhD, MPH.

Priorities/Goals: To explore the impact of COVID-19 on special populations, specifically Louisiana's prison population (examining the # of positive cases, deaths, age, gender, race, geographic location); and to draft a comprehensive plan to address safety and prevention of COVID-19 in Louisiana's prison population.

First person testimony of incarcerated person's experience.

5/21/2020 11:58 AM

Hello [redacted]
Thank you for writting me. Yes my sister [redacted] is very concerned about me. I have several problems going on here. I have 4 leaking heart valves and they cannot do surgery because I will not survive. They started to leak after the prison would continually run out of my heart meds that I take 2 times a day. They ran out again last week and my sister called up here and that made some people mad. Now I have the corona virus. I have no immune system so my sister is really worried. It's been days the doc. ordered a z pack, but I still haven't got it as of yet. Today they ran out of my blood pressure pill I take 3 times a day to raise my blood pressure because I have very low blood pressure. My sister wants to talk to you if you can call her at [redacted] She is concerned how we are treated. So these are some issuses I have . Thank you for the support you give to us here.
[redacted]

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"I don't know how much longer this is going to go on before this entire prison be totally infected with this virus...if we test positive and have some type of weak immune system this will be their excuse why the inmate died, we need help serious help because this virus is starting to spread in this place, somebody needs to come out here and see investigate what is going on here !!!" - 5.14.20, from inside Raymond Laborde Prison[1]

Executive Summary

The purpose of the Louisiana Health Equity Task Force Special Populations – LA Prisons Sub-Committee was to explore the impact of COVID-19 on special populations, specifically Louisiana's prison population (examining the # of positive cases, deaths, age, gender, race, geographic location); and to draft a comprehensive plan to address safety and prevention of COVID-19 in Louisiana's prison population. The sub-committee members agreed to expand the population of focus to include all people who are incarcerated, including prisons, jails, and juvenile detention centers.

As a result of the sub-committee members' exploration of the impact of COVID-19 on people who are incarcerated in Louisiana correctional facilities, we found the following:

1. Infections and deaths for people in detention facilities, including staff and the incarcerated, are likely to rise. This increase will continue to have a disproportionate impact on Black, Indigenous, *and* People of Color (BIPOC) and the elderly. Medical risk of death is not (and should not be) part of a person's sentence.
2. Prisons, juvenile detention centers, and jails have not sufficiently reduced their populations to enable social distancing or employ other basic preventative tools to combat the spread of COVID-19.
3. Prisons and jails have attempted to separate infected people from non-infected without the benefit of widespread testing, based on the presence of a high temperature or overt symptoms.
4. Separation measures between positive COVID-19 people and non-infected have not been strictly enforced and in some cases, like Camp J, are impossible because of staffing and incarcerated labor.
5. The use of solitary, instead of ethical medical isolation, to address COVID-19 is dangerous because it punishes reporting, impedes treatment, and limits public health responses.
6. Medical treatment for COVID has been plagued by lack of staff, uniform procedures, protocols, and implementation, and has impacted the ability of detention facilities to treat other medical and mental health issues.
7. The shortage in publicly available information about COVID-19 infections among incarcerated populations and staff endanger public health. There is no public safety without public health.[49]

Based on these findings, we recommend the following (*See Summary of Recommendations below for additional details*):

Immediate-term Recommendations

- #1. We recommend the governor appoint a Statewide Public Health & Corrections COVID-19 Coordinator to work in close collaboration with a team to support jails and prisons in complying with CDC and OSHA guidelines and make recommendations regarding pandemic practices, policies, and procedures in prisons and jails.
- #2: Decarceration or controlled evacuation to enable proper social distancing.
- #3. Ensure appropriate health care treatment, including evacuation where symptomatic, for all incarcerated people who test positive.
- #4. Enable social distancing as the cornerstone of mitigation
- #5. Prioritize Testing, Hygiene, and Sanitation
- #6. Adopt measures to address COVID-19 related mental health concerns:
- #7. LDH to work in collaboration with DOC to provide real-time, publicly available data on COVID-19 deaths, cases, and facility COVID-19 preparedness and response protocols:

Long-term Recommendations

- #8. Deepening capacity to plan, prepare, and respond.
- #9. Ensuring measurement of evaluation and impact.

Statement of the Problem

According to *The Marshall Project* [2], by May 27, at least 34,584 people in prisons nationwide had tested positive for COVID-19, an 18 percent increase from the week before. Much of this growth has been due to a handful of states that began aggressively testing nearly everyone at prisons where people had become sick. This suggests that coronavirus has been in prisons in much greater numbers than known in the early weeks of this pandemic. Clearly the problem for us to fully address and solve is urgent and life-threatening: to protect the safety and health of people who are incarcerated as well as the facility's employees. In Louisiana, infection rates do not appear to be as high yet, however we know that universal testing measures are not currently in place. Incarcerated people have a higher risk of being infected, becoming seriously ill, and dying from COVID-19. [3] Incarcerated people are prohibited from employing basic preventative tools to combat the spread of COVID-19, including social distancing and ready access to testing, PPE, and robust medical care (see Appendix A).[4] Jails, prisons, and detention centers, unlike other government-run institutions, also operate without independent oversight or public transparency, creating informational gaps that are essential to protecting public health during this crisis. Black, Indigenous, *and* People of Color are likely to be disproportionately impacted because they are overrepresented in these facilities[5] and are more likely than non-Hispanic white people to have been diagnosed with underlying health conditions (e.g., diabetes, hypertension, obesity, etc.)[6], making incarcerated people uniquely vulnerable to the COVID-19 crisis. The spread of COVID-19 in these facilities endangers not only incarcerated people, but also the employees in these institutions, the families of both staff and incarcerated people, and ultimately, the general public.

Background

Louisiana leads the nation, and the world, in incarceration per capita.[7] Approximately 50,000 people are incarcerated across the state in 140+ detention facilities (including parish jails, state and federal prisons, and juvenile detention centers.)[8] Juvenile detention centers house approximately 800-900 children daily.[9] Approximately 31,000 people are under state custody, of whom approximately 17,000 are housed in parish jails on behalf of the state.[10] The Department of Public Safety and Corrections (DPS&C) releases an average of approximately 15,000 people per year who have completed their sentence. Jail releases are even higher as people may be released with or without bond, charges may be dropped, and people complete their short-term sentences. Incarceration is also generally associated with lower life expectancies and is widely acknowledged to impact an individual's health.[14] Incarcerated populations are two times more likely to suffer from diabetes and hypertension.[15] As a group, Louisiana incarcerates populations who are uniquely vulnerable to this COVID-19 crisis due to:

Age: The average age of the state prison population is 40 years old, with over 4500 people aged 55 years or older.[11] The Centers for Disease Control and Prevention indicate the severity of COVID-19 related complications increase with age, with 8 out of 10 deaths reported in the U.S. being among adults 65 years old and older.[12]

Race: Two-thirds of the state prison population are African-American.[10] Black, Indigenous, *and* People of Color have "higher burden of chronic health conditions associated with a poor outcome from COVID-19, including diabetes, heart disease and lung disease."[13]

Most detention facilities, due to their design, risk becoming a COVID-19 cluster. Incarcerated people share open toilets, sinks, and shower facilities. The average size of a cell is roughly 48 square feet (6' x 8') for two people, which is less than the 6-foot social distance recommended for the general public. In dormitory housing in detention facilities, 100 square feet per person is recommended to enable both social distancing and minimal freedom of movement.[16] Centralized kitchens (including meal preparation, utensils) are the norm for providing meals to incarcerated people. Most facilities have centralized services (medical, kitchen, commissary, etc.), which incarcerated people can only access with a staff escort. Though incarcerated people may live in separate units/tiers/dorms, staff may become super-spreaders within the facility, carrying the virus from one unit to another.

Louisiana detention facilities have historically struggled to provide adequate health care to incarcerated people. Prior to COVID-19, at least two state prisons were defendants in class action litigation to secure basic medical services.[17] Several prisons employ medical staff who have had their licenses restricted or previously suspended by the Louisiana State Board of Medical Examiners after disciplinary actions, including the Louisiana State Penitentiary Medical Director Randy Lavespere – who is also the interim Medical Director for the Louisiana DPS&C.[18] Jails often rely on privatized medical providers, such as Wellpath, which has been sued nationally. The Orleans Justice Center is currently under court supervision. East Baton Rouge Parish Prison has paid at least five million dollars in settlements, insurance, and deductibles since 2011 due to deaths and injuries sustained in facility.[19]

Detention facilities have a legal and moral obligation to protect the health of incarcerated people. Both the Louisiana and the U.S. Constitution protect against cruel and unusual punishments and prohibit the deprivation of life without due process of law.[20–22] International law, including the Mandela Rules on the Treatment of Prisoners, and Universal Declaration of Human Rights, recognizes the rights of incarcerated people to medical care.[23] United Nations human rights experts have urged U.S. detention facilities to reduce

their incarcerated populations to "prevent large outbreaks of COVID-19 and ease the mounting pressure on staff and the penitentiary system as a whole."[24] Consistent with this legal and moral obligation, the Louisiana Department of Health, under its statutory authority,[25] initially issued guidance on the prevention and treatment of COVID-19 in Louisiana prisons (see Appendix P). Though ultimately (and without explanation) rescinded,[26] the LDH guidance was consistent with national and international guidelines issued by the Centers for Disease Control[12] and the World Health Organization.[27]

The dangers of COVID-19 clusters in detention facilities have been recognized by national and international agencies, public health experts, advocates, and most importantly, by the people incarcerated themselves. COVID-19 clusters are flourishing in detention facilities nationwide.[28] These dangers include:

- escalated deaths/illness of incarcerated people, detention staff & leadership
- overwhelming local hospital capacity, particularly in rural areas where many prisons are located
- potential to influence broader community transmission, reversing any gains from the state "stay-at-home" order[29]
- strain on existing detention medical services interrupts providing medical care for pre-existing conditions
- COVID-19 related staff absences may lead to other types of harms for incarcerated populations, including contraband and violence.
- legal liability and damages for injuries and deaths in custody

Methodology. This subcommittee requested the following data from the Louisiana Department of Public Safety and Corrections (DPS&C) and all Louisiana sheriffs, as most of the requested data is not generally available on the DPS&C COVID-19 tracker:

Please share the plan each correctional institute is using to ensure the safety and prevention of COVID-19 in each facility. We're interested in whether your department is: Complying with guidelines, such as the Center for Disease Control and Prevention's Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities or the Standard Minimum Rules for the Treatment of Prisoners; Process for intake and COVID-19 screening, testing, and treatment for people who are incarcerated; and Process for screening staff and third party vendors who enter in any physical capacity into the correctional facility to mitigate further spread of the virus.

Is there currently a process or plan for controlled evacuation of people who are incarcerated who meet certain criteria, such as the ones noted below? If so, please indicate the number of people who have been released by correctional institute. *Detained, but not charged with a crime; Charged with, but not yet convicted of a crime; Convicted per a conviction that is not finalized; or Serving time on a finalized conviction. NOTE: For each case, the following factors must be weighed: nonviolent offense, the nature of crime(s) involved, a person's behavioral record while incarcerated, his/her medical/physical condition, etc.*

The subcommittee received six responses (see Appendix R). The subcommittee also reviewed publicly available materials, including submissions by Louisiana United International, the Louisiana Stop Solitary Coalition, and Voice of the Experienced as well as news articles, court litigation, and websites. A sample of material reviewed is listed in the references and appendices to this report.

Supporting Data/Evidence

Current Crisis for Incarcerated People. COVID-19 has infected hundreds of people living and working in detention facilities across the state, but a fully accurate account is impossible due to different testing practices and lack of centralized publicly available data. According to the CDC, as of late April 2020, "[a]mong the 46 [Louisiana] facilities with confirmed COVID-19 cases, 17 (37%) reported cases in both incarcerated or detained persons and staff members, 15 (33%) reported cases only in staff members, and 14 (30%) reported cases only in incarcerated or detained persons. Facilities with cases were located in all nine Louisiana health regions and ranged in population size from 12 to >5,000 incarcerated or detained persons, housed juvenile and adult populations, and included 31 local jails, and 11 state, one federal, and three private facilities."[29]

- *Prisons.* As of May 27, 2020, at least 17 people have died and 660 people have tested positive in state prisons.[30] While the state has publicly prioritized "universal testing" in congregate settings, including prisons, reports indicate DPS&C has only administered approximately 1000 tests out of 31,000 people incarcerated.[11] News reports indicate COVID-19 clusters at Louisiana Correctional Institute for Women at Hunt and the Louisiana Correctional Institute at Jetson.[31] Individual reports from inside Louisiana State Penitentiary, Rayburn and Laborde also raise the alarm of COVID-19 clusters.
- *Jails.* There is no statewide information on deaths or positive infections in parish jails, however news reports widespread infection in the New Orleans and East Baton Rouge parish jails.
- *Federal prisons.* In April 2020, Oakdale Federal Prison in Allen Parish, LA had 34 confirmed cases of COVID-19 among inmates, another 13 infections among staff, and 5 people had already died in a severe coronavirus outbreak, which at that time was reported to have the most deaths from COVID-19 of any prison in the federal system[32]. In a USA Today Article published on May 22, 2020, U.S. Attorney General William Barr "We are experiencing significant levels of infection at several of our facilities, including the Federal Correctional Institution Oakdale (Louisiana), Danbury (Connecticut) and Elkton (Ohio),"

Barr said. "We have to move with dispatch in using home confinement when appropriate to move vulnerable inmates out these institutions."

- *Youth detention centers.* As of June 1, 2020, 28 children and 49 staff have tested positive in four facilities managed by the state Office of Juvenile Justice; and zero have died.[33] Information is not available on the remaining juvenile detention centers operated by local authorities. In facilities operated by the state Office of Juvenile Justice, tests have not resumed since April 12, 2020.[9] Louisiana has the highest rate of "known cases in any juvenile correctional system in the country."[30,34]

Even the publicly available data from DPS&C[35] is incomplete. Agencies have not released their criteria for testing or defined what is considered a COVID-19 related death. Information on staffing and workplace safety is particularly lacking, since staff are the primary vector for COVID-19 entering and circulating within detention facilities. The DPS&C tracker also only provides this incomplete data for the 9 state prisons, despite the housing of at least 17,000 people confined in local jails on behalf of DPS&C.

Initial Government Responses to the Pandemic: Minimal releases. Despite having the nation's highest per capita incarceration rate, Louisiana lags behind other states in COVID-19 related prison releases.[36] Recognizing that detention facilities must de-populate, the Governor created an expedited furlough system for people within 90 days of release and convicted of a non-violent offense.[37] The DPS&C Review Panel is limited to specific eligibility criteria – which only includes about 1,100 of 50,000+ incarcerated people – and can approve release with five out of six votes in favor. As of mid-May, only 86 of 483 (17.8%) people have been approved for furlough.[1] It's important to note that this Review Panel is ending as we enter into phase two. Pre-COVID-19, roughly 3000 people per month were released from DOC custody, thus roughly 9,000 people would have been expected to leave from March 1 - June 1. Local jurisdictions, in light of guidance issued by the Louisiana Supreme Court, have reduced admissions to local jails and in some cases, have released people on bail/bond. Both New Orleans and East Baton Rouge have used low-to-no bonds at arraignments to limit new jail admissions. In several jurisdictions, police have issued summons (in lieu of arrest) to create fewer bookings into jails. Public defenders have filed individual and mass petitions for release with little success. Juvenile facilities have reportedly only considered extended furloughs for seven (out of more than 200) incarcerated children.[34]

Consolidation at Camp J, Angola. The DPS&C has instructed all local jails and sheriffs to send any patients who cannot be appropriately medically isolated in their facilities to Camp J at Louisiana State Penitentiary at Angola (LSP). COVID-19 patients from other housing areas of LSP are also being sent to Camp J. Camp J consists primarily of disciplinary lockdown cells and was previously shuttered in 2018 at the request of LSP, at least in part because of its crumbling infrastructure and sub-standard conditions. As of May 28, 2020, there are 76 incarcerated people at Camp J from the local level facilities: 4 for Isolation: 2 from Madison, 1 from Tangipahoa and 1 from WINN in isolation, 72 current cases in Step-Down Unit: 17 from Caldwell, 1 from DeSoto, 5 from Franklin, 1 from Lafourche, 6 from Madison, 2 from Pt. Coupee, 22 from Richland DC, 7 from St. Bernard, 1 from St. John, 2 from St. Tammany, 4 from Tangipahoa, 1 from Terrebonne and 3 from Union Parish. 108 offenders have been returned to their original local level housing assignments: 2 from Bienville, 12 from Caldwell, 18 from E. Baton Rouge, 27 from Franklin, 1 from Iberville, 2 from Ouachita, 6 from Pt. Coupee, 10 from Richland DC, 5 from St. Police Barracks, 9 from St. John, 9 from St. Tammany, 2 from Terrebonne and 5 from Union Parish. There are 3 female offenders (E. Baton Rouge, Franklin and LSP) in Step-Down housed at LCIW and 1 female offender from Franklin Parish that has recovered and returned to the local level housing. In summary, LSA reported 187 total positive cases in local jail population statewide. Of those, 85 are assigned to or being moved to Camp J for isolation, 1 is at LCIW, and 2 are hospitalized (1 Pt Coupee reported above and 1 EBR). The remaining incarcerated patients are being isolated onsite at the jails. There are 151 pending tests for individuals in local jails, the majority of those being in Orleans (103), where they are testing the entire population.

Other responses. Facilities have almost universally suspended in-person visitation for all incarcerated people and many have also indicated they have suspended all volunteers and related programming. DPS&C has waived medical care co-pays for incarcerated people and has issued 2 free calls a week and 2 free stamps per person to support family communication.[30] Anecdotally, several parish jails refuse to use their statutorily designated furlough authority to release people who have a sick or dying family member.

Building/Facility Issues: Lack of Space, Ventilation, Co-mingling, Aging Infrastructure. Detention facilities present challenges to preventing the spread of COVID-19. Louisiana prison administrators "reported challenges in implementation, related to limited space to quarantine close contacts of COVID-19 patients and inability of incarcerated and detained persons to engage in social distancing, particularly in dormitory-style housing."[29] Built to prevent escapes, these buildings do not generally provide cross-ventilation or fresh air[38] to disperse respiratory droplets. The architecture of detention facilities also relies on co-mingling incarcerated people with staff, as the buildings often have centralized services, which require staff escorts of incarcerated people to access basic needs, such as medical and meals. Many of the facilities in Louisiana were built over twenty years ago in sync with the growing incarceration rate and therefore need significant repair and maintenance. Older building units that had previously been closed because of disrepair are now housing incarcerated patients. Individuals at LSP report living areas filled with rust, mold, and vermin.

