IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF LOUISIANA

DADA, *et al*., *Petitioners-Plaintiffs*, v. WITTE, *et al.,* *Respondents-Defendants*.	Civil Action No.: 1:20-cv-458 Judge Dee D. Drell Magistrate Judge Joseph H.L. Perez-Montes **ORAL ARGUMENT REQUESTED**

PLAINTIFFS' MEMORANDUM OF LAW IN SUPPORT OF THEIR
MOTION FOR A TEMPORARY RESTRAINING ORDER

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INTRODUCTION

Today's global pandemic of the COVID-19 virus is the worst the world has seen since 1918. Public health experts have admonished that the only effective way to reduce the risk of severe illness or death for vulnerable individuals is sustained social distancing and vigilant hygiene. Such measures are impossible to achieve in crowded detention centers. For this reason, health care professionals – including two of the Department of Homeland Security's own medical experts – have urgently called for the release of detained immigrants, particularly elderly or medically vulnerable ones.[1] Yet, Respondent-Defendants ("Defendants") continue to detain thousands of individuals in Louisiana facilities and across the country, including those at severe risk of serious illness or death, despite the ready availability of release, including under community-based alternatives to detention.

Petitioner-Plaintiffs ("Plaintiffs") are sixteen individuals detained in Louisiana and who, due to their age and pre-existing medical conditions, are particularly vulnerable to serious illness or death if infected by COVID-19. While detained, it will be impossible to engage in necessary social distancing practices to protect themselves and others; they are vulnerable to infection because they eat, sleep and otherwise comingle in tight proximity to others and because sanitary conditions in these facilities is poor, lacking sufficient, basic supplies of soap and hand sanitizer.

Even with the measures ICE is attempting so as to limit the spread of COVID-19, immigration detention centers are a hotbed for spread of the virus, which broadly endangers public health and will strain vulnerable hospital systems. For at-risk individuals like Plaintiffs, protection from the virus is a matter of life or death. The danger posed by Plaintiffs' continued detention during the COVID-19 pandemic is "so grave that it violates contemporary standards of decency to

[1] Catherine E. Shoichet, *Doctors Warn of 'Tinderbox Scenario' if Coronavirus Spreads in ICE Detention*, CNN, Mar. 20, 2020, *available at* https://www.cnn.com/2020/03/20/health/doctors-ice-detention-coronavirus/index.html.

expose anyone unwillingly to such a risk" and violates their constitutional right to safety in government custody. *Helling v. McKinney,* 509 U.S. 25, 36 (1993). Without this Court's intervention, Plaintiffs will continue to face the imminent risk of severe illness or death. Release – which this Court, like many others who have already acted, is fully authorized to order – is the only meaningful way to protect Plaintiffs from grave, irreparable harm.

FACTUAL BACKGROUND

I. COVID-19 Is an Unprecedented and Lethal Global Pandemic.

COVID-19 is a highly contagious disease that is easily transmitted through respiratory droplets, especially when one is within six feet of an infected individual. Meyer Decl. ¶20. It can result in severe and widespread damage to lungs, heart, liver, or other organs. In many cases, COVID-19 results in death. *Id.* ¶21. A patient's condition can seriously deteriorate within days.[2]

Those who develop serious complications will need advanced medical support. *Id*. ¶22. This level of support is especially difficult to provide for detained individuals. *See id*. ¶¶16, 32-33. The need for advanced medical care and the likelihood of death are much greater from COVID-19 infection than from influenza. *See Id.* ¶19.

There is no vaccine against COVID-19, nor any known medication to prevent or treat infection from the virus. *Id*. ¶ 19. The only effective measure to reduce the risk of infection and thus severe illness or death to vulnerable individuals is to enforce regular social distancing (remaining physically separated from known or potentially infected individuals) and vigilant hygiene, including frequently washing hands with soap and water. *See Id*. ¶¶9-12.

II. COVID-19 is Exceedingly Dangerous for Individuals Like Plaintiffs, Who Have Underlying Health Concerns.

[2] Centers for Disease Control and Prevention, "Clinical Presentation" *Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19)* (Mar. 31, 2020) *available at* https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html.