Correctional Practices: Solitary Confinement. Hundreds of phone calls from incarcerated people indicate that symptomatic and positive COVID-19 incarcerated patients are being put in punitive lockdown, (see Appendix B) instead of "medical isolation." Extended lockdown, also known as solitary confinement or restrictive housing, is the practice of confining incarcerated people in their cells for 22 hours or more in a 24-hour day. It is traditionally used as punishment for violations of facility rules or other unlawful behavior and has been widely condemned for negative impacts on the psychological and physical health of incarcerated people.[39] Patients, including children, are being consolidated in previously closed buildings designed for disciplinary punishment and lockdown (see Appendix C). Children in juvenile detention centers report the suspension of all educational activities and confinement to their dorms for 23 hours at a time.[40] In contrast to solitary confinement, the use of medical isolation includes (see Figure 1):

- daily visits by physical and mental health staff;
- clear and daily communication from healthcare staff about the rationale and duration of medical isolation;
- opportunities for going outside and exercise;
- enhanced access to television, tablets, radio, and reading materials; and
- free and accessible means for communicating with loved ones.[41]

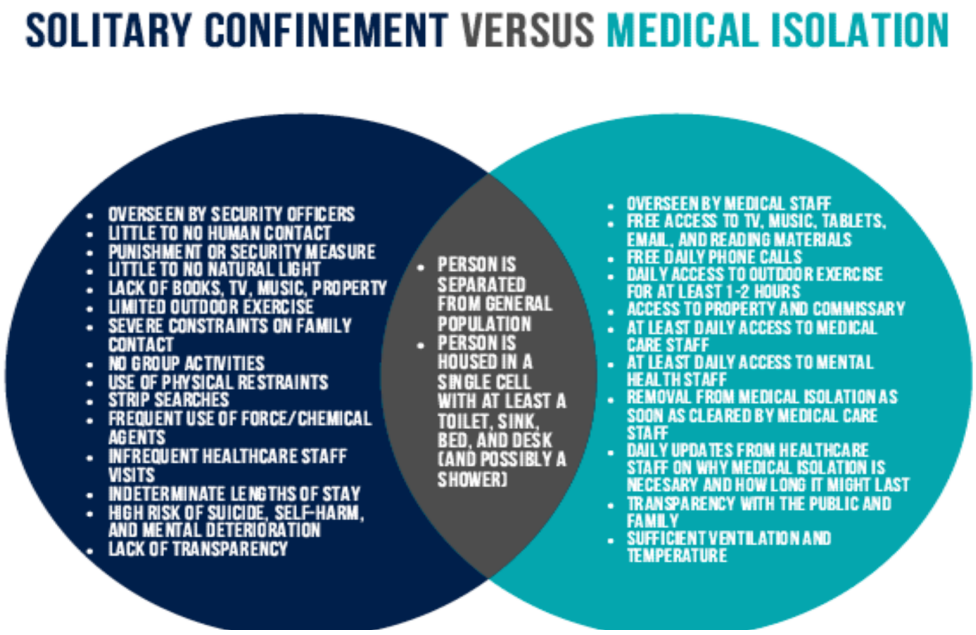

Figure 1

Incarcerated people may be dissuaded from reporting[29] symptoms of the virus if they believe the response is transfer to Camp J or lockdown of their unit if they admit they are feeling ill. Lockdown and solitary also decrease the interaction of staff with prisoners, allowing symptoms to accelerate to dangerous levels before the facility can take proper precautions.

Unsanitary housing for positive COVID-19. Incarcerated people report being housed in buildings without proper cleaning supplies and adequate personal hygiene supplies. Children who tested positive at the Swanson Center for Youth Services in Monroe (see Appendix D) were held in inappropriate and unsanitary medical isolation areas.

> "The warden said they can't test us or provide ventilators because there is not enough to go around for the free world citizens. " - Angola, 4.24.20[42]

Lack of comprehensive testing and testing protocols. Despite the Department of Health's public commitment to "repeated comprehensive testing" in congregate settings,[42] reports indicate that testing of incarcerated people is haphazard and episodic.[9] According to the Marshall Report, other states are testing all incarcerated people and staff, "since undetected cases in prisons could contribute to community spread outside." *Incarcerated* people*:* According to DPS&C, as of May 28, 2020, only 926 incarcerated people in state facilities have been tested, of which 536 tested positive, approximately 58% positive.[30] DPS&C has also quarantined 1,849 incarcerated people and isolated 429 incarcerated individuals, for a total of 2,278. It appears as if DPS&C is quarantining/isolating people without positive tests, given the total number of 926 tests. In the four cases of widespread testing in

state and local detention facilities (several months into the pandemic), a high percentage of asymptomatic or pre-symptomatic people were found.[31] OJJ has also tested only 29 children in state juvenile custody, though these facilities average ~250 children in custody.[43] *Detention facility staff:* Staff testing is also unclear. Of the six responding facilities to this subcommittee, all indicated procedures for screening staff and people detained upon arrival to the facility, however, did not consistently report testing and treatment protocols. Appendix Q. DPS&C reports that as of 5/28/2020, a total of 801 DPS&C staff members have been tested, with 157 positive results, although it is unclear if these tests are required for staff or administered by DPS&C.[30] According to epidemiologists, aggressive testing, particularly of staff in the congregate prison system, is of paramount importance. "The force of infection can be extraordinarily high in prisons. The most dynamic of that group is the people who work there." .

> "There has been no one to help the 85% mental health patients on this dorm since the pandemic. This may be my last email, I am losing the battle with my sanity, I can't get any professional help, my anxiety and depression is at an all-time high, I've been sleepwalking, sleep deprived and hallucinating." - - EHCC, 4.22.20[44]

> "Anyway, in this prison you would have to be dying to get proper medical attention. We have long waits to see a doctor and the nurses here don't want to be bothered." - DCI, 5.6.2020[44]

Lack of adequate medical and mental healthcare. Incarcerated COVID-19 patients across institutions report that they are not receiving adequate medical monitoring and treatment (see Appendix E). Some reports indicate inadequate staffing to provide medical monitoring, including a lack of doctors (see Appendix F). DPS&C reports that on 5/27/20 for example, there were 127 DPS&C employees absent for COVID-19 related issues, including 85 security staff and 6 healthcare staff.[30] As a result of staffing and space shortages, it appears as if some correctional officials are improperly "cohorting" incarcerated patients. "Cohorting" involves grouping residents and staff into mini communities of as few people as possible and maintaining absolute social distancing between cohorts. Cohorting to contain infectious disease outbreak is long-practiced, evidence-based, and a hallmark of CDC infection control guidelines for residential settings. However, if done improperly, cohorting can impact the ability to provide appropriate medical care. Cohorts should be no larger than can be cared for by the facility and/or surrounding healthcare systems should every member of a cohort be infected. AMEND estimates that very few correctional facilities, if any, have access to sufficient healthcare resources to allow for cohorts of larger than 10 people, though optimal cohort sizes may differ by facility.[41] The pandemic has also impacted non-COVID-19 health care.

Discipline for incarcerated people for adhering to public health guidelines. Several reports indicate that incarcerated people are punished when they implement public health guidelines. At least two trustees at Camp F[45] were disciplined and sentenced to administrative segregation (solitary) for refusing to move to Camp J to provide necessary services such as cooking and maintenance. Incarcerated people at a federal prison in Oakdale were reportedly pepper-sprayed when they protested the transfer of quarantined incarcerated patients into their dorm.[46]

> "We're still at risk of our health by constant contact with prison officials, including those who were sent home, who are now back to work around us." - EHCC, 4.22.20[44]

> "Employees are not wearing their masks--and cameras at DCI will show this." - DCI, 5.2.20[44]

Staff infection and Personal Protective Equipment. While most facilities have instituted daily temperature checks, staff are not uniformly subject to elevated testing, raising the risk of asymptomatic transmission to incarcerated people. Face coverings have not been required for all staff in direct contact with incarcerated people, though DPS&C reports that surgical masks have been distributed to all state prison staff.[30]

> "...these people just locked down two other people in our dorm cause they work in nursing around all those sick people and one of those sick people tested positive. I think its kinda messed up that people who show signs of the virus, and then put the same inmates that are working around those who might have it, back in the dorm with all those who don't, putting us all at risk of catching it. " - EHCC, 5.4.2020[44]

Co-mingling of positive and other populations. There are numerous reports of co-mingling, (see Appendix G) which enhances the risk of COVID-spread within these detention facilities. COVID-19 patients recently housed at Camp J report cross-contamination of the infection across living areas.[47] Incarcerated people report that people testing positive have been moved into close proximity with people who were COVID-negative. The reliance on incarcerated labor - both within facilities and outside of facilities - creates

additional opportunities for exposure to and transmission of the virus. Within facilities, incarcerated people bring meals and supplies for quarantined/isolated units. Outside of facilities, incarcerated people on work details return to their units at night, creating additional vectors for virus exposure and spread. Treating and isolating COVID-19 patients from across the state at Camp J at LSP also puts the population of Angola, many of whom are elderly or have comorbidities, at risk of medical complications or death if they contract COVID-19.

Potential for violation of other legal rights. Within this crisis, there is the potential for the violation of other legal rights of incarcerated people. Attorneys have reported difficulties in confidentially communicating with their clients. Children detained at Swanson are being denied access to their parents and attorneys.[48] Disruptions in correctional staffing[30] due to COVID-19 create additional stress (and the potential for violence) by both staff and incarcerated people.

Findings

In summary:

1. Infections and deaths for people in detention facilities, including staff and the incarcerated, are likely to rise. This increase will continue to have a disproportionate impact on Black, Indigenous, *and* People of Color (BIPOC) and the elderly. Medical risk of death is not (and should not be) part of a person's sentence.
2. Prisons, juvenile detention centers, and jails have not sufficiently reduced their populations to enable social distancing or employ other basic preventative tools to combat the spread of COVID-19.
3. Prisons and jails have attempted to separate infected people from non-infected without the benefit of widespread testing, based on the presence of a high temperature or overt symptoms.
4. Separation measures between positive COVID-19 people and non-infected have not been strictly enforced and in some cases, like Camp J, are impossible because of staffing and incarcerated labor.
5. The use of solitary, instead of ethical medical isolation, to address COVID-19 is dangerous because it punishes reporting, impedes treatment, and limits public health responses.
6. Medical treatment for COVID has been plagued by lack of staff, uniform procedures, protocols, and implementation, and has impacted the ability of detention facilities to treat other medical and mental health issues.
7. The shortage in publicly available information about COVID-19 infections among incarcerated populations and staff endanger public health. There is no public safety without public health.[49]

Summary of Recommendations	
Immediate-term Recommendations	
#1. We recommend the governor appoint a Statewide Public Health & Corrections COVID-19 Coordinator to work in close collaboration with a team to support jails and prisons in complying with CDC and OSHA guidelines and make recommendations regarding pandemic practices, policies, and procedures in prisons and jails.	• The Coordinator and team would ensure that incarcerated people and correctional facility staff are protected from COVID-19 and would support facilities administered by DPS&C, sheriffs, and the Office of Juvenile Justice in compliance with CDC and OSHA guidelines for living and working conditions; and urge federal facilities located in Louisiana to adopt same. • We recommend the Statewide Public Health & Corrections COVID-19 Coordinator be based out of LDH, under their statutory authority (La. Rev. Stat. 40:4(A)(13) and 40:5(A)(1),(2), & (4) and work in close collaboration with a team of stakeholders, including but not limited to representatives from DPS&C, the Louisiana Sheriffs Association, & non-governmental advocacy and public health organizations, including people who were formerly incarcerated. • Collaborate with LDH, OSHA, and CDC for advice and support. • Conduct a pandemic safety audit, and inspect all facilities where people are detained. • Interview staff, along with current and former patients in jails and prisons, correctional and external medical providers, and anyone else who is essential in studying the scope of the prison pandemic practices, policies and procedures in prisons and jails.

#2: Decarceration or controlled evacuation to enable proper social distancing.
 	
Responsible entities: State of Louisiana agencies (LDH, DOC, OJJ) shall work in collaboration with parole board members, health care providers and organizations with a track record of supporting this recommendation.
	• Children in state custody who can return to the community safely should be sent home.
	• The following mechanisms can be used to assist in identifying people to evacuate:
	  ○ Pardons, furloughs, geriatric parole, medical furlough, (traditional) temporary release (sheriff authority), parole, good time parole supervision and the temporary expedited DPS&C review panel (referenced above) sufficient to enable social distancing (see Appendix H).
	  ○ Existing and Pardon Board approved applications for clemency can be signed by the Governor .
	• Mandate every facility to create and keep up to date a list of medically vulnerable incarcerated people within the facility for possible release.
	• Provide all people leaving incarceration with up-to-date, medically accurate information about safe re-entry
	• Collaborate with Medicaid MCOs to provide case management to all people leaving incarceration who become enrolled in the Medicaid through the Medicaid pre-release enrollment program. In addition to Medicaid enrollment, ensure appropriate linkage to care for people who are re-entering into community through appropriate referrals to health care providers to ensure people do not fall out of care, including but not limited to telehealth visit to Medicaid provider and ensuring referral monitoring and follow-up.
	• Formerly incarcerated people should lead re-entry efforts for any person released.

#3. Ensure appropriate health care treatment, including evacuation where symptomatic, for all incarcerated people who test positive. **Responsible entities:** State of Louisiana (LDH, DOC, OJJ) shall work in collaboration with parish jails, Louisiana Sheriff's Association, Louisiana Commission for Law Enforcement, local governments with juvenile detention centers, federal prisons (e.g., Bureau of Prisons and Department of Justice), and organization(s) with a track record of supporting this recommendation.	• This process should include evacuating incarcerated people who are COVID-19 positive and symptomatic to an outside medical facility for observation/treatment by coordinating with COVID-19 medical monitoring stations, as in New Orleans and Baton Rouge.
#4. Enable social distancing as the cornerstone of mitigation **Responsible entities:** State of Louisiana (LDH, DOC) in collaboration with judges, Sheriffs, District Attorneys, and defense attorneys	• We recommend industrial hygienists tour each detention facility to identify facility-specific safety precautions to be taken immediately (i.e., changes to traffic flow, air ventilation patterns, etc.). • In dorms, single beds should be placed at least 9 ft apart to enable social distancing. • Extended lockdown cells, room or solitary confinement, and unit lockdowns should not be used to quarantine incarcerated children and adults or to manage understaffing. Quarantine and medical isolation should follow standards outlined above. • To address lack of ventilation, detention facilities should house people in every other cell and enable cross-ventilation whenever possible.
#5. Prioritize Testing, Hygiene, and Sanitation **Responsible entity:** State of Louisiana (LDH)	• Conduct mass universal testing across the prison system every 14 days. Per CDC guidelines, cohorting individuals who test positive for COVID-19 in a particular area or specialized ward in the facility for the recommended period of 14 days. A negative COVID-19 test should be necessitated before individuals are placed back into the general population. • Test everyone coming from the outside during the initial phase of intake is recommended regardless of symptoms. • Inmates that have tested positive for COVID-19 and scheduled to be moved to another area or facility should not be moved until testing negative to COVID-19. This approach is mandated in the New York hospital system before transfer into a congregate setting such as a nursing home; or prison in this context. • Staff testing is necessary as the prisons, jails and detention centers are classified as congregate settings. New York State has expanded testing capacity in the nursing home congregate setting by testing staff every two days to control the virus entering the congregate setting. • Providing education/training and checkoffs to staff on proper PPE usage. Improper donning and doffing of PPE can be a blind spot. Education and checkoffs should be a yearly mandated skills competency. This model is used in hospital settings to assure adequate competencies. • Provide quality soap, CDC-recommended hand sanitizer, comprehensive and continuing sanitation of facilities, and quality medical care, free of charge.

#6. Adopt measures to address COVID-19 related mental health concerns **Recommended entities:** State of Louisiana (LDH – OPH & OBH)	• Allow incarcerated people, especially children, to have frequent contact with their family members—electronically or via phone— at no charge and without limitation. • Ensure that children in custody have the same access to remote learning materials as children in the community have. • Provide telephonic and confidential access to mental health counseling for all incarcerated people. • Continuing communication by detention facility staff to incarcerated people on COVID-19 conditions, precautions, and exposure.
#7. LDH to work in collaboration with DPS&C to provide real-time, publicly available data on COVID-19 deaths, cases, and facility COVID-19 preparedness and response protocols	• Create a more comprehensive online dashboard (see e.g., Michigan50) that includes all jails, prisons, and detention centers, numbers of tests administered, positive diagnoses, numbers and locations for hospitalizations, race/age, and medically vulnerable. • As an indicator to measure *Recommendation #2: Decarceration or controlled evacuation to enable proper social distancing,* we recommend DPS&C collect and track the number of people in the following categories: a) within 90 days of release; b) within 6 months of release; c) within one year of release; d) within two years of release • Develop and require adoption of guidelines on use of personal protective equipment inside facilities and periodically publish information on the purchase and/or manufacturing of PPE, medical and sanitation equipment (see e.g. Illinois). • Collect and track operational capacity (beds, staffing, units/dorms) available for treatment as well as current occupancy levels. Capacity levels should be informed by CDC guidelines.
Long-term Recommendations	
#8. Deepening capacity to plan, prepare, and respond	• Correctional facilities should work closely with their LDH regional medical directors/administrators to ensure facilities employ best practices from public health. • Require every facility to develop and annually update pandemic preparedness and response plans, including potential releases, staffing, family communication, and publication of data. • Recruit and retain licensed health care professionals to properly staff COVID-19 and non-COVID-19 medical and mental health care. • Continue to robustly apply short-term release mechanisms to keep the incarcerated population low, enhance social distancing inside for the safety of incarcerated people and staff. • Address the needs of individuals/families with incarcerated loved ones by creating a community-curated community-led resource (including behavioral health support and treatment – when desired-- as well as access to healthcare and other necessities). • Continue to limit admissions to carceral environments which can be accomplished by judges not sentencing children to adult jail or prison custody for non-violent offenses, misdemeanors, or probation violations; and by police issuing summons instead of engaging in arrests where permissible.
#9. Ensuring measurement of evaluation and impact	• LDH works in collaboration with DOC to measure evaluation and impact: How did we do in the management of this crisis and what lessons were learned?

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Appendices

Appendix A. "LSP [Louisiana State Penitentiary] has worse living conditions and higher comingling of people than cruise ships and nursing homes, where COVID-19 is known to have easily spread. Prevention of contact with an infected droplet is significantly more difficult in a prison than in the community."] Though the federal court in Gumns ultimately denied the plaintiffs' motion for a temporary restraining order to prevent transfers to Camp J due to crediting DOC testimony and legal standards for emergency injunctive relief, the testimony and evidence presented in Gumns is nevertheless illustrative of the impact of Covid-19 on incarcerated populations. See Gumns, 2020 US Dist Lexis 85908 (M.D. La. May 15, 2020).

Appendix B. Patients detained in the Orleans Justice Center and who have tested positive for COVID-19 and experiencing symptoms are being held in their cells for almost 24 hours a day. See Decl. of Antonio Gallagher at ¶ 5 ("I am in my cell for almost 24 hours a day. I am let out of my cell for 30 minutes to an hour each day to make phone calls or take a shower"), Gumns, Rec. Docs. 26-9.