Older individuals and those with certain medical conditions face greater chances of serious illness or death from COVID-19. *Id.* ¶¶ 21. Certain underlying medical conditions increase the risk of serious COVID-19 disease for individuals of any age, including but not limited to lung disease, chronic liver or kidney disease, diabetes, epilepsy, hypertension, compromised immune systems, blood disorders, inherited metabolic disorders, stroke, and pregnancy. *Id.*; Bazzano Decl. ¶8. Individuals detained in immigration detention centers, including those in the New Orleans Field Office area of responsibility, are also more susceptible to experiencing complications from infectious diseases than the population at large. Meyer Decl. ¶14. This is especially true for the following Plaintiffs, with underlying conditions such as diabetes, lung disease, kidney disease, or other illness. *Id.* ¶13.

- **Tatalu Helen Dada** suffers from asthma, Grave's Disease, hypothyroidism, hypertension, malnutrition, and vision loss, and has been hospitalized numerous times due to her rapidly deteriorating health all putting her at a high risk of severe complications or death if she contracts COVID-19. Bazzano Decl. ¶b. She has a place to live if released. Compl. ¶ 22.

- **Matilde Flores de Saavedra** is 78 and suffers from uncontrolled diabetes and hypertension which puts her at high risk of severe illness or death if she contracts COVID-19. Bazzano Decl. ¶d. She has a place to live if released. Compl. ¶23.

- **Sirous Asgari** is 59 years old, and suffers from chronic lung conditions, hypertension, and liver disease. His medical conditions put him at high risk of severe illness or death if he contracts COVID-19. Bazzano Decl. ¶i. He has a place to live if released. Compl. ¶24.

- **Suresh Kumar** suffers from Hepatitis C, malnutrition, and chronic pain, and is immunocompromised. His medical conditions put him at high risk of severe illness or death if he contracts COVID-19. Bazzano Decl. ¶e. He has a place to live if released. Compl. ¶30.

- **Pardeep Kumar** suffers from malnutrition, is immunocompromised, and has failing kidneys. These medical conditions put him at high risk of severe illness or death if he contracts COVID-19. Bazzano Decl. ¶f. He has a place to live if released. Compl. ¶31.

- **Rosabel Carrera** is 59 years old and suffers from diabetes. She also has a history of stroke and suffers from heart disease, hypertension, arthritis, and vision loss. She is at high risk of severe illness or death if she contracts COVID-19. Bazzano Decl. ¶a. She has a place to live if released. Compl. ¶26.

- **Sonia Lemus Tejada Dejaso** suffers from heart disease and hypertension, putting her at a high risk of severe illness or death if she contracts COVID-19. Bazzano Decl. ¶c. She has a place to live if released. Compl. ¶27.

- **Griselda Del Bosque** is 59 years old and suffers from severe asthma putting her at high risk of severe illness or death if she contracts COVID-19. Bazzano Decl. ¶h She has a place to live if released. Compl. ¶28.

- **Nadira Sampath Grant** suffers from diabetes and diabetic related complications such as neuropathy and issues with her kidneys putting her at high risk of severe illness or death is she contracts COVID-19. Bazzano Decl. ¶g. She has a place to live if released. Compl. ¶29.

- **Abraham Gebremedhin Gebremichael** suffers from bradycardia, a heart condition that leaves his body without sufficient oxygen, which puts him at high risk of severe illness or death is he contracts COVID-19. Bazzano Decl. ¶o. He has a place to live if released. Compl. ¶32.

- **Hasan Saleh** suffers from hypertension, diabetes, high cholesterol and blood clots, and is 62 years old. His age and medical conditions put him at high risk of severe illness or death is he contracts COVID-19. Bazzano Decl. ¶j. He has a place to live if released. Compl. ¶35.

- **Rolando Alex Colon** suffers from hypertension and high cholesterol, putting him at high risk of severe illness or death if he contracts COVID-19. Bazzano Decl. ¶k. He has a place to live if released. Compl. ¶33.

- **Karthikeyan Ponnusamy** suffers from hypertension, diabetes, and Low Lactate Dehydrogenase, putting him at high risk of severe illness or death if he contracts COVID-19. Bazzano Decl. ¶p. He has a place to live if released. Compl. ¶34.

- **Aracelio Rodriguez** suffers from severe asthma, putting him at high risk of severe illness or death is he contracts COVID-19. Bazzano Decl. ¶n. He has a place to live if released. Compl. ¶36.

- **Desmond Nkobenei** suffers from hypertension, putting him at high risk of severe illness or death is he contracts COVID-19. Bazzano Decl. ¶m. He has a place to live if released. Compl. ¶37.