Appendix C. Children who tested positive at the Swanson Center for Youth Services in Monroe were transferred to areas closed in 2005 that previously served as solitary confinement and disciplinary punishment. See Decl. of A.B. at ¶¶ 8-9 ("After my son tested positive for COVID-19, they put him in a dirty room at Cypress with no air conditioning. He was in there without water for 2-3 days."), J.H. et. al v. Edwards et. al, 20-cv-293, Rec. Doc. 1-10 (M.D.La.)

Appendix D. Decl. of A.B. at ¶¶ 8-9 ("After my son tested positive for COVID-19, they put him in a dirty room at Cypress with no air conditioning. He was in there without water for 2-3 days."), J.H. et. al v. Edwards et. al, 20-cv-293, Rec. Doc. 1-10 (M.D.La.)

Appendix E. COVID-19 patients recently housed at Camp J[1] report a lack of medical monitoring and treatment. See Decl. of Paul Nash at ¶ 9 Gumns, Rec. Docs. 26-5. Patients detained in the Orleans Justice Center and who have tested positive for COVID-19 and experiencing symptoms without adequate medical treatment or attention. See Decl. of Dijon Curtis at ¶ 4, Gumns, Rec. Doc. 26-11. In East Baton Rouge Parish Prison# (a local jail), patients who have tested positive for COVID-19 are not provided with adequate medical attention and treatment. See Supp. Decl. of Julius Allen at ¶¶ 6-14, Gumns Rec. Doc. 26-15.

Appendix F. See Decl. of Paul Nash at ¶ 9, 11 ("I was in a dormitory at Camp J with 40-50 people. There were at least 30 people who are really, really sick. Some of them have respiratory issues. One person has pneumonia in his lungs. Nobody has been taken to the hospital. I was told by the nurse that "this is our hospital". There are no doctors"), Gumns, Rec. Docs. 26-5.

Appendix G. Specific policies to be adopted could include:

- Local sheriffs could use their temporary release and furlough powers (La. Rev. Stat. 15:811 and 15:833), which are independent from DPSC authority.
- Pardon Board should expedite pending decisions, and accept new applications for review;
- Restoration of lost Good Time will allow some to have an accelerated release on Good Time Parole Supervision (GTPS);
- The Parole Board should expedite its process (and possibly be temporarily expanded in number) for medical furlough, geriatric parole, and standard parole.
- COVID Furloughs (meaning someone must be returned to prison to finish their sentence) should be expanded to a) all within one year of release, either to GTPS or to flatten their time altogether; b) all people with a Low Risk designation of their TIGER Score. These furloughs should be through administrative review, (i.e. Office of Probation + Parole) for all people convicted of non-violent crimes within one year of release and for all crimes

within 90 days of release. Panel members and Probation and Parole should work with community organizations focused on re-entry.

- Parole / Probation Reductions
- In order to allow for increased caseloads of furloughed people, Parole and Probation should move the lowest risk, in-compliance, people to an unsupervised status

Appendix H. Amend, *Limiting COVID-19 Transmission and Mitigating the Adverse Consequences of a COVID-19 Outbreak in Correctional Settings: Release, Cohort, Test* (April 26, 2020), *available at* https://amend.us/wp-content/uploads/2020/04/Cohorting-Guidance.Amend_.UCB_.pdf

Appendix I. CDC, *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities* (Mar. 23, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html

Appendix J. CDC, *Activities and Initiatives Supporting the COVID-19 Response and the President's Plan for Opening America Up Again* (May 2020), https://www.cdc.gov/coronavirus/2019-ncov/downloads/php/CDC-Activities-Initiatives-for-COVID-19-Response.pdf?referringSource=articleShare

Appendix K. Covid-19 in Critically Ill Patients in the Seattle Region — Case Series, The New England Journal of Medicine (March 30, 2020), https://www.nejm.org/doi/pdf/10.1056/NEJMoa2004500?articleTools=true

Appendix L. Declaration of Thomas Haller Jackson (April 28, 2020).

Appendix M. Letter by Louisiana public health experts, https://sph.tulane.edu/open-letter-covid19-jail

Appendix N. Marshall Project COVID-19 Tracker: https://www.themarshallproject.org/tag/coronavirus

Appendix O. Proposed Public Health and Public Safety Pathways for Criminal Justice Systems Responses to COVID-19: https://williamsinstitute.law.ucla.edu/publications/justice-pathways-covid-19/

(cont. next page)

Appendix P. Memorandum from the LDH to the Department of Public Safety and Corrections and Office of Juvenile Justice (Apr. 8, 2020) (rescinded via Memorandum from the Louisiana Department of Health Office of Public Health to the Department of Public Safety and Corrections and Office of Juvenile Justice (Apr. 9, 2020).[1]

John Bel Edwards
GOVERNOR

Stephen R. Russo, JD
INTERIM SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Public Health

TO: **DEPARTMENT OF PUBLIC SAFETY & CORRECTIONS and OFFICE OF JUVENILE JUSTICE**

FROM: **LDH OFFICE OF PUBLIC HEALTH**
Jimmy Guidry, M.D. *Jimmy Guidry, M.D.*
State Health Officer

RE: **COVID-19; recommendations regarding prisons and juvenile detention centers**

DATE: **April 8, 2020**

On January 30, 2020, the International Health Regulations Emergency Committee of the World Health Organization declared the COVID-19 outbreak a "public health emergency of international concern" (PHEIC). On January 31, 2020, Health and Human Services Secretary Alex M. Azar II declared a public health emergency (PHE) for the United States, effective January 27, 2020. Pursuant to the Louisiana Health Emergency Powers Act, R.S. 29:760, *et seq.*, a state of public health emergency resulting from the outbreak of "coronavirus disease 2019" (COVID-19) was declared to exist in the entire State of Louisiana by Proclamation Number 25 JBE 2020.

In the days since the referenced declaration of the state of the public health emergency in the state, the COVID-19 outbreak in Louisiana has expanded significantly. The number of reported cases and deaths is expected to rise significantly in the state in the coming weeks. Additional measures are necessary to protect the health and safety of the public. The measures recommended herein are in line with the best guidance and direction from the U.S. Centers for Disease Control and Prevention, and are necessary because of the ability of the COVID-19 virus to spread via personal interactions and because of physical contamination of property due to its propensity to attach to surfaces for prolonged periods of time.

The Louisiana Department of Health - Office of Public Health (LDH-OPH) expressly finds that the measures recommended herein are necessary to help control and prevent further spread of COVID-19, a communicable, contagious, and infectious disease that represents a serious and imminent threat to the public health. If the following measures

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are not taken, said infectious disease could spread within correctional and detention centers which would overwhelm the state's medical facilities and which would cause further spread to the citizens of the State of Louisiana.

Pursuant to the powers vested in the State of Louisiana – Office of Public Health by L.R.S. 40:1 *et seq.*, **I do hereby make the following recommendations**:

Correctional and detention centers should take safe and adequate measures to ensure that the COVID-19 coronavirus disease shall not spread within its facilities. Specifically, correctional and detention centers should:

- Practice proper hand hygiene. Wash hands with soap and water for at least 20 seconds.
- If soap and water are not readily available and illicit drugs are not suspected to be present, use an alcohol-based hand sanitizer with at least 60% alcohol; this protocol applies to all staff, visitors, and inmates.
- Refrain from touching faces with unwashed hands; this protocol applies to all staff, visitors, and inmates.
- Have a trained Emergency Medical Service/Emergency Medical Technician (EMS/EMT) assess and transport anyone you think might have COVID-19 to a healthcare facility.
- Ensure only trained personnel wearing appropriate personal protective equipment (PPE) have contact with individuals who have or may have COVID-19.
- Separate sick individuals from other individuals in the facility, this is known as isolation. Isolate a sick individual in a specific "sick room" if possible, and away from other individuals in the facility. Use a separate bathroom, if available.
- Wear a facemask when around sick individuals at the facility.
- Cover coughs and sneezes. Cover the mouth and nose with a tissue when coughing or sneezing. Throw used tissues in a lined trash can, then immediately wash hands with soap and water for at least 20 seconds.
- Wash hands often with soap and water for at least 20 seconds. This is especially important after blowing nose, coughing, or sneezing; going to the bathroom; and before eating or preparing food.

- Avoid sharing personal items. Do not share dishes, drinking glasses, cups, eating utensils (after using these items, wash them thoroughly with soap and water or put in the dishwasher), towels, or bedding with other individuals in the facility.

- Clean high-touch surfaces in the isolation area ("sick room" and bathroom) every day while wearing a mask. Clean and disinfect high-touch surfaces in other areas of the facility every day. High-touch surfaces include, remote controls, counters, tabletops, doorknobs, bathroom fixtures, toilets phones, keyboards, and tablets.

- Immediately clean and disinfect areas that may have blood, stool, or body fluids on them with household cleaners and disinfectants: Clean the area or item with soap and water or another detergent if it is dirty. Then, use a household disinfectant. Be sure to follow the instructions on the label to ensure safe and effective use of the product. Many products recommend keeping the surface wet for several minutes to ensure germs are killed. Many also recommend precautions such as wearing gloves and making sure you have good ventilation during use of the product.

- Ensure that all inmates at correctional and detention centers, staff, and visitors maintain a distance of at least 6 feet from each other. If said distance cannot be maintained within the current prison population and if following all of the above referenced protocols does not protect correctional and detention staff, visitors, and inmates, then OPH recommends that correctional and detention centers work with the District Courts, the Public Defender's Office, and District Attorney's Office to reduce the size of the jail population of the least non-violent inmates in order to comply with this recommendation.

Thank you for that all that you are doing in this crisis to mitigate the spread of COVID-19 throughout the State of Louisiana.

Sources: www.ldh.la.gov; www.cdc.gov

Sincerely,

Jimmy Guidry, M.D.

Jimmy Guidry, MD
State Health Officer
Louisiana Department of Health

Appendix Q. Responses from Request for Information to DPS&C, Parish Sheriff's, and Jails across the state.

COVID – 19

ASCENSION PARISH JAIL

2384 LEMANNVILLE CUTOFF ROAD

DONALDSONVILLE, LOUISIANA 70346

Compliance of Guidelines: Procedures were put place at the beginning of the pandemic that were consistent with Louisiana Department of Corrections guidelines suggestions. Also, these guidelines are consistent with the Center of Disease Control regarding medical isolation, quarantine processes, and medical evaluations. The offender population has been informed and provided the supplies for proper hygiene practices. The information provided to the offenders has come in the form of literature and through the medical staff and Correctional Officers. This facility is staffed with full time on-site medical professionals who are taking precautions and evaluating offenders daily. This facility has obtained resources and supplies to take care of a short-term outbreak of Covid-19 if this occurs.

Process of offender Intake: Extra precautions were taken at intake where offenders are medically evaluated in our sally port before entering the facility. We have special holding areas where the incoming offenders are place away from the general population. We currently have dorms assigned to quarantine offenders to prevent the possible outbreak of any Covid-19 into our general offender population. Offenders who displayed symptoms or originated from areas of high risk are housed in one of the special intake dorms.

Staff and Third-Party Screening: Since the start of the pandemic our facility ceased all third-party entry into our facility to protect our offenders from possible exposure. Inmate visitation has been suspended until further notice. Offenders received additional free telephone usage through Alley Telecom due to Covid-19. The only vendors allowed in the facility are deemed essential to maintenance of the facility. The vendors are evaluated based screening and temperature monitored. PPE was utilized and no contact with offenders was allowed. Correctional staff adhered to a strict screening process which included temperature evaluations and the screening questions. This process is conducted at roll call by supervisors / medical staff before any offender contact is established. Enforcement staff are allowed inside the facility since they are also screen before going on duty. Staff has been advised not to report to work and to get a medical clearance from their physician if he/she had experienced any symptoms related to the Covid-19. Staff are provided PPE.

Controlled Release of Offenders due to Covid-19 Pandemic: The Ascension Parish Sheriff's' Office has not released offenders who are serving time for convicted crimes due to the Covid – 19. All Department of Corrections offender releases have been authorized by the Department of Corrections which provided the proper documentation. Pre-trial offenders' releases have been conducted through the agreement of the defense attorneys', District Attorney's Office, and the Judges Office. Of the offenders' release none were crimes of violence, sex crimes, felonies related to driving while impaired or domestic related.

Is there currently a process or plan for controlled evacuation of people who are incarcerated who meet certain criteria, such as the ones noted below?

- Yes

If so, please indicate the number of people who have been released by correctional institute.

- **Detained, but not charged with a crime.**

  None

- **Charged with, but not yet convicted of a crime.**
  129
- **Convicted per a conviction that is not finalized.**
  None
- **Serving time on a finalized conviction.**
  None

Assumption Parish Detention Center

1. **Please share the plan each correctional institute is using to ensure the safety and prevention of COVID-19 in each facility.**
   We're interested in whether your department is:
   - Complying with guidelines, such as the Center for Disease Control and Prevention's Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities or the Standard Minimum Rules for the Treatment of Prisoners.

   APDC's Response: The APDC uses applicable procedures in line with the Center for Disease Control and Prevention's Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities.

2. **Process for intake and COVID-19 screening, testing, and treatment for people who are incarcerated.**

APDC's Response:

Arrestee:

1. Any arrestee with a temperature of 100.4 or more, the Nurse shall be notified for additional instructions.
2. All Arrestees will be quarantine / isolated for 14 days.
3. After the 14 days quarantine, the arrestee' temperature will be checked before being placed in general population.
4. All arrestees suspected of COVID 19, will be tested by the Assumption Community Hospital.
5. The APDC will report all positive COVID 19 tests to the DPS&C and follow their instructions.

3. **Process for screening staff and third-party vendors who enter in any physical capacity into the correctional facility to mitigate further spread of the virus.**

APDC's Response:

1. All staff members (Deputies and Correctional Officers) are required to have their temperature checked at the beginning of their tour of duty. Employees are required to wear a mask when they come in contact with an arrestee or an inmate.
2. All visitors / vendors, including bail bondmen, attorneys, police jury's representatives, etc., entering the APDC's are required to wear a mask and have their temperature checked.
3. All arrestees (A person just arrested) and inmates returning to the APDC's are required to have their temperature checked.
4. Anyone with a temperature of 100 or more but under 100.4 has to have the Warden's approval.
5. Any Staff member or vendor that has a temperature of 100.4 will be denied entry to the APDC.
6. Staff members will be instructed to be tested for COVID 19.

4. **Is there currently a process or plan for controlled evacuation of people who are incarcerated who meet certain criteria, such as the ones noted below? If so, please indicate the number of people who have been released by correctional institute.**
   - *Detained, but not charged with a crime;*
   - *Charged with, but not yet convicted of a crime;*
   - *Convicted per a conviction that is not finalized; or*
   - *Serving time on a finalized conviction.*
   - *NOTE: For each case, the following factors must be weighed: nonviolent offense, the nature of crime(s) involved, a person's behavioral record while incarcerated, his/her medical/physical condition, etc.*

APDC's Response:

The 23rd District Judges reduced several inmates' bonds that were nonviolent offenders and one was transferred to a rehabilitation center because of his drug addiction / medical condition. The APDC's responses to the remaining questions are as follows:

- **Detained, but not charged with a crime**
  - None
- **Charged with, but not yet convicted of a crime – Yes**
  - 49 Pre-Trial inmates

- 4 Pre-Trial for other Parishes

- **Convicted per a conviction that is not finalized –**
  - None
- **Serving time on a finalized conviction – Yes**
  - 21 DOC's inmates
  - 5 Parolees
  - No – inmate Serving Parish Time.

Respectfully,

Warden Roland Rodrigue, AU 100
Assumption Parish Detention Center
Office: 985.369.7283 (Ext. 10)
Cell: 985.498.6282
Fax: 985.369.2933

BOSSIER CITY POLICE DEPARTMENT

P.O. Box 6216
BOSSIER CITY, LOUISIANA 71171 – 6216
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Facsimile: (318) 741-8614

The Bossier City Police Department Jail does comply and follow the guidelines provided by the Centers for Disease Control. The jail was operating with only essential personnel until recently. All arrestees and officers must wear proper personal protective equipment masks before entering the jail. The arrestee's temperature is taken with a "No Touch" thermometer and a series of COVID-19 related questions are asked before the booking process begins. The jail staff and arrestee wear masks during the entire booking and fingerprinting process. The jail has a medical officer through the Bossier City Fire Department that assists with identifying any possible COVID-19 related issues. The medical officer has direct contact with a medical director/doctor for the City. Jail staff have their temperature taken at the beginning of every shift. Any bondsmen or third-party vendors must wear masks before entering the jail and their access is limited.

The jail is currently only accepting felonies, driving while intoxicated (DWI's), and crimes that require transfer to the parish facility. All other offenses are issued a summons or released on their own recognizance. This has reduced our jail count down to a minimum. Currently there are five (5) prisoners housed in our jail. The jail is in a position to release the prisoners if there was need to evacuate. If there were circumstances that prevented a prisoner from being released when there was a need to evacuate, the jail staff is able to immediately transfer and transport the prisoner(s) to the parish facility. The nature of the crime and the prisoner's condition would factor into this decision to release or transport to the parish facility.

The jail has PPE, hand sanitizer, and disinfectants to deal with COVID-19 concerns. The jail is sanitized with an Aeroclave machine every other day. The jail has the ability to isolate any prisoner that raises any COVID-19 concerns. All jail personnel are familiar with the signs and symptoms of COVID-19.

Parish of Caddo
Department of Juvenile Services

Continuity of Operations Plan in response to COVID-19 for
Caddo Parish Juvenile Services

Caddo Parish Juvenile Services will operate under a two-tiered system in response to COVID-19. Each Level will be activated through the approval of Caddo Parish CEO, in coordination with the Caddo Parish Juvenile Court, the Caddo Parish District Attorney's Office, the Caddo Parish Public Defender, the Caddo Parish School System, the Shreveport Police Department and the Caddo Parish Sheriff's Office. The goal of the response system is to decrease the number of visitors to the Juvenile Detention Center and Caddo Parish Juvenile Court, thereby decreasing exposure to staff and detention residents, as well as limiting the congregation of citizens.

Level I
Juvenile Detention

- **Sanitation:** The sanitation of the facility has been increased. Hand sanitizer is available at all entrances into the facility and all persons who enter must immediately use the sanitizer before conducting business. Each shift will conduct two scheduled handwashing breaks during the shift.
- **Visitation:** Visitation is suspended. Only Probation Officers and Attorneys are able to visit with the residents. Because visitation is suspended, the residents will now have four (4) free phone calls -- one for each day visitation is normally held.
- **Programming:** The programming at the Detention Center is reduced. The only outside programs that will be available to the residents are Goodwill, the Multicultural Center for the South, and Art Therapy. These programs are necessary for the residents and require only one person from the community to enter the facility. School will continue for the residents. All other programs, including all volunteer programs, are cancelled.
- **Reporting Illness**: All staff have been notified to report any illness other than seasonal allergies and to follow reporting and testing protocols before returning to work.
- **14 Day Self Quarantine:** Staff who are returning from other states, countries or cruises which have reported cases of COVID-19 will self-quarantine for 14 days before reporting to work.

Juvenile Probation

- **Sanitation:** The sanitation of the facility has been increased. Hand sanitizer is available at all entrances into the facility and all persons who enter must immediately use the sanitizer before conducting business.
- **Social Distancing:** While visiting clients and families in the community and in school, Probation Officers shall keep a distance of at least six feet from other persons and shall use hand sanitizer after each visit. Clients coming into the main building and Annex will be asked to use hand sanitizer as they enter the building. Probation Officers shall maintain as much distance from the clients as possible while in the office. After clients have visited the office, the office shall be cleaned with disinfectant spray and/or wipes.
- **Drug Court:** Drug Screening and Treatment Groups in the Juvenile Court Annex shall continue as scheduled with current policies regarding safety and sanitizing after drug screening. Staff and counselors shall keep a distance of six feet from clients and use hand sanitizer and disinfectant after client contact. Probation Officers shall continue to drug screen clients in the office, sanitizing after each screen. Drug Screening in the field (adults and juveniles) is suspended.
- **Reporting Illness:** All staff have been notified to report to the Probation Manager any contact with any clients or family members who may have been ill or displaying symptoms of a cold or flu. All staff shall report any personal symptoms of a cold or flu or any family members with symptoms of cold or flu to the Probation Manager.

- **14 Day Self Quarantine:** Staff who are returning from other states, countries or cruises which have reported cases of COVID-19 will self-quarantine for 14 days before reporting to work.

Level II
Juvenile Detention

- **Alternating Management Schedules:** Detention Management will alternate with the Manager and Assistant Manager in three day increments. The schedule will be determined by the Detention Manager.

- **Sanitation:** The sanitation of the facility has been increased. Hand sanitizer is available at all entrances into the facility and all persons who enter must immediately use the sanitizer before conducting business. Each shift will conduct two scheduled handwashing breaks during the shift.
- **Visitation:** All visitation is suspended. Probation Officers and Attorneys will have access to telephone contact with the residents. Because visitation is suspended, the residents will now have four (4) free phone calls -- one for each day visitation is normally held.
- **Programming:** The programming at the Detention Center, including all volunteer programs, is cancelled. School is cancelled.
- **Cafeteria:** Lunch for anyone other than detention staff and residents is cancelled
- **Incoming Residents and Reporting Staff:** All Staff reporting for their shift and any juveniles that are coming into the facility will have their temperature checked. Any staff with a temperature over 99 degrees will need to follow reporting and testing protocols before returning to work. Juvenile residents with a temperature between 99 degrees and 101.4 degrees will be isolated and proceed with an emergency risk assessment for release or remand. Juvenile residents with a temperature over 101.4 must be medically cleared before entering the facility according to Louisiana State Juvenile Detention Standards.
- **Daily Resident Checks:** Each morning before breakfast and each evening after supper, all residents will have their temperatures checked. Any resident with a temperature between 99 degrees and 101.4 degrees will be isolated and monitored. Juvenile residents with a temperature over 101.4 must be transported to LSU-Ochsner for testing.
- **Reporting Illness:** All staff have been notified to report any illness other than seasonal allergies and to follow reporting and testing protocols before returning to work.
- **14 Day Self Quarantine:** Staff who are returning from other states, countries or cruises which have reported cases of COVID-19 will self-quarantine for 14 days before reporting to work.

Juvenile Probation

- **Alternating Management Schedules:** Probation Management will alternate with the Manager and Supervisors in three day increments. The schedule will be determined by the Probation Manager.
- **Probation Officers:** Probation Officers will take the Court vehicles home and will work from home. Probation Officers shall maintain contact with their clients on the basis of risk level.

  a. Lower risk clients may be contacted by phone at least once per week. The contacts shall be documented in writing to be input into IJJIS upon the Probation Officers' return to the office.

  b. Higher risk cases, Intensive cases and cases that need to be monitored more closely shall be visited at home at least once per week. The visits shall take place outside the home with the Probation Officer maintaining a distance of at least six feet from the client and family.

  Hand sanitizer shall be used immediately following contact with the client and family.

  Visits shall be documented on the mileage reports and case notes shall be entered into IJJIS upon the Probation Officers' return to the office.
- **Court Hearings:** Court hearings will be held on a case-by-case basis as determined by the Caddo Parish Juvenile Court. Continued custody hearings, trials and any other Court hearings will be scheduled only as needed. Supervisors will be present in Court for the Probation Officers. Probation Officers will send an email or text message with pertinent information for any case scheduled for Court during this time. Probation Officers must ensure that their case files are accurate and completely up to date with case notes, school records and any other pertinent information in case the supervisor has to stand in for the Probation Officer in Court.
- **Sanitation:** The sanitation of the facility has been increased. Hand sanitizer is available at all entrances into the facility and all person who enter must immediately use the sanitizer before conducting business.

- **Social Distancing:** Clients coming into the main building and annex will be asked to use hand sanitizer as they enter the building. Probation Officers shall maintain as much distance from the clients as possible while in the office. After clients have visited the office, the office shall be cleaned with disinfectant spray and/or wipes.
- **Drug Court:** Drug screening of clients and in-house treatment (adults and juveniles) is suspended.
- **Reporting Illness:** All staff have been notified to report to the Probation Manager any contact with any clients or family members who may have been ill or displaying symptoms of a cold or flu. All staff shall report any personal symptoms of a cold or flu or any family members with symptoms of cold or flu to the Probation Manager.
- **14 Day Self Quarantine:** Staff who are returning from other states, countries or cruises which have reported cases of COVID-19 will self-quarantine for 14 days before reporting to work.

Level III

Juvenile Detention

- **Alternating Management Schedules:** Detention Management will alternate with the Manager and Assistant Manager in one-week increments. The schedule will be determined by the Detention Manager.
- **Sanitation:** The sanitation of the facility has been increased. Hand sanitizer is available at all entrances into the facility and all persons who enter must immediately use the sanitizer before conducting business. Each shift will conduct two scheduled handwashing breaks during the shift.
- **Visitation**
  All visitation is suspended. Probation Officers and Attorneys will have access to telephone contact with the residents. Because visitation is suspended, the residents will now have four (4) free phone calls -- one for each day visitation is normally held.
- **Programming**
  The programming at the Detention Center, including all volunteer programs, is cancelled. School is cancelled.
- **Cafeteria**
  Lunch for anyone other than detention staff and residents is cancelled
- **Incoming Residents and Reporting Staff**
  All Staff reporting for their shift and any juveniles that are coming into the facility will have their temperature checked. Any staff with a temperature over 99 degrees will need to follow reporting and testing protocols before returning to work. Juvenile residents with a temperature between 99 degrees and 101.4 degrees will be isolated and proceed with an emergency risk assessment for release or remand. Juvenile residents with a temperature over 101.4 must be medically cleared before entering the facility according to Louisiana State Juvenile Detention Standards.
- **Daily Resident Checks**
  Each morning before breakfast and each evening after supper, all residents will have their temperatures checked. Any resident with a temperature between 99 degrees and 101.4 degrees will be isolated and monitored. Juvenile residents with a temperature over 101.4 must be transported to LSU-Ochsner for testing.
- **Reporting Illness**
  All staff have been notified to report any illness other than seasonal allergies and to follow reporting and testing protocols before returning to work.
- **14 Day Self Quarantine**
  Staff who are returning from other states, countries or cruises which have reported cases of COVID-19 will self-quarantine for 14 days before reporting to work.

Juvenile Probation

- **Alternating Management Schedules:** The Assistant Director, Probation Manager and Supervisors will now work from home. Communication with Probation Officers will take place daily to monitor caseloads and supervision levels. All Administrative staff must work from home on assigned data projects. The main phone line will be forwarded and monitored from 8am to 5pm by the Director.
- **Probation Officers:** Probation Officers will take the Court vehicles home and will work from home. Probation Officers shall maintain contact with their clients on the basis of risk level.
  a. Lower risk clients may be contacted by phone at least once per week. The contacts shall be documented in writing to be input into IJJIS upon the Probation Officers' return to the office.
  b. Higher risk cases, Intensive cases and cases that need to be monitored more closely may also be contacted by phone at least once per week and shall be visited at home as needed. The visits shall take place outside the home with the Probation Officer maintaining a distance of at least six feet from the client and family.

  Hand sanitizer shall be used immediately following contact with the client and family.
  Visits shall be documented on the mileage reports and case notes shall be entered into IJJIS upon the Probation Officers' return to the office.
- **Court Hearings:** Continued custody hearings will be scheduled only as needed. Trials and any other Court hearings are postponed. The Director will be present in Court for Probation. If any Probation Officer needs to file an Order to Take into Custody, the Probation Officer will send an email with pertinent information to the Director. Probation Officers must ensure that their case files are accurate and completely up to date with case notes and any other pertinent information in case the Director has to stand in for the Probation Officer in Court.
- **Sanitation:** The sanitation of the facility has been increased. Hand sanitizer is available at all entrances into the facility and all person who enter must immediately use the sanitizer before conducting business.
- **Social Distancing:** The Courthouse is closed to any clients or visitors.
- **Drug Court:** Drug screening of clients and in-house treatment (adults and juveniles) is suspended.

- **Reporting Illness:** All staff have been notified to report to the Probation Manager any contact with any clients or family members who may have been ill or displaying symptoms of a cold or flu. All staff shall report any personal symptoms of a cold or flu or any family members with symptoms of cold or flu to the Probation Manager.
- **14 Day Self Quarantine:** Staff who are returning from other states, countries or cruises which have reported cases of COVID-19 will self-quarantine for 14 days before reporting to work.

COVID-19 IN SPECIAL POPULATIONS

Livingston Parish Detention Center

Livingston, La

Compliance of Guidelines

We implemented procedures in the beginning of the pandemic that were consistent with the guidelines suggested by the Louisiana Department of Corrections. These guidelines are consistent with the Center of Disease Control in regard to medical isolation, quarantine processes, and medical evaluations. We have educated our offender population on proper hygiene practices and provided the resources to accomplish these hygiene practices. The education process has come through literature provided by the Center of Disease Control and through daily contact with our deputies. Our office has obtained resources and supplies to sustain a short term outbreak of Covid-19 in the event that this occurs. Our detention center is staffed with numerous full time on-site medical professionals who are taking precautions and evaluating offenders daily.

Process of offender Intake

At the beginning of the pandemic our office utilized a secondary detention facility not adjoined to our detention center for all new intakes. Extra precautions were taken to ensure that new intakes were medically evaluated and had limited contact to outside sources that could alter the evaluation process. After being medically evaluated the offender was transferred to our detention center where he/she was medically evaluated before being placed into an intake dorm which consisted of only offenders that were arrested since the beginning of the pandemic. We initiated this to protect our general population from outside sources. We currently have three new intake dorms assigned to this task in an attempt to prevent the possible outbreak of any Covid-19 into our general offender population. All offenders who displayed symptoms or originated from an area of high risk throughout our state was isolated and tested for Covid-19 before being implemented into one of the special intake dorms. All inmate intakes were conducted by staff within the guidelines of the Louisiana Department of Correction screening sheet. This screening included the evaluation of new intakes temperatures as well as a series of questions to determine health risk of a new intake.

Staff and Third Party Screening

At the beginning of the pandemic our office ceased all third party entry into our facility in order to protect our offenders from possible exposure. Trustee contact visits were ceased and free video visits were granted to supplement their visitation. All offenders received additional free telephone usage through our vendor due to the pandemic. The only vendor allowed in the facility was deemed essential to maintain the video visitation system which also generates offender request to our staff. This vendor technician was evaluated based on the Louisiana Department of Corrections screening form and temperature monitored. PPE was utilized and no contact with offenders was allowed. Livingston Parish Detention Center staff adhered to a strict screening process which included temperature evaluations and the screening questions provided by the Department of Corrections. This process was conducted at roll call by supervisors and medical staff before any offender contact was established. No enforcement staff was allowed inside the facility and an alternate location was provided by the sheriff for them to complete their arrest documents. Staff was advised not to report to work and to get a medical clearance from their physician if he/she had experienced any symptoms related to the Covid-19. Staff were provided PPE and mandated to wear mask and gloves when in contact with offenders.

Controlled Release of Offenders due to Covid-19 Pandemic

No Covid-19 related releases have been conducted by the Livingston Parish Sheriff's Office in relation to offenders who are serving time for convicted crimes. All DOC offender releases have been authorized by the Department of Corrections who provided the proper release documents. Numerous pre-trial offenders have received continued court dates and notice of appearance. These have been

generated by the district judicial system and municipal judicial systems. None of the offenders were crimes of violence, domestic related, sex crimes, or felonies related to driving while impaired.

SLIDELL POLICE DEPARTMENT
Nationally Accredited

Randy Fandal, Chief of Police

May 26, 2020

Lieutenant Newman,

In response to the request concerning COVID-19 in Louisiana Prisons, I am supplying the following information pertaining to how we have responded to the pandemic to this point.

The following protocols have been in place;

- Correctional employees have their temperature taken at either the Slidell Memorial Hospital or with an infra-red thermometer, which is assigned to the jail. Temperatures are taken daily prior to beginning duty. Protective masks, gowns, goggles and latex gloves are made readily available for the officer's and offenders protection. "Social distancing" is adhered to whenever possible.

- All prisoners brought to the Slidell City Jail are met outside of the jail facility for screening prior to being admitted into the jail. The screening consists of their temperature being taken, oxygen levels are taken, pulse / heart rate is taken, and blood pressure is taken. A series of COVID-19 related questions is also asked which are printed on a form (See Attached). The questions were either provided by our contract medical staff, or added due to being possible COVID-19 risk factors.

- Any prisoner running fever or otherwise failing the admittance process will be refused by the jail facility until the prisoner has been medically cleared.

- Any prisoner with a felony arrest who tests positive for the COVID-19 will be issued a protective mask, brought to jail, and booked. The Sheriff's Office Jail is contacted during booking and advised of the prisoners condition so they can prepare for his reception. Immediately after the booking process is complete the felony prisoner will be transported to the St. Tammany Parish Jail. The Corrections employee making the transport will utilize available protective equipment during contact and transport.

- Upon removal of the prisoner from the jail booking area, any area contacted by the prisoner is immediately sanitized. The transporting unit will also be sanitized upon its return to the police department.

To help with combating the COVID-19 pandemic, the Chief and Slidell City Court Judge have instituted guidelines that have reduced the threat of infection. These guidelines include making summons arrests whenever possible, which is practiced in all except for very rare cases. Authorization has also been obtained to issue arrested subjects either "OR" or "Signature Bonds" for release.

It has also been the Chiefs policy to keep all DOC inmates confined strictly to the police compound. All visitations have also been cancelled to decrease outside contacts and risk factors.

In the event that we encounter a non-bondable misdemeanor prisoner, or a DOC inmate who contracts COVID-19, these prisoners will be confined in Cell 1, which has been designated as a "quarantine cell." Any employee coming into near contact with a prisoner in the quarantine cell will at all times utilize protective equipment. Additionally, all items touched, or in close proximity to a quarantined prisoner will be immediately sanitized.

Although these polices are in place specifically for the handling of COVID-19 prisoners, the Slidell City Jail maintains cleanliness and sanitization practices on a consistent basis. Trustee inmates mop the floors with chemical disinfectant and wipe down walls, door knobs and other commonly handled items within the jail with a bleach solution or disinfectant spray. Food trays are sanitized after meals by use of a commercial dishwasher designed and rated specifically to sanitize plates, cups and utensils.

The questionnaire also makes inquiry concerning;

- "Process for screening staff and third party vendors who enter in any physical capacity into the correctional facility to mitigate further spread of the virus."
In the event of third party entry into the jail facility, the third party is required to wear protective masks.

- "Detained but not charged with a crime."
This is non applicable to this facility. We do not detain subjects in our facility without criminal charges.

- "Charged with, but not yet convicted of a crime."
Procedures such as "OR" bonds and "Signature bonds" have been put in place to effectively eliminate the jail population.

- "Convicted per a conviction that is not finalized; or serving time on a finalized conviction."
The only convicted persons serving sentence in the Slidell City Jail are Louisiana Department of Corrections inmates. They will be released at the direction of DOC.

If I can be of further assistance, please let me know.

Captain R. McLellan
Commander
Corrections / Training

*2112 Sgt. Alfred Drive, Slidell, Louisiana 70458 * Phone (985)643-3131*

SLIDELL POLICE DEPARTMENT
Nationally Accredited

Randy Fandal, Chief of Police

CORRECTIONS DIVISION

Name: _____ Item or DOC # _____

Have you been out the country recently? Yes No

What date _____ & what country? _____

Have you been in the company of someone who has been out of the country? Yes No

Medical Questions

1. Do you have any **breathing difficulties** at this time, such as **shortness of breath**? Yes No

If Yes, when did it start_____

2. Have you been experiencing a **dry coughing**? Yes No If Yes, when did it start_____

3. Do you feel like your **chest is congested**? Yes No If Yes, when did it begin _____

4A. Do you have **seasonal allergy**? Yes No **4B.** Have you been **sneezing**? Yes No

A. If Yes, when did it start _____ **B.** When did it start? _____

5. Do you feel **fatigued?** Yes No **Circle all that applies:**

Weakness, irritability, stiff shoulders, body tiredness, trouble concentrating, exhaustion-

even after sleeping, nervousness, anxiety or impatience? Date started? _____

6. Have you been experiencing **headaches?** Yes No If Yes, For how long? _____

7. Are you experiencing **diarrhea**? Yes No If yes for how many days? _____

8. Have you experienced and **dizziness or confusion?** Yes No **When?** _____

9. Any known **Drug allergies or latex allergy?** **Yes No List:** _____

10. Blueness to fingers or face? _____

LOUISIANA COVID-19 HEALTH EQUITY TASK FORCE

SUBCOMMITTEE REPORT

Subcommittee Name: Special Populations – Nursing Homes

Subcommittee Members: Dr. Alicia Bates, Dr. Jeanine Thomas, Dr. Leanne Fowler, Dr. Kathleen Tate, Mrs. Cindra Schneider, and Dr. Lisa VanHoose

Priorities/Goals: (1) Explore the impact of COVID-19 on special populations, specifically Louisiana nursing home population [examining the number of positive cases, deaths, age, gender, race, geographic location]; (2) Develop a comprehensive plan to address safety and prevention of COVID-19 in nursing home residents.