- **Eduardo Devora Espinosa** suffers from hypertension and diabetes, putting him at high risk of severe illness or death is he contracts COVID-19. Bazzano Decl. ¶l. He has a place to live if released. Compl. ¶25.

III. Relevant ICE Detention Facilities Are Ticking Time Bombs; They Do Not, and Cannot, Meet Public Health Standards to Prevent Widespread Infections.

The LaSalle, Winn, Jackson, Catahoula, Pine Prairie, and Richwood facilities are located in Louisiana.[3] As of April 13, 2020, there were nearly 21,100 COVID-19 cases in Louisiana, and over 880 deaths.[4] These data include cases in all of the parishes in which these facilities are located.

Detention centers present a particularly high risk of outbreaks, which is exemplified by the skyrocketing numbers of cases in New York City jails. Meyer Decl. ¶¶7-17. The only effective way to prevent infection is to practice proper hygiene and, crucially, social distancing: maintaining a distance of at least six feet between oneself and others. *Id.* ¶¶11, 20. But several Plaintiffs describe conditions in these facilities that render it impossible to practice social distancing: many sleep in dorms that they share with over 50 other individuals, in beds—sometimes double- or triple-bunk beds—that are well under six feet apart, in some cases less than two feet apart (Dada Decl. ¶¶15-16; del Bosque Decl. ¶8; Flores de Saavedra ¶5; Carrera Decl. ¶10; Asgari Decl. ¶18; Sampath Grant Decl. ¶6; Nkobenei Decl. ¶ 4; Rodriguez Decl. ¶13; Gebremichael Decl. ¶10; ; Obser Decl. ¶¶13-15; Ponnusamy Decl. ¶10). They share bathrooms and dining halls (*Id.*), and in one case forty-four men share one shower. Asgari Decl. ¶18. To make matters worse, Defendants have not adopted adequate mitigation measures: the staff at detention centers do not wear masks or gloves (Dada Decl. ¶¶15-16; del Bosque Decl. ¶5; Flores de Saavedra Decl. ¶7; Carrera Decl. ¶11; Suresh Kumar Decl. ¶8;Sampath Grant Decl. ¶5; Saleh Decl. ¶6), and Plaintiffs do not have adequate access to soap or hand sanitizer (Sampath Grant Decl. ¶5; del Bosque Decl. ¶7; Dada Decl. ¶16; Gebremichael Decl. ¶11; Rodriguez Decl. ¶17; Tejada Dejaso Decl. ¶9; Ponnusamy Decl. ¶9). Richwood, in particular, even prohibits staff from wearing personal protective equipment. Nochomovitz Decl. ¶16. Plaintiffs also describe instances where individuals

[3] Detention Facility Locator, U.S. Immigration and Customs Enforcement, *available at* https://www.ice.gov/detention-facilities.
[4] Louisiana Department of Health, *Coronavirus (COVID-19)* (Apr. 13, 2020), http://ldh.la.gov/coronavirus/.

who are ill – including those presenting symptoms consistent with COVID-19 – are not tested or given adequate medical care. Sampath Grant Decl. ¶ 7; del Bosque Decl. ¶ 9; Dada Decl. ¶ 15; Gebremichael Decl. ¶12.

COVID-19 has already reached at least some of the immigration detention centers in Louisiana. Huber Decl. ¶10. Dorms at Pine Prairie, Winn, and Basile are currently under indefinite quarantine. *Id.* Pine Prairie has two confirmed COVID-19 cases, and both Winn and Richwood each have one as well. At least 11 staff members and 6 detained persons have so far tested positive for COVID-19 at Louisiana ICE facilities.[5] There is an immediate and impending threat that COVID-19 will become widespread in these detention centers. In fact, in the absence of widespread testing, there is no way to be certain that infection is not already present across other facilities. Once one person in a detention facility contracts the virus, it spreads quickly because individuals in detention centers live, sleep, eat, and use the bathroom in close proximity with others, which "make it difficult if not impossible to contain transmission." Bazzano Decl. ¶14. And, given the daily entry of staff and guards from the community, and the continued influx and transfer of dozens of new people into detention facilities on a daily or weekly basis, *see*, *e.g.*, Asgari Decl. ¶¶ 13, 17; Sampath Grant Decl. ¶7; del Bosque Decl. ¶9; Nkobenei Decl. ¶7; Nochomovitz Decl. ¶14, it is only a short matter of time before the disease becomes widespread throughout all of these detention centers.

IV. ICE's Response to COVID-19 Is Insufficient to Prevent the Spread of This Life-Threatening Disease.

As these conditions show, Defendants have not and cannot ensure mitigation of COVID-19 in ICE detention facilities. Bazzano Decl. ¶15. While ICE policy is to test and isolate those who are at high epidemiologic risk, this is insufficient: not everyone who contracts the virus is

[5] ICE COVID-19 Guidance, https://www.ice.gov/coronavirus (Apr. 13, 2020).

symptomatic, and few detention centers have negative pressure rooms, which are required to prevent spread of the virus from the isolated individual's room to others. Meyer Decl. ¶14; *Matter of Extradition of Toledo Manrique*, No. 19MJ71055MAG1TSH, 2020 WL 1307109, at *1 (N.D. Cal. Mar. 19, 2020) ("symptoms of COVID-19 can begin to appear 2-14 days after exposure, so screening people based on observable symptoms is just a game of catch up").

Further, although ICE has temporarily suspended social visitation in all detention facilities, staff, contractors, and vendors continue to arrive and leave the detention centers.[6] Meyer Decl. ¶ 8. Detained individuals are also frequently transported to, from, and between facilities. *Id*. Given the general lack of available testing, it is impossible for detention facilities to consistently and adequately screen detained persons and staff for new, asymptomatic infection. *Id*. ¶30. Anything short of aggressive screening and testing of detained individuals, staff, officials and other care and service providers who enter the facility is insufficient to prevent infection. Neither ICE nor the Louisiana detention facilities have the resources necessary to engage in such an effort. *Id.* ¶¶25-30; Bazzano Decl. ¶ 15.

Importantly, the COVID-19 pandemic—and ICE's unsatisfactory response to it—will significantly strain ICE's already broken medical care system, while the medical system in surrounding areas is expected to soon be overloaded, significantly reducing the capacity to provide emergency, life-saving medical care to all. Bazzano Decl. ¶¶ 7-9. Long before the COVID-19 outbreak, numerous reports (including by DHS itself) have identified serious and substantial flaws in ICE's medical care system. Compl. ¶¶138-42.

V. The Consensus of Public Health Experts is That Individuals Most Vulnerable to COVID-19 Should Immediately Be Released to Protect them From Serious Illness or Death.

[6] *ICE Guidance on COVID-19*, U.S. Immigration and Customs Enforcement, *available at* https://www.ice.gov/covid19.

Public health experts with experience in immigration detention have recommended the release of vulnerable individuals. Two DHS medical experts sent a letter to Congress warning of the severe public health risks of keeping individuals detained and recommending release of most persons in immigration detention.[7] A former Acting Director of ICE has stated that ICE "can, and must, reduce the risk [COVID-19] poses to so many people, and the most effective way to do so is to drastically reduce the number of people it is currently holding."[12]

Releasing the most vulnerable people, such as Plaintiffs, would also reduce the burden on regional hospitals and health centers. Meyer Decl. ¶¶16, 35-37. In case of an outbreak at a detention center, those institutions would bear the brunt of having to treat infected individuals from detention centers and would have fewer medical resources available for the general population. *Id*. ¶16. Governments worldwide have recognized the threat posed by the spread of COVID-19 among detained and incarcerated populations and have released detained persons in response. For example, Iran temporarily released more than 70,000 people to curb the spread of the virus. *Id*. ¶ 24. In the United States, several jurisdictions including Los Angeles, New York, and Chicago have also released detained individuals for the same reasons, as has New Orleans. Compl. ¶154. On March 22, the New Jersey Supreme Court issued a consent order for the presumptive release of approximately 1,000 persons by March 26. And on April 2, 2020, the Chief Justice of the Louisiana Supreme Court offered guidance on reducing the jail population, encouraging district court judges to release detained persons because a coronavirus outbreak in jails and prisons would be "catastrophic for jail staff, the families of jail staff, and inmates."[8]

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[7] Letter from Dr. Scott Allen and Dr. Josiah Rich, to House Comm. on Homeland Sec., Mar. 19, 2020, *available at* https://www.documentcloud.org/documents/6816336-032020-Letter-From-Drs-Allen-Rich-to-Congress-Re.html#document/p4/a557238; Catherine Shoichet, *Doctors Warn of "Tinderbox Scenario" If Coronavirus Spreads in ICE Detention*, CNN.com, Mar. 20, 2020, *available at* https://www.cnn.com/2020/03/20/health/doctors-ice-detention-coronavirus/index.html.