Statement of the Problem:	Currently, ***1,152*** Nursing Home (NH) residents in Louisiana have died from contracting the coronavirus. These deaths account for ***40 %*** of the state's overall death rate. The rapid rise of COVID-19 related deaths within Louisiana's nursing homes is alarming and warrants immediate attention.
Background:	Based on the congregate nature of the nursing home population, as well as the prevalence of co-morbidities and frailty in the elderly, viral infections such as COVID-19 are more likely to spread, potentially causing clusters, or hotspots, of the virus. As COVID-19 quickly evolved, it became evident that nursing homes were lacking in policies, procedures, and practices regarding testing, tracking, trending, capacity, and compliance. However, since the outbreak, new regulations and procedures have been implemented among Louisiana's nursing homes. In compliance with the requirements of the Centers for Medicare and Medicaid (CMS), all licensed facilities are required to report certain measures to the Louisiana Department of Health, as well as the Center for Disease Control (CDC)'s National Healthcare Safety Network. These measures include the number of positive COVID-19 cases, number of deaths, and the number of positive COVID-19 staff cases. According to the Institute of Medicine [IOM] (2016), health equity is defined as "providing care that does not vary in quality based on personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status." Health equity means giving patients the care that they need when they need it (IOM,

	2016). Differences in demographics can shed light on those differing, yet specific needs. Currently, the tracking and reporting of demographic data (age, gender, race, and geographic location) among positive COVID-19 cases and deaths is insufficient, preventing group analysis. This speaks to yet another problem. Without knowing the demographics of the NH residents, it will be challenging to discern inequities among the NH population.
Supporting Data/Evidence:	Since May 18, 2020, 278 facilities have reported data for the weekly Louisiana Nursing Home Report published by the Louisiana Department of Health. This report was accessed on May 18, 2020, May 25, 2020, and June 1, 2020 for the most recent NH data and can be reviewed on the following webpage, http://ldh.la.gov/index.cfm/page/3965. Additional supporting data was accessed and reviewed from the Louisiana COVID-19 Dashboard, as well as the U.S. Census Bureau Population Division. Louisiana's Homeland Security provided updated data about state and regional definitions and can be viewed at the following website, https://gohsep.la.gov/ABOUT/STATE-REGIONS. There are several agencies with written guidelines that govern nursing homes and provide recommendations related to COVID-19. Overall, these agencies have similar guidelines, and are now collaborating. The following agency's guidelines were reviewed: • CDC Recommendations and Resources • CMS Guidelines • LDH Guidelines and Resources • The Joint Commission Guidelines • Veterans' NH Administration Guidelines • Louisiana Nursing Home Association Position Statement
Summary of Findings:	The overall findings of the nursing home data are based on information provided by the Louisiana Department of Health (LDH). As of June 1, 2020, there have been a total of ***4,739*** positive COVID-19 cases among the 278 nursing homes within the state of Louisiana. Even more daunting is the exponential death rate. Of the ***2,825*** deaths in the state of Louisiana, ***1,152*** are attributed to nursing homes, which represents 40% of the state's death toll. Thus far, the deadliest outbreak (based on highest number of deaths), has occurred in St. Tammany Parish with a total of 65 positive resident cases and 37 deaths (n=120) at just ***one*** NH facility. For some parishes, when comparing the COVID-related NH deaths to the overall parish deaths, the percentages are well over 50 %, which further validates that nursing homes are disproportionally affected by the coronavirus. Likewise, there is a significant and positive relationship between COVID-19 NH resident deaths and the number of positive staff cases ($r(61) = 0.98$, $p < 0.001$).

	Due to the inconsistency with data collection, limited data is reported regarding the demographics (age, gender, race, and geographic location) of Louisiana's NH residents. Additionally, the inconsistencies with testing, tracking, trending, compliance, and capacity have led to an increase in positive resident and staff cases and deaths.
Recommendations (based on priorities):	Since COVID-19 can lead to deadly outbreaks, it is imperative that standardized, evidenced-based practices are implemented to ensure the safety and prevention of COVID-19, as well as decrease the number of deaths within Louisiana's nursing homes. Nationally, the CDC has developed key recommendations and strategies that all long-term care facilities should implement. In alignment with these key strategies, the nursing home platform, the **3T's plus the double C's** has been developed. The platform includes the following- elements: **I. Testing** 1. In addition to the guidelines published by LDH, all residents should be tested upon **new admission and prior to readmission** to the nursing home facility. a. Facilities should utilize same day testing. b. Facilities should confirm negative test results before resident admission or readmission. 2. In compliance with CMS's recommended COVID-19 screening and precautions (e.g. hand hygiene, social distancing), up to 2 individuals can visit the facility per day and should be tested upon entry into the facility. a. Facilities should utilize same day testing. 3. All NH Staff should be tested immediately **upon hire.** a. Facilities should consider including requirements for self-reporting positive test results. b. Facilities should consider requiring staff to report other employment because this places the staff at a higher risk for disease transmission (e.g. 2nd job at another healthcare facility). **II. Tracking (Tracing)** 1. In partnership with LDH's contract tracers, nursing home facilities with less than 100 residents should have at least one (1) employee designated and trained as a *contact tracer.* This will help to facilitate the interview process, which could be challenged by the resident's sensory, cognitive, or communication deficits. Facilities that have greater than 100 residents, should utilize their Infection Prevention and Control (ICP) coordinator as the contact tracer.

a. These designated NH *contact tracers* should keep a database of all positive **RESIDENT** cases and contacts and report this information to LDH.
b. The contact information (phone number) for the designated contact tracer should be available publicly on the NH website(s).
c. All demographic data collected by NH contact tracers should be reported to the LDH.

2. All contact tracers, whether employed by the NH or LDH, should collect accurate demographic data (e.g. age, gender, ethnicity, and geographical location) on all positive staff and resident cases.
3. A ***formal data sharing agreement*** with LDH should be established that includes the sharing of available, raw data related to COVID-19. Specifically, the collection of resident's demographic information (e.g. age, gender, ethnicity, and geographical location) and co-morbidities is needed.

III. Trending

1. In contrast to the CDC recommendations, and due to the congregate nature of the nursing home population, as well as the increased transmission rate (1 person can infect up to 5.7 persons), a 5 % increase of positive cases during weekly testing requires a return to Phase One (Sanchen et al., 2020).

2. LDH will aggregate and trend demographic data (e.g. age, gender, ethnicity, and geographical location) on all positive staff and resident cases and/or deaths.

IV. Compliance

1. All NH facilities should examine their current COVID-19 policies and procedures for compliance with the established CDC, CMS, and LDH guidelines.

2. Inconsistencies and/or lack of compliance should be addressed by administration, and a performance improvement plan should be developed and implemented.

3. All NH facilities should conduct weekly compliance audits that are recorded and tracked. Facilities that are noncompliant with the established CDC, CMS, and LDH guidelines should be reported to the Healthcare Associated Infections Resource Center, located at the LDH, for continued monitoring.

4. NH administrators, LDH, and the Task Force will partner and develop a focus group with the intent of conducting a SWOT analysis of findings related to various COVID-19 standards and practices.

	5. The COVID-19 Health Equity Task Force (specifically the nursing home subcommittee) will collaborate with LDH to ensure that the recommended demographic data is representative of the nursing home population. **V. Capacity** **1.** All NH facilities should implement frailty education and training among all staff and employees. **2.** At minimum, all nursing homes should screen residents greater than age 70 for frailty using a valid and reliable frail scale. The frailty assessment should be completed by a licensed nurse. Residents that are identified as frail are high risk and should receive more frequent screenings or assessments by licensed nursing personnel.
Responsible Parties and Timeline for Completion (if applicable)	30 Days **Disclaimer:** As a committee, we recognize that information regarding COVID-19 and nursing homes is constantly evolving and changing, sometimes on an hourly basis. This report is based on the current information that was available at the time that this report was written.
Committee Contact(s):	Dr. Alicia Bates, Dr. Jeanine Thomas, Dr. Leanne Fowler, Dr. Kathleen Tate, Mrs. Cindra Schneider, and Dr. Lisa VanHoose

LOUISIANA COVID-19 HEALTH EQUITY TASK FORCE

SUBCOMMITTEE REPORT

Subcommittee Name: COVID-19 Policy and Regulatory Affairs

Subcommittee Members: Damien Ejigiri – Co-Chair; Eric van Holm, Ph.D. – Co-Chair; Deleso A. Alford J.D., L.L.M; Tavell L. Kindall, DNP, APRN, FNP-BC; Alma C. Stewart, RN, MS; Christopher J. Tyson, J.D.; Representative Dustin Miller

Priorities/Goals: Develop policy and regulatory recommendations to minimize inequitable distribution of healthcare services

Statement of the Problem:	The emerging conversation around the social and political determinants of health provides a rich framing for thinking about government's response to the COVID-19 pandemic and its disproportionate impact on black communities. Research underscores the link between public health and a host of factors that reflect the cumulative impact of political, socio-economic, and spatial policy decisions that had the intention and impact of marginalizing, disinvesting, and isolating black communities. The scope of these decisions stem from every category of public activity and the state's role in structuring civil society. Today racial disparities in health reflect this legacy of discrimination. Reckoning with this legacy must therefore be the starting point for a broader consideration of policy and regulatory responses to address the inequitable distribution of healthcare services and outcomes in the COVID-19 response.
Background:	With regard to the political drivers of health disparities, Louisiana's post-emancipation history saw the maintenance of white supremacy as one of the chief organizing principles for the distribution of resources and human development. This meant the pursuit of politics and implementation of policy was explicitly race-based and racist. Whether in housing, transportation, natural resources development, education, criminal justice, or health care, black communities were perceived to be exploitable. While the post-Civil Rights period has been one of formal equality, the consequences of decades of formal, intentional, and coordinated black subordination have never been systematically addressed. Furthermore, their impacts are transferred

	intergenerationally, accumulating in the many disparities between black and white Louisianans. These politics and policies have specific socio-economic consequences, robbing black families of income and wealth creating opportunities while subsidizing the creation of wealth in white families and communities. The result is a climate of deprivation and scarcity in black communities which manifests itself in high rates of crime, increased stress, addiction, and abuse. These developments have been understood to be the result of cultural factors – a nod to the long history of biologically-based notions of black inferiority. This narrative became the justification for even more draconian, retributive, and punitive policies that further marginalized black communities. The ensuing wealth gaps, over-policing, over-criminalization, and social stigmas are popularly understood as pre-political and inevitable. Finally, there is an underappreciated spatial dimension to systemic and institutionalized black subordination. The de jure and de facto segregation of black communities constitutes the guiding logic for the spatial organization of cities in Louisiana and throughout the nation. Every city in Louisiana is racially segregated, resulting in racial and spatial stratification in quality of life and quality of location. Substandard housing, abandoned buildings, vacant lots, and over-exposure to environmental harms are the distinct mark of Louisiana's predominately black communities. The lack of green space, quality affordable housing, and access to healthy food compound the stress on black communities. Moreover, the location of highways, polluting industries, and the development of flood-prone property has all contributed to black communities' greater susceptibility to illness and disease. The persistence of spatially concentrated, inter-generationally transferred black poverty and disadvantage is a defining feature of the life in Louisiana and has a direct link to public health problems, as is evident through the COVID-19 epidemic. These political, socio-economic, and spatial drivers of general well-being and mental and physical health are persistent. Incessant black subordination is being challenged by emerging racial justice movements like Black Lives Matter and the global uprising in the wake of the murder of George Floyd, Breonna Taylor, and countless others. These movements have pushed mainstream race discourse beyond a limited focus on interpersonal relationships and diversity towards a broader, more systemic conception of racial equity and justice. Consideration of how systems, institutions and processes operate to maintain and exacerbate racial inequality is essential in constructing durable and impactful solutions to the current COVID-19 crisis and its disproportionate racial impacts. The political, socio-economic, and spatial dimensions of black subordination, throughout Louisiana's history and continuing today, must be rigorously examined and explored if there is to be any meaningful policy and regulatory response to the reality of health disparities.
Supporting Data/Evidence:	Louisiana ranks 25th in the nation for the share of its population that is uninsured. According to Wallethub's "**2018's Best & Worst States for Health Care**," Louisiana had

the worst health care in the nation.[1] Further data published in that report breaks down the rate of uninsured into separate groups.

	2018 Overall	2018 children uninsured rate	2018 adult uninsured rate	White uninsured rate	Black uninsured rate	Hispanic uninsured rate
Uninsured	8.5%	3.38%	9.55%	6.22%	8.03%	27.69%
National Rank	(25)	(14)	(30)	(28)	(14)	(45)

TABLE 1. DATA COLLECTED FROM HTTPS://WALLETHUB.COM/EDU/UNINSURED-RATES-BY-STATE/4800/

Roughly 40% of the state is enrolled in Medicare, following the state's expansion of access in 2016.[2] In addition, there has been a steady increase in enrollment since the initial outbreak of COVID-19. According to a report published by the Louisiana Department of Health, the state's uninsured rate for non-elderly adults has declined from 18% in 2015 to 13% in 2018 largely because of the Medicaid expansion.[3]

Louisiana ranks 49h overall among the 50 states in the United Health Care Foundation's report, *America's Health Rankings 2019*.[4] The poor overall health of Louisiana is likely partially driven by relatively higher rates of heart disease, HIV, and drug-related mortality than other states as shown by a report published by the Center of Disease Control (CDC).[5] Health disparities exit within those figures. Black residents are the most likely to report fair or poor general health, the most likely to be obese, and the least likely to access regular care from a doctor. These figures all exceed national averages.[6]

In addition, Louisiana is at or above the national average for measures of problems related to mental health[7] and access to care is among the ten lowest in the nation.[8] These problems will likely be compounded by COVID-19, as mental distress has tripled since COVID-19 compared to 2018.[9] **HB 449**, which allows for greater access to telehealth services, is a promising start in this regard. However, of the trillions spent on health by the federal stimulus, very little has gone to expanding mental healthcare.[10]

Expanding the ability of nurse practitioners to work at the highest level of their education and training without restriction may help to increase access to healthcare. Nurse practitioners are currently required to have a collaborative agreement with another health provider to provide patient care. However, nurse practitioners have

[1] https://www.thecentersquare.com/louisiana/report-louisiana-has-worst-health-care-in-u-s/article_037fbd76-a0a5-11e8-ab0b-278784b98881.html
[2] http://ldh.la.gov/assets/medicaid/AnnualReports/MedicaidAnnualReport2018_v4.pdf
[3] http://ldh.la.gov/assets/media/3and4.2019FinalReportMedicaidExpansionstudy.pdf
[4] https://www.americashealthrankings.org/
[5] https://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_02.pdf
[6] https://www.kff.org/health-reform/fact-sheet/the-louisiana-health-care-landscape/
[7] https://www.kff.org/health-reform/fact-sheet/the-louisiana-health-care-landscape/
[8] https://www.mhanational.org/sites/default/files/2019-09/2019%20MH%20in%20America%20Final.pdf
[9] https://time.com/5833619/mental-health-coronavirus/
[10] https://www.theadvocate.com/baton_rouge/opinion/article_fb53a668-a673-11ea-a0eb-4b4948f61ae9.html

	been found to provide similar levels of service and expand access particularly to hard to reach populations.[11] For many years, legislation has been introduced to address the issue of granting full practice authority for nurse practitioners in Louisiana; however, it has been met with tremendous resistance. Most recently, House Bill (HB) 864 was brought forth and considered, but it did not make it out of the House Health and Welfare Committee before the end of the 2020 Regular Session. Meanwhile, there are many states which allow full practice authority for nurse practitioners. Currently, many leading authorities are calling for the evolution of healthcare to include nurses working at their highest level the highest education and training without restriction.
Summary of Findings:	Louisiana needs to make significant progress in healthcare access to increase the physical and mental health of its residents. The state trails well behind the nation in most measures of health and access to health care. As such, significant effort is required to improve the health equity for the state's residents.
Recommendations (based on priorities):	1. Remove restrictive regulatory barriers that prevent nurse practitioners from practicing to the full extent of their education and training. Further, the Louisiana Legislature should carefully consider all legislation that addresses the issue to grant full practice authority to nurse practitioners revolutionizing healthcare in Louisiana to move towards a healthier state with greater access to the quality healthcare that nurse practitioners are more than capable to provide. 2. Allow nurse practitioners, clinical nurse specialists, and certified nurse midwives to practice to the full extent of their licensure and education by removing practice barriers. This will expand access to care in Louisiana's health professional shortage areas and increase the supply of APRNs in the state. Expand Medicaid recipients' access to care. (Health professional shortage areas is a broader umbrella and includes rural, tribal, etc.). 3. The Legislature should draft language to *state an exception to* LA Rev Stat § 14:313§313 which prohibits the wearing of masks in public places during the continued COVID-19 crises. 4. Mandate the provision of personal protective equipment (PPE) by employers to frontline workers, as Illinois (IL 5769) and California (CA 2537) have done. Emphasis should be placed on providing equipment to workers that are economically disadvantaged. 5. Implement trauma informed mental/behavioral health services that are evidence-based and include training and screening for adverse childhood experiences [see attachment A and B].

[11] https://www.aanp.org/advocacy/advocacy-resource/position-statements/quality-of-nurse-practitioner-practice

	6. Provide access to timely healthcare and healthcare coverage for COVID-19 related illnesses at no cost to patients that are uninsured. 7. The state should Adopt PolicyLink' guiding principles for an equitable recovery to guide the allocation of COVID-19 funding and resources: 1) Center Racial Equity; 2) Put People First; 3) Invest in Community Infrastructure; 4) Build an Equitable Economy, 5) Protect and Expand Community Voice and Power.[12] 8. Invest in a statewide health equity entity to continue health equity work on an ongoing basis and lead efforts that reduce inequities and disparities that impact African Americans and people living in or near poverty to improve their quality of life in Louisiana. One such entity is the Louisiana Center for Health Equity, established in 2010 as a nonpartisan 501 (c) (3) public charity non-profit organization. LCHE's purpose is to promote better health outcomes for Louisiana residents who face significant barriers to being healthy with a focus on wellness and community health. LCHE's most impactful accomplishment was leading the fight for Medicaid expansion to close the coverage gap for uninsured Louisianans. 9. Prioritize increasing economic security for African Americans who have been disproportionately impacted by COVID-19 and are most economically disadvantaged in Louisiana and people living in or near poverty through race-conscious policies and investments to stabilize people during the crisis enabling shared prosperity to reduce the impact of future emergencies.[13] 10. Dedicate funding for communities that have been most impacted by COVID-19.Allocate for retraining unskilled workers who cannot return to their old jobs and assist micro and small minority business owners restructure and restart, start or relocate their businesses in those impacted communities.
Responsible Parties and Timeline for Completion (if applicable)	N/A
Committee Contact(s):	Dr. Eric van Holm (evanholm@uno.edu)

[12] https://www.policylink.org/covid19-and-race/principles

[13] https://iwpr.org/wp-content/uploads/2018/09/R557_Lousiana.pdf;
https://cdn.americanprogress.org/content/uploads/2019/08/07112848/EconSecurity-LA.pdf

LOUISIANA COVID-19 HEALTH EQUITY TASK FORCE

SUBCOMMITTEE REPORT

Subcommittee Name: COVID-19 Community Outreach and Stakeholders Engagement (COSE)

Subcommittee Members: Margarita Echeverri (Co-Chair), Raymond Jetson (Co-Chair). Catherine Gray Haywood, Christian Engle, Frederick Thomas, Orlando McMeans, Rhoda Reddix, Rudy Macklin, Theron Jackson, Tiffany Netters, and Tina Granger.

Priorities/Goals: Develop a comprehensive guide for best practices, strategies, and resources to address COVID-19 utilizing community and faith-based organizations as it relates to isolation, grieving, and COVID-19 survivorship inclusive of older adults. This subcommittee will also identify platforms to increase community engagement and outreach for COVID-19.

Statement of the Problem:	According to the 2009 Post H1N1 Influenza Pandemic CDC report, community outreach and multi-level stakeholder engagement are "essential to ensure timely and effective use of non-pharmaceutical interventions to limit disease spread during a pandemic" (Qualld et al, 2017). In the same report, and after evaluating the different prevention tools readily available for persons and communities to help slow transmission of viruses during the initial stages of a pandemic, CDC concluded that "engaging communities in planning activities well ahead of the next pandemic, is critical to enable appropriate local decision-making during the early stages of a pandemic". However, after 4 decades of "Healthy People" goals to decrease health disparities, 15 years since the Katrina hurricane, and 10 years after the H1N1 pandemic, we are still reporting today the same gaps in health outcomes and mortality rates that plague minorities and more specifically, Black communities in our region. We have not yet built the foundations to embrace our community and stakeholder organizations to develop and sustain long-term relationships that will allow us to *act* in a timely manner to address the widespread transmission of a new pandemic, such as COVID-19, rather than *react* when faced with similar emergency situations. So today, we want the focus our work on moving beyond a checklist of recommendations, to an action plan with short and long-term goals that will prepare us to protect our communities and, as a result, address barriers to healthcare in future pandemics instead of continuing to report on healthcare disparities that have existed throughout history.
Background:	Effective community outreach strategies and stakeholder engagement during past infectious disease pandemics provide the foundation for emerging and

	innovative approaches to address disparities in underserved and underrepresented populations. For example, community outreach mechanisms employed during the 2009 H1N1 Influenza Pandemic demonstrated the importance of establishing strong networks of trusted community leaders and stakeholders from different segments of the community, in collaboration with local public health departments, to reach medically underserved residents in diverse geographic regions (Hutchins, 2009). In 2009, stakeholder networks disseminated culturally competent and low-literacy pandemic education, through a wide-range of communication materials (ethnic media, radio, television, etc.), to diverse racial/ethnic minority populations; established key partnerships with schools, businesses, community-based organizations, faith-based organizations, and engaged volunteers, and students from local high schools, colleges and universities to assist with the distribution of food, services and educational campaigns; strengthened community health systems, e.g., Federally Qualified Health Centers (FQHCs); hosted open forums between community members, city officials and public health agencies; and established a registry listing community agencies, services, leaders, vulnerable populations and barriers (Hutchins, 2009). Today, many states have established COVID-19 Health Disparity Taskforces consisting of multi-level stakeholders including trusted community leaders, anchor faith-based and community-based organizations, and representatives from higher education, health care providers and public health practitioners. These networks address barriers to accessing COVID-19 resources in racial/ethnic minority populations. In each instance the importance of effective outreach and engagement is consistently held. Three exemplary models of COVID-19 taskforces on Racial Disparities/Health Equity in Michigan, Illinois and New York are presented here with an emphasis on community outreach strategies and stakeholder engagement interventions involving anchor-community public and private partnerships. Briefly, the COVID-19 Task force on Racial Disparities formed by Michigan's Governor Whitmer, is a *centralized* taskforce which coordinates statewide multilevel networks of stakeholders (Independent sector, faith-based, business, political/legal, higher education, etc.), across municipalities to reach diverse underserved racial/ethnic and disabled populations. The taskforce has identified short- and long-term goals with measurable outcomes to dissolve barriers to accessing healthcare and mental health resources, mitigating environmental and infrastructure factors that increase COVID-19 exposure, improving economic systems to enhance post pandemic recovery. Additionally, the taskforce aimed to provide recommend changes to existing policies or establish new policies and laws to eliminate health disparities within the community. In contrast to Michigan, Illinois and New York have *decentralized* taskforces on Racial Disparities/Health Equity in major cities. Mayor Lightfoot of Chicago, Illinois spearheaded the COVID-19 Racial Equity Rapid Response Team (RERRT), consisting of three anchor corporations within the community and neighborhood network partners (work groups and community leaders). This

	effort was led by Candace Moore, the City's first Chief Equity Officer, and Dr. Sybil Madison, the City's Deputy Mayor for Education and Human Services. The initial action of the RERRT was to identify communities with the highest COVID-19 impact to immediately address COVID-19 issues and needs of the residents (e.g., mask distribution, multimodal information sharing, health and wellness checks, food insecurities and homelessness). The long-term goals of RERRT include sustaining neighborhood network partner working groups that are essential for continued improvements in health inequities. For example, the Education/Communication Working Group promotes ongoing dialogues, town hall meetings, and education responsive to residents in diverse underserved communities(e.g. guidance for essential workers and multigenerational households concerning ways to mitigate the transmission of the COVID-19). In Buffalo, New York, the Erie County Medical Center (ECMC) Corporation and the African American Health Equity Task Force (AAHETF) developed a 12-week community outreach program targeting priority zip code areas with a large percentage of underserved and underrepresented racial/ethnic groups. The directors of the ECMC and AAHETF in collaboration with local community leaders will coordinate the outreach program. Fifteen churches in the targeted zip codes areas have agreed to adopt the 12-week outreach program for their local residents. The purpose of the outreach program is to assess and respond to residents' social determinants of health needs that compound the adverse health effects of COVID-19. These include comprehensive medical care, mental and behavioral health, pastoral care, food insecurities, housing assistance and social service needs. This type of program is beneficial for low-income communities that do not have broadband access and therefore cannot utilize online services such as telehealth, other virtual services and information. The outreach program is funded by a $1.125 M grant from the Erie County Medical Center Corporation. In summary, the Health Equity taskforce models provide evidence that there is a strong link between stakeholders' engagement and community outreach. Each play crucial roles when organizing for social change. However, it is necessary to differentiate these two approaches to define best practices as well as strategies and resources needed to address COVID-19 issues. "Outreach" is considered more for a short-time, and usually marketing, of initiatives that relate to a specific topic and benefit a group in particular. "Engagement" has a long-term perspective that includes shared decision-making, requires formal relationship building, and focuses on what we can do together to benefit the community in general (Hamerlinck, 2019).
Supporting Data/Evidence:	Evidence documenting best practices of community outreach and stakeholder engagement interventions that address the issue of racial/ethnic health inequities associated with infectious disease pandemics forms the conceptual framework that guides this work. Best practices are defined as something that is "better at delivering a particular result than any other process" (Bergek et al, 2008) and "better" may refer to achieving desired goals or doing things properly (Khodyakov et al, 2018). Although, a literature review on scientific evidence-based best practices for

	community outreach and stakeholder involvement found no results, following is the list of the key strategies recommended: A consulting company, SimplyStakeholders.com, focused exclusively on stakeholder engagement, recommend 14 best practices: Make a plan; List your stakeholders; Define your key stakeholders; Tailor your communication and message; Be inclusive; Communicate clearly; Listen; Respond quickly and follow up; Be flexible and ready to act; Encourage participation from beginning to end; Track interactions; Define what success looks like; Provide updates and reports; and Use a stakeholder engagement tool (Hendricks, 2019). A research organization, The RAND Corporation, that develops solutions to public policy challenges to help make communities safer, healthier and more prosperous, recommended six best practices for stakeholder engagement and community outreach for the "All of Us" research project: Expand existing community partnerships; Foster a spectrum of leadership support; Engage a mix of study champions; Make the topic relevant to participant and community priorities; Build an engagement team with diverse expertise; and Be prepared to talk about uncertainties (Khodyakov et al, 2018). However, instead of simply making a list of "best practices" to be recommended to the Task Force, we preferred to identify the strategies used by key stakeholders and type of community resources that are or are not available in real time to assist vulnerable communities affected by COVID-19 in our region. Accordingly, we first, identified *key* stakeholder networks (national, state and local) who could be doing important COVID-19 community outreach efforts and who may have an impact in our vulnerable communities. These vulnerable communities include racial and ethnic minorities; rural or socially isolated populations; those with low education, limited English skills or health literacy; low-income residents and homeless; and older and young populations. Second, we conducted a rapid scoping review of websites of selected stakeholders to identify COVID-19 content/resources available and strategies used to reach the community and disseminate the information. Finally, we summarized resources available and identified key gaps that should be addressed. Criteria for the revision of stakeholder's engagement and community outreach included: ● Sectors represented (faith, education, social, civic, health, etc.) ● Information and resources produced from reliable sources ● Strategies that are specifically targeted to the community ● Information that is responsive to cultural and language differences ● Outreach using different media (social media, TV/radio, brochures, face-to-face, Internet, etc.) and formats (images, videos, audios, text, bullets, etc.) ● Scope and type of information disseminated (news, reports, blogs, etc.) ● Outreach level: national, regional, local **Limitations:** Due to the rapid scope review and limited time to conduct the review, the stakeholders selected were identified by Committee members' own knowledge and experiences with these organizations.

Summary of Findings:	In total, we identified 39 stakeholder organizations, similarly distributed among the different sectors represented: Faith-based organizations (17.9%), community-civic organizations (25.6%), health-related organizations (28.2%), and academic/education organizations (28.2%). The top five forms of outreach strategies used by these organizations included: phone & email (89.7%), Facebook (84.6%), list-server/email lists (77.8%), Twitter (66.7%) and Instagram (48.7%). Most organizations in the sample were focused on disseminating news (61.5%), conducting advocacy campaigns (61.5%) and providing education or training opportunities (59.0%). The main type of resources disseminated by these organizations were: newsletter/bulletins (69.2%); invitations or information related to webinars and conferences (56.4%); organized links to different websites (51.3%;) and videos/audios embedded in websites or available on YouTube (33.3%). Most of the organizations (56%) were disseminating information regarding COVID-19. While eight organizations have developed a webpage specifically for this issue, 13 organizations have focused more on posting updates in their social media sites. Through our assessment we concluded that 23 (59%) of the sampled organizations were performing well in community engagement. Conversely, we found that 10 organizations (25.6%) definitely needed support in their efforts. Although some organizations possessed notable strength in their Facebook page activity, regarding COVID-19, we considered the "Roadmap to Recovery'' (http://powercoalition.org/Downloads/PolicyDemands-Comprehensive.pdf), developed by Power Coalition, to be an exemplary work. It includes "People-Centered" policy solutions that are not only data driven but also developed in consensus among different community-based organizations to address the many factors impacting health disparities, particularly in minority and underserved communities. In summary, we found that anchor-community public and private organizations are essential for building "community resilience" especially among underrepresented minority populations and during healthcare crises and environmental disasters. Organizations built as collaboration efforts or connected coalitions, have become stronger umbrella" organizations, with increased access to resources and, as result, have a bigger impact in the communities they serve.
Recommendations (based on priorities):	Community outreach and stakeholder engagement are becoming even more paramount to mitigating the widespread transmission of COVID-19 and narrowing the gap in health outcomes and mortality rates that plague racial/ethnic minority communities during this pandemic. Existing resources to address the repercussions of COVID-19 include outreach programs, state and federal programs, and local state and national support systems. However, there is an overwhelming need for expanded and new programming to address populations that have been disparagingly affected by COVID-19.

	After revising results from our literature review and findings from the rapid scoping review of websites and social media and looking again at the priorities defined for the Task Force, we see that there are important synergies between our "Community Outreach and Stakeholder Engagement" and the "Communication and Messaging" subcommittees. Considering that the "Communication and Messaging" subcommittee is already developing a website with a social media platform that considers culturally linguistic relevant messaging, and incorporates measures to reach rural communities, the youth, the elderly, and those with limited or no access to broadband, our recommendations are first focused on strategies and options that may be incorporated in such a website: **The Task Force's website should:** 1. **Include a repository of accurate, timely, and culturally and linguistic appropriate information.** Our subcommittee holds this to be an important first step in the effective outreach and engagement of key communities of interest. Where information on COVID-19 was observed during our review, there was a lack of consistency, timeliness and cultural/language sensitivity. The creation and launch of a primary repository would provide access to a reliable source of information to share with their respective networks and communities. In this way, anchor community organizations do not need to incur special efforts or costs to produce information that may lack accuracy or timeliness. An initial step to creating this repository may be to identify resources already produced by trusted organizations, like the CDC, and that use plain language, are culturally/linguistically sensitive and are available in different formats. These resources may be classified by topics that are easily navigated by lay people. 2. **Foster two-way interactions between the key stakeholder networks and anchor communities**. To increase the synergy of efforts, respond to new and relevant learnings, and maximize the level of engagement, it is our recommendation that some consistent, structured, and timely set of interactions occur. The expressed intent of these interactions is to stimulate the propagation of accurate and culturally - linguistically appropriate information to a wide range of, not only important or "umbrella" stakeholders but also small "anchor" community organizations, which will highly benefit from these interactions. These two-way interactions will allow for mutually beneficial exchanges between those who have more access to resources and political connections and those who have daily contact with the populations served. 3. **Design and implement an aggressive, far reaching social media campaign.** The practice of outreach and engagement has been forever altered by the introduction of social media, a truth this effort must embrace. It is the respectful suggestion of this group that the infrastructure and resources required to undertake a multi-platform, polyethnic, and intergenerational social media campaign be identified and established as expeditiously as possible. The execution of a robust social media campaign is critical in

	unleashing a multisectoral and expansive communications effort that tactically supports outreach and engagement. **However, in order to successfully implement the recommendations above, it will be necessary to work towards the following two priorities highly recommended by our Subcommittee:** 1. **Advocate for broadband and free Internet services to increase access to timely information, network interactions, virtual training and telemedicine.** The establishment of effective community outreach strategies and stakeholder engagement led by umbrella organizations and strengthened by anchor-community public and private partnerships with long-standing investments within the local communities are paramount to the success of the Task Force. However, leaders of these organizations and communities all need to "get on the train" instead of being "left behind" because of the lack of access to fast evolving and reliable technology communication resources. Although access to the resources is the first step, the "package" needs to be complemented with appropriate training so organizations and communities can maximize their use of these resources. **Suggested actions:** 1) Define a communication strategy that is responsive to the needs of each specific organization in the hub (mission, goals, audience and resources); 2) Assess the communication and interactions needs in each organization in the hub; and 3) Provide the technology, training and services required for an effective interaction with the communities in the hub and their audience (social media, print media, etc.) 2. **Develop "umbrella" (coalitions) organizations that connect and strengthen the anchor community organizations that target vulnerable populations.** It is the position of the subcommittee that meaningful diligence be undertaken in identifying and/or building key networks that connect populations under a specific set of ideals (faith-based, social, health, education, etc.) Our group has begun such a process but harbor no illusions of having compiled an exhaustive listing of key stakeholder networks. This work must continue and the list can always be expanded upon. A framework and strategy for interaction should be implemented and undertaken. When doing this, it is important to apply the stakeholder engagement and community outreach existing best practices, and more specifically, those that are data-driven and evidence-based. **Suggested actions:** 1) Identify key community organizations from each sector (health, education, policy, financial, faith, social, etc.), which are already playing a crucial role in disseminating information and serving different population groups in each of Louisiana's regions ; 2) Create an inter-sectoral, multicultural coalition with these organizations; 3) Evaluate their weakness and strengths; and 4) provide the resources needed for these organizations to become a hub or umbrella that will work with small anchor organizations in the same sector/region to replicate efforts at different levels.

	A critical decision to be considered is placement of responsibility for this work. Community outreach and stakeholder engagement are pivotal to the State's efforts to ameliorate the disparate impact of COVID19 on Black and brown communities. In order for this to occur, there must be an entity within state government charged with effective execution and oversight. It is our further recommendation that the designated entity pursue this work on an ongoing basis and not only as an artifact of the State's response to COVID-19. As stated earlier in this report, our government has not done an admirable job of sustaining efforts from previous crises to tangibly impact subsequent crises. It is our impassioned position that this time should and must be different.
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LOUISIANA COVID-19 HEALTH EQUITY TASK FORCE

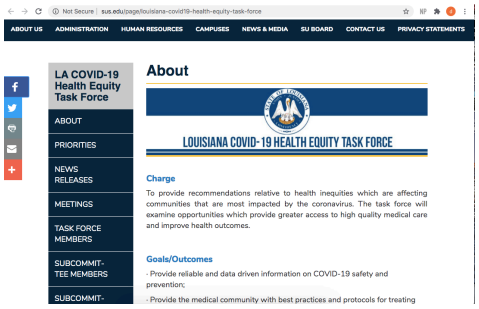
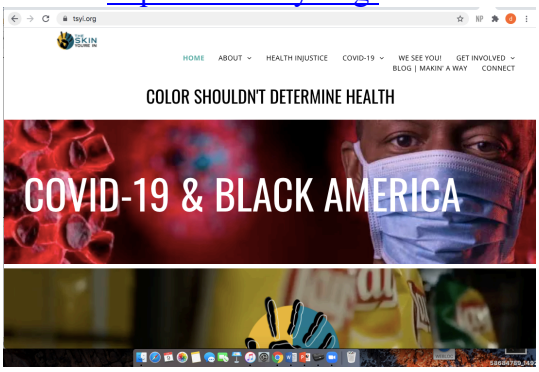
SUBCOMMITTEE REPORT

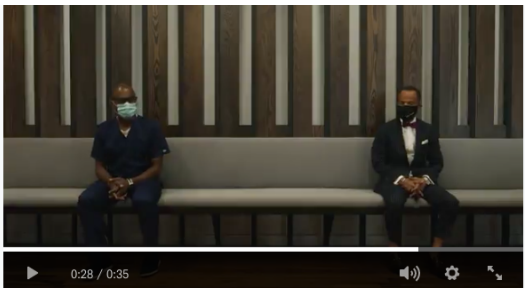
Subcommittee Name: Communication and Messaging

Subcommittee Members: Dr. Keith C. Ferdinand, Dr. Corey Hebert, Councilwoman Helena Moreno, Councilwoman Cyndi Nguyen, Dr. Dereck J. Rovaris, Sr. (chair), Ms. Janene Tate, Dr. Sandra Brown (ex-officio) and Dr. Thomas LaVeist (ex-officio)

Priorities/Goals: Deliver health and safety content messaging to those who are most vulnerable and those who are at the heart of health disparity in Louisiana including the aged, young adults, people of color, and those who are economically disadvantaged.

Statement of the Problem:	• Cases and Deaths from COVID-19 have continued to increase in most states in the U.S including Louisiana. As of July 1st 2020, in the U.S. there were 2,624, 873 total cases and 127,299 total deaths and in Louisiana total cases 58,095 and total deaths 3,221. One week later those Louisiana numbers increased to 71,994 cases (an increase of almost 14,000 cases) and deaths increased by 26 people. • These increases are staggering and are sharply increasing in the 18-24 aged group. For all of our populations, COVID-19 cases are increasing exponentially. Hospitalizations and death are lagging indicators and may continue to increase soon, giving greater urgency to our communications strategies. • Any delay in communication and messaging can increase the likelihood that more people with contract COVID-19, more hospitalizations will result, and ultimately more people will die. • The Task Force must get these messages out quickly, at an affordable cost, to younger and older members of the health disparity groups as well as those who are economically disadvantaged.