[8] Chief Justice Bernette Joshua Johnson, Letter To the Louisiana District Judges, April 2, 2020, *available at* ttps://www.lasc.org/COVID19/2020-04-02-LASC-ChiefLetterReCOVID-19andjailpopulation.pdf; *see also* Javonti

Dr. Meyer has concluded that "[r]educing the size of the population in jails and prisons can be crucially important to reducing the level or risk both for those within those facilities and for the community at large. Meyer Decl. ¶35. Dr. Meyer recommends "that individuals who are already in [ICE facilities] be evaluated for release," and that "[t]his is more important still for individuals with preexisting conditions… or who are over the age of 65." *Id.* ¶¶ 35-36. In light of Plaintiffs' medical conditions, Dr. Bazzano has determined that Plaintiffs face a substantial risk of severe illness or death as a result of continued detention. Bazzano Decl. ¶¶ a-p.

ARGUMENT

Under Rule 65 of the Federal Rules of Civil Procedure, a movant is entitled to temporary restraining order to preserve the status quo—here, the health and lives of Plaintiffs—by showing: (1) a substantial likelihood of success on the merits of their claims for relief; (2) a substantial threat of in irreparable injury absent the injunction; (3) that the threatened injury outweighs any damage that injunction may cause the opposing party; and (4) that the injunction will not disserve public interest. *Lake Charles Diesel, Inc. v. General Motors Corp*, 328 F.3d 192, 195 (5th Cir. 2003). The Court likewise has wholly independent authority under habeas corpus, 28 U.S.C. § 2241, to order immediate release from unconstitutional confinement.

There is voluminous evidence in the record showing that Plaintiffs are particularly vulnerable to severe illness and death, through highly likely exposure to the surging COVID-19 virus. The evidence demonstrating the serious risk they face to their health, including a risk of death, constitutes the clearest form of irreparable harm that the law recognizes. In contrast, Defendants can identify no sufficiently countervailing interest in continuing to subject those in

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Thomas, *Louisiana Chief Justice calls for reduced jail populations to combat COVID-19 outbreak,* KALB, April 3, 2020, *available at* https://www.kalb.com/content/news/Louisiana-Chief-Justice-calls-for-reduced-jail-populations-to-avoid-COVID-19-outbreak--569348241.html

civil immigration detention to such a grave health risk. In the last two weeks, dozens of courts have recognized as much and ordered detained persons released. Because subjecting persons in civil immigration detention to such dangerous conditions of confinement is punitive as well as recklessly indifferent to the known risks Plaintiffs face, and because continued detention in the face of such risks serves no legitimate nonpunitive government interest, Plaintiffs are likely to succeed on the merits of their substantive due process claims. And, because Plaintiffs face severe practical limitations on counsel access and procedures such as a bond hearing to vindicate their fundamental right to be free from unjustified detention, they are likely to succeed on their procedural due process claim.

Detaining these vulnerable individuals for civil immigration purposes contrary to expert consensus that they face substantial risk of illness or death represents the height of arbitrary detention and compels judicial intervention. Plaintiffs' lives are at stake.

I. PLAINTIFFS WILL SUFFER IRREPARABLE HARM IN THE ABSENCE OF A TEMPORARY RESTRAINING ORDER

"Perhaps the single most important prerequisite for the issuance of a preliminary injunction is a demonstration that if it is not granted the applicant is likely to suffer irreparable harm before a decision on the merits can be rendered." *Monumental Task Comm., Inc. v. Foxx*, 157 F. Supp. 3d 573, 582–83 (E.D. La. 2016), *aff'd sub nom. Monumental Task Comm., Inc. v. Chao*, 678 F. App'x 250 (5th Cir. 2017) (quotations omitted). The Fifth Circuit requires only a "substantial threat" of irreparable injury, *DSC Commc'ns Corp. v. DGI Techs., Inc*., 81 F.3d 597, 600 (5th Cir.1996), which is defined as "harm for which there is no adequate remedy at law," such as monetary damages. *Daniels Health Scis., L.L.C. v. Vascular Health Scis., L.L.C.*, 710 F.3d 579, 585 (5th Cir. 2013).