Background:	• An existing website, "The Skin You're In" hosted by Tulane University was agreed to be used as the host website for Task Force messaging. https://www.tsyi.org/. Louisiana's COVID-19 Health Equity Task Force website has been linked to this website alongside other information designed to inform our communities about health disparity and injustice.  • It is important to note that this subcommittee unlike most of the other subcommittees was not designed to do deep dive research but instead charged with producing "product" in the form of advertisements and other messaging to the general public and the targeted groups. • The subcommittee has spent a number of weeks studying the marketing mechanisms needed to best target messaging. This included presentations from the LSU Manship School of Communications on market outreach and message content. This was somewhat debilitating in that we were unable to get any messaging out besides what was placed on the websites. • The need for messaging is now. While awaiting a vaccine and curative treatments, messaging is essential to maintain proven hygienic measures including: wearing a mask, social distancing and hand washing. For special populations by race/ethnicity, targeted messaging which is culturally-sensitive, literacy-level appropriate and evidence-based are urgently needed. • Also, of note, is the very recent change in the leadership of this subcommittee. Unable to effectively lead a subcommittee while also co-chairing the task-force, Dr. LaVeist amid mounting work responsibilities asked Dr. Rovaris to take over the subcommittee chair two weeks ago on June 26th. The subcommittee has begun in earnest to get additional messaging out to include commercials, billboards, and other ad placements.
Supporting Data/Evidence:	• "The Skin You're In" website hosted by Tulane University is being used to host the website for the Task Force https://www.tsyi.org/ 

	• Initial messaging will center around protecting older individuals and those with high risk conditions, mask wearing and the concept that younger adults should do it for the community since "we are one" and the Covid-19 pandemic is "not over", "it ain't over". Additionally, messages will focus on continued hand washing and physical distancing. All messages should be culturally sensitive and avoid demeaning racial/ethnic groups. Messages in Spanish and Vietnamese will be developed. As a first step translations in text will be superimposed on present videos if possible. • The first commercial message has been developed by Dr. Eric "Doc Griggs" Griggs. https://www.docgriggs.com/home  • The spot will run on the social media platform used for the Get Serious Louisiana campaign as well as the Task Force and The Skin You're In websites and on the Task Force digital and social media platforms. https://www.dropbox.com/sh/9k1e07mfr7z8js6/AABnpGkWywFTStSQXiRBIw86a?dl=0&preview=HebertGriggsMask4kVer.mp4  • The subcommittee plans to utilize the Governor's website to promulgate social media messages on Instagram, Twitter and Facebook. Since the task-force is an arm of the office of the Governor, they have resources and abilities to help disseminate messages quickly to a broader audience and at no additional cost to the Task Force. • The Communication and Messaging Subcommittee is also establishing stand-alone Facebook, Twitter and Instagram accounts to launch future urgent videos.
Summary of Findings:	• Given a budget of $150k to deliver an urgent statewide messaging campaign requires that we produce high-quality messages that can be shared most broadly and at an affordable cost. We will table the use of network and cable television as well as radio spots for now and focus on the more affordable avenues. Later plans include using tv and radio advertising. • We will continue to utilize the more affordable social and digital media platforms. • We will place messaging on The Advocate's Baton Rouge, New Orleans, and Acadiana websites. • Digital billboards will be purchased.

	• Buses and streetcar placements will be explored. • A new logo is being considered for the ad campaigns. The current one is fine for our internal documents but we seek something that is more "logo-like" for external messaging.
Recommendations (based on priorities):	• The Task Force needs to secure additional funding to enable the Task Force to utilize television and radio platforms in addition to digital media. Both platforms are more expensive than social media and other digital platforms, but have tremendous reach, especially to those who do not typically use internet-based technology (computers, smart phones, etc.) • An analysis of the effectiveness of communication and messaging to reach, inform, and impact change should be completed.
Responsible Parties and Timeline for Completion (if applicable)	Key contributors: Dr. Keith C. Ferdinand Dr. Corey Hebert, Dr. Dereck J. Rovaris, Sr. Ms. Janene Tate Dr. Sandra Brown Dr. Thomas LaVeist
Committee Contact(s):	Dr. Dereck J. Rovaris, Sr. drovaris@lsu.edu 504-723-3857

Appendix:

1:30pm UPDATES…

- Finalizing two new **logo** options
- The **new social media** (Facebook, Instagram and Twitter) accounts as soon as the logo is finalized and approved.
- For now, we will post what the governor has published (graphics and video) as well as Dr. Griggs' video did.
- SU designer is working on three branded **graphics** with messaging about social distancing, wearing a mask and testing.
- We have quotes for **bus shelters and back-of-the-bus advertising** for Baton Rouge; awaiting New Orleans.
- Rep for **digital media** (social media and behavioral) is working on a quote for statewide. We can start with Baton Rouge and New Orleans immediately on social media for approximately $3K for a month.
- Working on the **billboard** quotes (Baton Rouge, New Orleans, Lafayette, etc.)
- We can move on to TV and radio next. We have a quote for **statewide television** (Nextar Fox and NBC broadcast networks for $9K). We will also look at buys on the top major news channels like WAFB, WWL, etc., in addition to a small cable buy.
- Thanks Janene!

LOUISIANA COVID-19 HEALTH EQUITY TASK FORCE

COVID-19 Racial Disparities in Health Care Subcommittee Report

Subcommittee Members: Rebekah Gee, MD, MPH (Co-Chair), Robert Maupin, MD (Co-Chair), Kristi Anderson, Ph.D., Amy Lesen, Ph.D., Takeisha C. Davis, MD, MPH, Amanda Dumas, MD, MSc, Eboni Price-Haywood, MD, MPH, FACP

Contributors: Krystle Pew, MD, MPH, Peomia Chela Brown, MD, Matthew Lammi, MD, MSCR, Will Boles

Priorities/Goals: Review Crisis of Care Standards for Louisiana and make recommendations for modification or updates. Review provider bias influence on health outcomes. Explore medical mistrust among African Americans. Provide a comprehensive inventory of best practices, evidence-based solutions that address racial disparities in healthcare for Louisiana.

Table of Contents

Statement of the Problem: COVID-19 pandemic spread rapidly across countries and continents since its identification in December 2019. Louisiana has experienced challenges with testing, obtaining results, and slowing the spread of the virus. These challenges are pronounced among nonwhite communities in Louisiana, with a high disparity in testing, morbidity, and mortality in African American communities. Such challenges stem from a lack of access to testing and healthcare facilities, high rates complicating co-morbidities, and mistrust of medical institutions due to centuries of exploitation.

Previous pandemic responses have failed to mitigate, but not failed to recognize, structural racism in their planning. The opportunity for Louisiana in the present pandemic is to begin a sustainable process for rolling back these inequities. The most rapid need is in addressing access issues by ensuring quality testing for COVID-19 in marginalized communities, assess gaps in the ability to afford and receive high-quality care and treatment, and then to begin the process of culture change in healthcare in Louisiana to eliminate disparities in healthcare that will leave all of Louisiana better prepared for future pandemics.

Background: Racial disparities in healthcare in Louisiana are primarily born by its African American communities. 32.2% of Louisianans are African American, the second-highest proportion by population in the US. However, as the pandemic has spread, African American Louisianans comprise 55.33% of the mortality of COVID-19. As in other states, there are urgent data needs that must be addressed to accurately assess gaps in testing, diagnosis, and treatment of COVID-19, and how these disparities might be addressed.

Several factors have likely contributed to these disparities and are evident around the US. African American communities have been exploited by medical institutions in the US for centuries, leading to deep-seated mistrust. Further, most physicians have an implicit pro-white bias that they are not trained to recognize. This influences how they diagnose and treat certain groups in clinical encounters. Nor are healthcare providers educated to understand racial health disparities, which exacerbate poor outcomes. Indeed, recent polling suggests 22% of African Americans avoid care because of fear of discrimination.

More largely, health systems and hospitals have struggled to close gaps in care for nonwhite groups. Key indicators of the "health" of health systems in the US broadly have been lacking, including infant and maternal mortality, and are even more pronounced in Louisiana. In other states, these outcomes can be mitigated by integrating social and community programs and benefits. Infectious diseases are a litmus test of societal inequalities, and COVID-19 is showing the cracks in Louisiana's healthcare system. There is much work to be done, but substantial, and actionable evidence exists to begin the important work of closing the gaps in care by race.

Priority 1: Update Crisis of Care Standards to reflect equitable processes.

Priority 1a: Recommendations for Addressing Disparities in Critical Care

Background

It is important that when an event triggers implementation of Crisis Standards of Care, there is a transparent plan in place to ensure that allocation of critical care resources, personnel, and therapies

are equitably distributed. Hospital policies to address a disaster should be developed with health equity, social justice, and cultural competency in order to best reflect the values of the surrounding communities. Race, gender, and socioeconomic factors are often the most commonly cited factors that contribute to morbidity and mortality in the U.S. The gap in healthcare outcomes is also noted across various disease states in the acutely ill, most commonly compounded by social determinants of health that make black, indigenous people of color individually more susceptible to disparities in clinical presentation.

In the face of a progressive pandemic, initial preparation for a surge of critically ill patients should be determined by individual institutions, as it is recognized that individual institutions may be reaching surge capacity at different times. Each individual institution should be responsible for the initiation of limiting need protocols and the pursuit of maximizing surge capacity.

RECOMMENDATION #1

Hospitals and healthcare institutions have a duty to provide culturally competent care both preceding, during, and after a pandemic or mass casualty event. Each institution should have a Community Engagement and Health Equity Committee to ensure that decisions regarding policies, protocols, and delivery of healthcare are informed with best available information that best serves the population in order to ensure health equity.

RECOMMENDATION #2

Hospitals have a duty to plan regarding Crisis Standards of Care for the acutely ill. Triage protocols developed by a Triage Committee should be in place on an institutional level functioning to guide physician and healthcare worker decisions about patient triage. Triage protocols ensure that each patient is assessed by the same standards for consistency and fairness. Members of the Triage Committee should have undergone implicit bias training to ensure that protocols are developed with the lens of health equity so as not to perpetuate health disparities and mitigate implicit bias in decision making. See Appendix I.

RECOMMENDATION #3

The current LDH CSOC does not include comprehensive guidelines for in-hospital triage of critically ill patients and allocation of critical care resources. The addition of CSOC guidelines for critical ill patients should be included in the document to further assist individual institutions with planning their response to a pandemic event so that protocols are developed in consideration of health equity to best serve the diverse population of Louisiana. Furthermore, providing evidence based guidance to inform policies about patient triage, palliative care and equitable allocation of resources ensures fairness and equity. Suggested additions to the CSOC are listed in Appendix I.

RECOMMENDATION #4

Individual health care systems should develop a morbidity/mortality score in collaboration with community stakeholders that places emphasis on the values of the surrounding community in order to ensure equitable allocation of resources during crisis standards of care. This morbidity/mortality score should inform Triage Committee decision making. In addition, there should be an established appeal process for triage decisions headed by the Ethicist on the Triage Committee as means of ensuring equity and fairness if physicians, providers, patients, or patient family members are not in agreement with final Triage Committee decisions.

Priority 1b: Cultural Competence and Limited English Proficiency (LEP)

Cultural competence is about learning, understanding and respecting the values of vulnerable populations, minorities and ethnic groups in order to provide quality care for individuals, groups and populations (Galanti, 2008). When caring for individuals from different backgrounds and ethnic groups in disasters, it is essential that healthcare providers have the basic knowledge of providing care and are able to address such issues as: communication, pain, personal space, social organization, religion and spirituality (Harkey, n.d.). It is also important to understand the impact of culture on how a person reacts to a disaster and how this influences the acceptance of disaster relief. Culture is important in a disaster because individuals prepare, respond and recover from a disaster within the perspective of their culture (e.g. beliefs, norms, rituals) *(Obtained from version 4.0 of LDH State Hospital Crisis Standard of Care Guidelines in Disasters).*

Cultural competence is imperative in order to narrow the gap in health disparities and equity. Specifically, linguistic diversity is a demographic reality in Louisiana. The state of Louisiana consists of a widely diverse group of people. In 2010 the population rose to more than 4.5 million people, with an annual growth rate of 0.75%. Thirty-seven percent of the population is of the minority with a breadth of ethnic and cultural backgrounds. Of the 4.5 million people who live here, there are approximately 40 different languages spoken outside of English. Based on the census in 2000, 90% of the population speaks English exclusively and French is spoken exclusively by 7% of the population. Various minority languages spoken include Spanish, Vietnamese, German, Italian, various Asian and European languages, and several languages of Native Americans. In the healthcare setting, language discordance occurs when a patient has limited proficiency in the language(s) spoken by health care providers. Patients with Limited English Proficiency (LEP) are more likely to experience serious adverse events when compared to English-proficient patients. Medical errors in the care of patients with LEP include, but are not limited to, the patient's cultural beliefs and traditions, healthcare providers' reliance on their own second language skills, and the use of "ad-hoc interpreters" such as family members or hospital staff for communication.

RECOMMENDATION #1

Emergency information should be provided in the community's primary language. This should include written and oral materials, this also includes radio and television announcements.. Information should be provided at the literacy level of the community. *Refer to Priority 3b: Health Literacy and Health Promotion*

RECOMMENDATION #2

During conventional levels of care, healthcare organizations should implement strategies that can be used to meet the needs of various cultures. These strategies include composing a cultural competency profile of the community's various cultures. This profile should include data such as race, ethnicity, language, specific needs, belief, customs and rituals found in certain populations and groups.

RECOMMENDATION #3

Within the various healthcares systems, ongoing cultural competency training for healthcare providers does not exist. During the conventional phase of planning, this is necessary to respectfully provide effective and appropriate care and services. In order to deliver ongoing training, we should recruit representatives from various communities as well as providers who specialize in cultural diversity and training of healthcare professionals.

RECOMMENDATION #4

There is an increased lack of trust of public officials and healthcare professionals from individuals with limited english proficiency (LEP), especially when translation services are not available. Individuals with LEP require a longer time frame to explain instructions and to provide services, and they may not receive messages in an understandable or timely manner. During a crisis, personnel, time, and resources must be appropriately allocated. Recommended additions to the CSOC are listed in Appendix I.

Priority 2: Recommendations to Decrease Medical Mistrust by Reforming the Healthcare Workforce

Background

Scientific studies have identified the adverse influences of bias on the health care experiences and outcomes of African American patients, which also serve to foster mistrust. Whether conscious or unconscious, bias influences how healthcare systems and providers may treat certain groups in clinical settings with respect to cultural safety and respect. Additionally, healthcare providers frequently fail to understand that structural inequity and racism serves as the root cause of racial health disparities. Recent polling suggests that 20% of African Americans avoid care because of their fear of discrimination. That perception of discrimination can lead to poorer health outcomes as well as a mental/psychological strain that exacerbates illness and disease.

Long-term Vision

When African American patients are cared for by providers (e.g., nurses, doctors, dentists, therapists) and delivery systems (e.g., training programs, hospitals, pharmacies, insurance companies) that understand racial inequity, there is the opportunity to build trust with patients and communities. The dedication of finances and structured clinical resources to advance a racially equitable framework will provide the necessary support to strengthen the quality of life of African American patients and communities.

RECOMMENDATION #1

Foster early exposure to and preparation for health professional education.

a. Increase funding for outreach programs at elementary, middle, and high school levels that expose students Underrepresented in Medicine to a wide range of healthcare providers and careers.
b. Support a statewide, coordinated pipeline program between colleges and universities to increase matriculation of students Underrepresented in Medicine into healthcare training programs.
c. Commit resources to build and/or expand quality mentoring programs and opportunities tailored to the needs and circumstances of students Underrepresented in Medicine.

RECOMMENDATION #2

Diversify racial and ethnic representation in health professional training programs.

a. Make publicly available all demographic data on applicants, matriculants, and graduates in health professional training programs.
b. Individuals who have oversight for the admissions processes should participate in structured bias training and development to reduce this entering into the admissions process as set forth in House Resolution Number 33
c. Increase matriculation of students Underrepresented in Medicine into medical schools and other key health professional programs (e.g., Dental, Nursing, Allied Health) to reflect the state's racial and ethnic demographics. This information should be public and easily accessible.
d. Provide funding and sufficient staff to the LDH Office of Community Partnerships and Health Equity to assist health professional training programs in the implementation and monitoring of training and curricula focused on health equity, cross cultural education, structural competence, cultural safety and implicit bias for students, staff, and their community partners.

RECOMMENDATION #3

Reduce racism experienced by patients at healthcare system settings.

a. Incorporate questions about experiences of bias and racism into patient satisfaction surveys. These surveys will be one process used for assessment in order to derive intervention. These surveys, assessments, and interventional tools and resources

will be linked with the Office of Community Partnerships and Health Equity at LDH.

b. Advertise and recruit for open professional positions outside of local community networks to increase diversity of applicant pool.
c. Create and continually review institutional initiatives to ensure referral patterns and care networks do not result in de facto segregation in healthcare settings by race and insurance status.
d. Mandate that funding provided to treat Medicaid-insured and uninsured patients be shared more equitably among all private-public partnerships to increase access to and treatment at all health systems.
e. Provide funding and sufficient staff to the LDH Office of Community Partnerships and Health Equity to assist health professional licensing boards in the implementation and monitoring of publicly available standards and curricula on implicit bias, as set forth in House Resolution Number 33.

RECOMMENDATION #4

Increase healthcare systems' collaboration with community stakeholders to develop sustainable solutions for equitable care.

a. Conduct qualitative and community based participatory research to identify sources of racial and ethnic disparities and assess intervention strategies.
b. Incorporate transparent and substantial racial and health equity commitments to the shared community served by healthcare delivery systems and their health professional training program partners.
c. Mandate that healthcare system trainees, clinicians, staff, and administrators receive continuous professional development and education in confronting disparities in medicine as experienced in their community and with community participation as set forth in House Resolution 33.

Priority 3: Provide a comprehensive inventory of best practices, evidenced-based solutions that address racial disparities in healthcare for Louisiana.

Priority 3a. Accountability of Intersection of Community Health Needs Assessments and Community Benefit

Background:

Not-for-profit or charitable hospitals demonstrate their commitment to community service through organized and sustainable community benefit programs as the basis for tax-exemption as codified in Internal Revenue Code (IRC), Section 501(c)(3).The Internal Revenue Service (IRS), in its Revenue Ruling 69–545, describes the **Community Benefit (CB)** standard for charitable tax-exempt hospitals. Since 2008, tax-exempt hospitals have been required to report their community benefit and other information related to tax-exemption on the IRS Form 990 Schedule H.

The Patient Protection and Affordable Care Act (the ACA), enacted March 23, 2010, added new requirements codified under Section 501(r) for organizations that operate one or more hospital facilities (hospital organizations) to be described in Section 501(c)(3), as well as new reporting requirements and a new excise tax. These additional requirements are:

1. **Community Health Needs Assessment (CHNA)** ,
2. Financial Assistance Policy and Emergency Medical Care Policy,
3. Limitation on Charges , and
4. Billing and Collections

Non-Profit hospitals are required to conduct CHNA every three years and to adopt an implementation strategy to meet the community health needs identified through the CHNA.

The CHNA must:

- Take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and
- Be made widely available to the public.

The CHNA outlines the CB with an intent of where the needs and dollars connect. What has not been specifically designated within the state of Louisiana is accountability. In 2016 there was $22.7 million dollars contributed to the CB investment within the surrounding Louisiana communities that represented approximately 43 not-for-profit status hospitals. Our recommendations are to address the CHNA and CB that should intersect to show improvement in health outcomes that disproportionately affect African American and impoverished communities.

RECOMMENDATION #1

Nonprofit hospitals must provide internal revenue service (IRS) Form 990 as well as the CHNA for compliance with the Affordable Care Act (ACA).

- These documents are to be received no later than one week after the IRS deadline.
- These documents must be submitted to the Health Standards Section (HSS) of the Louisiana Department of Health Louisiana.

RECOMMENDATION #2

Establish Regional Committees to evaluate and analyze the intersection of the CB and CHNA received by HSS.

The Regional Committees will consist of members from the following**:**

Louisiana Department of Health

Regional CMOs of the areas analyzed

Deputy Director for the LDH Office of Health Equity, Community Partnerships or delegate from the office/community

Academic institutions/centers
Louisiana Public Health Institute
Community stakeholders that have respect and influence within the local communities represented.

The Regional Committees will be broken into three divisions:

North Louisiana:	LDH Regions 6, 7, and 8,
Central and West Louisiana:	LDH Regions 4, 5, and 6
South Louisiana:	LDH Regions 1, 2, and 3

The Regional Committees will be responsible for coordinating regular meetings (as determined by the committee chair) that will review and evaluate the CHNAs within that division.

This information will be submitted to LDH and posted on the appropriate website within LDH to allow public viewing and comment. Additionally, the committee will provide a written report back to the hospital to provide recommendations and suggestions for optimal performance and accountability. They will provide information on the following:

- Evaluation of the content within the CHNA
- Analysis of the content within the CHNA
- Dashboard to show the CHNA for the Louisiana hospitals and the funding tied to CB
- Evidence to demonstrate funding associated with needs of the community and dollars allocated to those needs for that three-year period.

RECOMMENDATION #3

In order to maintain integrity and transparency throughout the process of collecting the CHNA and holding hospitals accountable to the CB allocation and spending, hospitals should at a minimum allocate 30% of their funding to benefitting their community. Additionally, it should be linked to the needs assessed within the CHNA.

RECOMMENDATION #4

There should be a mandatory educational requirement for all stakeholders and key hospital personnel that are responsible for conducting the CHNA. The education will be centered around how to conduct these activities through an intentional health equity lens and centered on the development of individual's understanding of an introduction to the CHNA, Louisiana healthcare objectives, how to collect the data, partnerships, ACA requirements for 501(c)(3) hospitals, and any tool that could better provide insight and work surrounding the CHNA and the CB. The focus will be to ensure that those involved in the collection of data and allocating resources and funding, are clear in their roles and responsibilities to their communities.

RECOMMENDATION #5

Once the goals and objectives of the committee are determined and the committee provides its commitment to the state and hospitals within their region to which they represent, we ask that Recommendation 1 move to a Louisiana law within three years of its inception. This law shall provide governance and guidance to hospitals that declare themselves nonprofit. Once this recommendation can go into law, the committee can then hold the hospitals accountable. If the committee receives information that a hospital is not in compliance with the community benefit standard, the committee chairperson is required to hold a hearing, issue written findings, and impose appropriate penalties.

Central oversight for the effectiveness of this framework will be ultimately held by the LDH Office of Health Equity, Community Partnerships. In review of this office, it is noted that the Office of Health Equity, Community Partnerships may need to increase its staff in order to provide oversight, effectiveness and transparency with the deliverables outlined above. We believe that this office could and should provide meaningful use data that can then change the way in which communities are defined, and the ways in which our hospitals can offer benefit, growth and healthy development.

Priority 3b. Health Literacy and Health Promotion

Background

The United States Department of Health and Human Services defines health literacy as the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions. Death rates are higher among socially vulnerable population groups – those who are poor and minorities, as well as the elderly. Based on international adult literacy surveys lower health literacy skills are found among elders, societal minority groups, and those who live in high-poverty areas. Health literacy training may save the lives of the community's most vulnerable members and their families. Health literacy research has indicated a mismatch between the known skills of the public and the complexity and difficulty of health and science information. Our responsibility to the diverse population includes identifying and providing accessible healthcare workers who are able to share information while building trust between those who disseminate knowledge and these members of the public. Health literacy insights, combined with long-standing risk communication strategies, will support efforts to communicate information both in times of calm as well as in times of crisis. Health promotion can assist with addressing concerns during a crisis by focusing on behavior change, introducing interventions. Enabling people to increase control over their health and its determinants is at the core of health promotion.

RECOMMENDATION #1:

Increase community engagement and responsibility by establishing committees and focus groups to address culturally specific material for effective communication. Once committees and focus

groups are established, engage community stakeholders to create accessible forms of communication, particularly for vulnerable populations (eg. racial and ethnic minorities, elderly individuals, etc.). The information to be disseminated should be tested before releasing them to the public.

RECOMMENDATION #2

Health information should be made readily available via multiple streams of communication, emphasizing modalities that are not dependent on technologies (newspapers, billboards, flyers, etc) and access to computers or the internet. Communication must be distributed in both English and other languages that are commonly used in the region (e.g. Spanish, Cajun French, Vietnamese, etc). The messages should be actionable and should provide clarity, with use of culturally relevant language. Consider providing definitions, examples, and illustrations when introducing new words, phrases, or concepts to the community.

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APPENDICES

Appendix I: CSOC Suggested Additions to Address Critical Care
Appendix II: CSOC Recommended Additions to Address Limited English Proficiency

Appendix I: CSOC Suggested Additions to Address Health Disparities in Critical Care

Triage Committee

It is important to note that there are scores such as the Acute Physiology and Chronic Health Evaluation II [APACHE II] score or Sequential Organ Failure Assessment [SOFA] score that classify the severity of patient illness. However, these scoring systems should not be routinely used to triage patients. For example, utilization of the SOFA score during the swine flu epidemic did not have the positive predictive value assumed for viral pneumonias. Therefore, such scoring systems should only be used as prognostic indicators. Each triage committee should form a scoring system using an evidenced based approach with consideration to the diversity of the community served.

It is important to note demographic factors such as race, gender, disability, sexual orientation, religious beliefs, citizenship, or socioeconomic or insurance status *should not be* included in scoring systems given the likelihood that such practices would perpetuate health disparities in critical care outcomes.

As recommended by the Society of Critical Care Medicine and CHEST, the Triage Committee should include the following:

TRIAGE COMMITTEE		
Critical Care Pharmacist* Clinical Pharmacist	Critical Care Clinician	Infectious Disease Clinician
Palliative Care Clinician	Critical Care Nursing Administrator	Ethics Committee Representative
Patient Care Representatives or Community Liaison	Clinical Research Committee Member	Emergency Medicine Clinician

**Preferred*

The listed stakeholders will allow the patient response triage to be fluid in its surge-response strategy. A multi-disciplinary approach will facilitate situational awareness of available resources and demand, outcome monitoring, and timely review of evidence based data so that the Triage committee can modify protocols to best address the various stages of pandemic response.

Suggested CSOC Critical Care Guidance

Phase I: Conventional Level of Care
PREPARATORY PENDING PANDEMIC WITH MINIMAL IMPACT
During this phase, preparations are being made for an impending pandemic event. The pandemic's effect on staffing and daily operations is negligible. The focus is on increased awareness and the education of staff. Assess the status of all necessary supplies to ensure ample resources supplies, especially PPE have been acquired and are being pre-positioned for easy access.

- Stockpiling, inventory, and conservation of PPE
- Stockpiling and inventory of pharmaceuticals specific to the response to the pandemic
- Define in-hospital flow of critically ill patients in anticipation of patient surge
- Staff Preparation
    - Clearly define roles of hospital staff
    - Educate staff on anticipated changes in patient flow in response to patient surge
    - Develop adaptive plan to respond to changes in number of available staff, change in scope of duties, and changes to work/shift schedules

Phase 2: Contingency Level of Care
ESCALATING PANDEMIC IN SERVICE AREA
During this phase, plans and protocols should be in place to adjust for the increased number of critically ill patients. The focus should be to adjust ICU operations to adapt to influx of patients while supporting staff and actively monitoring use of resources.

- Real-time tracking of hospital system resources such as number of admitted beds, capacity available, ventilator capacity, etc
- Active tracking and conservation of PPE
    - Reduce number of healthcare workers that don and doff PPE
        i. Limit blood draws.
        ii. Schedule labs, assessments at same time.
        iii. Make efforts to bundle patient care such as oral care, wound care, turning, etc
- Early initiation of protocols for management of standard infusions such as sedation/analgesia/paralytics, for example:
    - Establishing limits infusion rates of standard medications

    - Establishing alternative medications on formulary should supplies become limited
- Expansion of in-hospital critical care areas and implementation of new patient flows
    - Establishment of dedicated units to the care patients with respiratory illness with separate entrances
        i. Establishment of a system of communication from within individual isolation patient rooms in dedicated care units to limit use of PPE and contamination, e.g. use of walkie-talkies
    - Early adoption of routine use of alternative therapies to bridge patients with respiratory symptoms such as high flow nasal cannula and non-invasive ventilation in anticipation of ventilator shortages
- Staff Preparation
    - To address preventable sources of staff shortage options include provision of shelter for staff and their families, provision of alternatives for child care, provision of mental health support, measures to mitigate fatigue, access to transportation services, and maintenance of a safe working environment.
    - Cancel pending vacations for essential personnel
    - Mobilization of physician and mid-level providers to practice outside of normal scope of practice i.e. subspecialty physicians covering hospital wards, CRNAs assisting Emergency Medicine and Critical Care services with intubations, invasive procedures such as central venous access and arterial blood pressure monitoring
    - Activate PRN employees and all available support staff medics

Phase 3: Crisis Standards of Care
WORST CASE PANDEMIC IN SERVICE AREA

- Suggested triggers for transition to Phase 3 include nurse-to-patient ratios, availability of ventilators/critical care bed capacity <10%, anticipated shortage of PPE despite rationing
- As suggested by the ACCP guidelines, care for the critically ill should be based on the best available evidence and available resources even during crisis standards of care
- Age, demographics, and comorbidities should NOT be used to allocate sources without input from community

- Individual systems should develop a morbidity/mortality score in collaboration with community stakeholders that places emphasis on the values of the surrounding community
- Establishment of an appeal process for triage decisions headed by the Ethicist on the Triage Committee as means of ensuring equity and fairness if physicians, providers, patients, or patient family members are not in agreement with final Triage Committee decisions
- Health care workers should not be given preferential care over community members without input from community

Appendix II: CSOC Recommended Additions to Address Limited English Proficiency

Interventions

- Determine the client's preferred language
- Ensure essential documents are translated into key languages (consent, intake forms, patient rights)
- Based on the demographic of the community surrounding the hospital, provide in-house medically certified interpreters (including sign language) and require documentation of certification.
- Recruit and train community members of the same racial/ethnhic background as the community in need during a disaster response.

LOUISIANA COVID-19 HEALTH EQUITY TASK FORCE

SUBCOMMITTEE REPORT

Subcommittee Name: COVID-19 Health Equity Dashboard

Subcommittee Members:

Demetrius Porche, DNS, PhD, APRN, ANEF, FACHE, FAANP, FAAN – Co-Chair
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Priorities/Goals: Develop a Louisiana Health Equity Dashboard. Explore Health Equity dashboards in other states to use as a guide.

Statement of the Problem:	In April 2020, African Americans (in Louisiana) represented 70% of those who die due to COVID-19. Presently, African Americans represent 53% of those who have died. This percentage indicates a considerable health disparity given African Americans only makeup 32% of Louisiana's overall population. Despite all people being at risk for getting COVID-19, some are more likely than others to become severely ill - requiring hospitalization, intensive care, or a ventilator, or even dying. Further, people at increased risk for severe illness (and death) have been those 65 years and older or with underlying chronic health issues. In Louisiana, before COVID-19, African Americans were disproportionately affected by many of the underlining chronic health issues that are associated with severe illness and death due to COVID-19. Louisiana's COVID-19 mortality and morbidity in African Americans (and other vulnerable populations – i.e., Latinos, Hispanics), has been exacerbated by Louisiana's overall chronic health burdens and African Americans' chronic health disparities and social determinants of health.
Background:	Racial and ethnic health disparities are higher rates of severe health conditions or deaths that affect African American, Latino/Hispanic, and other minority groups/populations. These disparities can result in shorter lifespans and lower quality of life, are rooted in inequities in the opportunities and resources needed for good health, such as education, employment, safe and healthy neighborhoods, and access to health care. These inequities are often the result of current and historical institutionalized racism or explicit racial bias.

	Enduring systemic health and social inequities have long affected Louisiana's African American and other racial and ethnic minority groups' chronic health outcomes (i.e., disparities). These inequities and consequential health disparities result in African Americans – who acquire COVID-19 – to experience severe illness and die disproportionately. Our workgroup believes the development of a Louisiana health equity dashboard will be useful in indicating how specific disparities are affecting racial and vulnerable populations in Louisiana. Our proposed dashboard would include health data and social determinants of health factors - at the state, health district, and zip code level, which would allow for racial (and other) de-aggregation of data and factors in the dashboard. Along with reporting features-tools, the dashboard would provide information on strategies and best practices used to counter or reduce the queried findings. The dashboard will fill an essential need for racial and vulnerable population data and the respective social determinants of health (SDoH), foster a more nuanced understanding of health and SDoH, and support associated priority-setting while building individual and community capacity to affect change.
Supporting Data/Evidence:	The subcommittee worked to identify the data elements of health equity determinants that will constitute the Health Equity Dashboard. This included review of existing dashboards in other states and identifying data elements specific for Louisiana. The subcommittee identified major categories of health equity determinants data, which included: a) personal, individual, behavioral, and lifestyle determinants; b) community and social determinants, c) economic stability, d) neighborhood and the built environment, e) economic determinants, f) environmental determinants, g) political determinants, h) health determinants, i) health care access, and j) population structure. The expected sources of data include: Centers for Disease Control and Prevention, U.S. Census Bureau, and Louisiana Department of Health, as well as other sources. The data elements are secondary data, which are readily available. The Health Equity Dashboard will present information on the parish level. Example data elements are a) tobacco usage, b) health status, c) high school graduation rate, d) number of persons receiving WIC, e) percent of the population below 200% of the poverty level, f) access to broadband at home, g) Medicaid enrollment percentage, h) median household income, i) average annual income, j) population density, j) number of registered voters, k) child immunization rate, l) adult immunization rate, m) infant mortality rate, n) diabetes prevalence rate, o) physician to population ratio, p) number of acute care hospitals, and q) population distribution by age, race, and gender.
Summary of Findings:	Some summary findings are: 1. COVID-19 has disproportionately impacted the black community; 2. Louisiana does not have a health equity dashboard; 3. Determinants of health is an appropriate framework used nationally to measure health equity; 4. Moral determinants of health are considered to consist of realization of health care as a right, restoring leadership to reverse climate change, achieving racial reform in the US criminal justice system, ending policies of exclusion, achieving compassionate immigration reform, ending

	hunger, ending homelessness, restoring order, dignity, and equity to US democratic institutions, right of each person's vote to count equally, and US ratification of basic human right treaties and conventions of international community. The sub-committee reviewed these moral determinants and consider them important to the intentional work of health care equity but not operationally measurable for inclusion in a health equity dashboard at this time; and 5. Community engagement and utilization of the health equity dashboard is essential to impact disparate health conditions.
Recommendations (based on priorities):	The COVID-19 Health Equity Dashboard propose the following recommendations: 1. The Office of Community Partnerships & Health Equity is provided the authority and administrative responsibility to create, implement, maintain, evaluate and continually improve the Louisiana Health Equity Dashboard based on current evidence and research; 2. The Louisiana Health Equity Dashboard should initially consist of 9 determinant of health domains: a. Personal, individual behavior and lifestyle b. Biologic and genetic c. Social i. Social and community context ii. Education iii. Economic stability iv. Neighborhood and build environment d. Economic e. Environment f. Political determinant of health g. Health behaviors and health status h. Health care and health care workforce i. Population structure 3. The Office of Community Partnership & Health Equity will ensure that a statewide community engagement process is used to inform the design of the dashboard and raise awareness of the dashboard among those most impacted by health disparities; 4. The Office of Community Partnership & Health Equity will develop a comprehensive state-wide communication plan on the Louisiana Health Equity Dashboard to include utilization training sessions for governmental, health care, and community based organizations; 5. The Office of Community Partnership & Health Equity will allocate 1.0 FTE to the creation, implementation, and maintenance of the Louisiana Health Equity Dashboard; 6. The Office of Community Partnership & Health Equity will allocate 1.0 FTE for the evaluation, quality improvement and community utilization and engagement of the Louisiana Health Equity Dashboard; 7. The Office of Community Partnership & Health Equity will develop and implement a comprehensive systematic quality improvement plan to evaluate the utilization, effectiveness, and state-wide impact of the Louisiana Health Equity Dashboard to include website data analytic metrics;

	8. The Governor will appoint a Louisiana Health Equity Dashboard Advisory Committee or Board with the following duties and representation: a. Louisiana Health Equity Dashboard Committee Duties – i. Ensure the implementation of the COVID-19 Health Equity Dashboard Sub-committee recommendations ii. Develop policies and procedures for the implementation of the Louisiana Health Equity Dashboard iii. Monitor the utilization, effectiveness and state-wide impact of the Louisiana Health Equity Dashboard; iv. Provide recommendations to the Governor and other executive agencies to improve the state-wide impact of the Louisiana Health Equity Dashboard on Health Equity issues b. Louisiana Health Equity Dashboard Representation – i. Governor's Office Liaison ii. Office of Community Partnership & Health Equity iii. Louisiana Hospital Association iv. Louisiana Public Health Association v. LSU Health – New Orleans School of Nursing vi. Southern University Baton Rouge School of Nursing vii. Urban League of Louisiana viii. Xavier University College of Pharmacy ix. Dillard University - Minority Health and Health Disparities Research Center 9. Funding will be allocated to conduct research on the utilization and impact of the Louisiana Health Equity Dashboard; 10. A contract or agreement will be signed with MySideWalk to create the Louisiana Health Equity Dashboard (attached MySideWalk proposal); 11. A contract or agreement will be signed with PolicyLink to provide strategic guidance on the Louisiana Health Equity Dashboard's development and design and to provide strategic guidance on the community engagement process.
Responsible Parties and Timeline for Completion (if applicable)	1. Contracts signed within a week; 2. Within one month MySideWalk will develop a dashboard template with the essential elements; 3. Within one month will conduct focus groups/interviews with the community; 4. Within three months MySideWalk will deploy an initial equity dashboard from the existing data set; 5. After the deployment of the initial equity dashboard, focus groups/interviews will be conducted with the community of interest; 6. Within 6 months 50% of the data elements will be deployed into an equity dashboard; 7. Within 1 year, most of the data elements will be deployed into an equity dashboard.
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