Without emergency relief from this Court, Plaintiffs face a substantial threat of imminent and irreparable injury, including death—harms no court can otherwise remediate. *See In re Bahadur*, No. EP-19-CV-00357-DCG, 2020 U.S. Dist. LEXIS 33455, at *14 (W.D. Tex. Feb. 27, 2020); *Chambers v. Coventry Health Care of Louisiana, Inc.*, 318 F. Supp. 2d 382 (E.D. La. 2004) (irreparable harm found where late detection of cancer could lead to death). Short of death, Plaintiffs are at grave risk of contracting severe and potentially lifelong medical conditions, which also establishes irreparable harm. *See, e.g.*, *M.R. v. Dreyfus,* 697 F.3d 706, 729 (9th Cir. 2012); *Jolly v. Coughlin*, 76 F.3d 468, 482 (2d Cir. 1996); *see also Unknown Parties v. Johnson*, No. CV-15-00250-TUC (DCBx), 2016 WL 8188563, at *15 (D. Ariz. No. 18, 2016), *aff'd sub nom Doe v. Kelly*, 878 F.3d 710 (9th Cir. 2017) (irreparable harm where evidence demonstrated "medical risks associated with . . . being exposed to communicable diseases").

Given their age and medical vulnerabilities, even those Plaintiffs who survive COVID-19 are likely to suffer lifelong ailments including neurologic damage and the loss of respiratory capacity, and may require extensive rehabilitation or profound reconditioning. And, short of release, there are no sufficient measures—preventative or palliative—that Defendants can implement to protect Plaintiffs, from crowded, unsanitary conditions. Bazzano Decl. ¶¶16-18. Medical experts conclude that COVID-19 poses unprecedented threats to the safety of these individuals—and those who come in contact with them, including ICE staff, healthcare providers, and local populations—and must be released. Meyer Decl. ¶¶35-37; Bazzano Decl. ¶¶16-18.

Plaintiffs can also demonstrate irreparable harm through a showing, *see infra* Section II, that Defendants have violated their constitutional rights. *See Opulent Life Church v. City of Holly Springs, Miss.*, 697 F.3d 279, 295 (5th Cir. 2012); *Castillo v. Barr*, CV 20-00605 TJH (AFMx), ECF No. 32, at 9 (C.D. Cal. Mar. 27, 2020) (concluding that "[a] civil detainee's constitutional

rights are violated if a condition of his confinement places him at substantial risk of suffering serious harm, such as the harm caused by a pandemic").

II. PLAINTIFFS ARE LIKELY TO SUCCEED ON THEIR DUE PROCESS CLAIMS

A. Plaintiffs' Continued Detention Violates Their Due Process Right To Protection From Harm And To Be Free From Punitive Conditions.

When the State holds individuals in its custody, the Constitution imposes an obligation to provide for their basic human needs, including medical care and reasonable safety. *DeShaney v. Winnebago Cty. Dep't of Soc. Servs.*, 489 U.S. 189, 199–200 (1989).

> The rationale for this principle is simple enough: when the State by the affirmative exercise of its power so restrains an individual's liberty that it renders him unable to care for himself, and at the same time fails to provide for his basic human needs—*e.g.,* food, clothing, shelter, medical care, and reasonable safety—it transgresses the substantive limits on state action set by the Eighth Amendment and the Due Process Clause.

Id. (citations omitted); *accord Hare v. City of Corinth, Miss.*, 135 F.3d 320, 326 (5th Cir. 1998).

1. Because They Are In Civil Detention, Plaintiffs Have a Right to be Free From Punitive Conditions Of Detention in ICE Detention Facilities.

A person in civil immigration detention has due process rights that are, at a minimum, similar to those of a person detained in pretrial detention prior to an adjudication of guilt, *Edwards v. Johnson*, 209 F.3d 772, 778 (5th Cir. 2000).[9] At a minimum, due process mandates that those in civil detention not be punished. *Hare*, 74 F.3d at 639. *See also Foucha v. Louisiana*, 504 U.S. 71, 80 (1992). Where the Eighth Amendment protects individuals in prison from punishment that rises

[9] Some courts have held that individuals in immigration detention have greater protections than those in pretrial detention because they rarely implicate penological interests associated with criminal confinement or suspicion. *In re Kumar*, 402 F. Supp. 3d 377, 384 (W.D. Tex. 2019); *Jones v. Blanas*, 393 F.3d 918, 933 (9th Cir. 2004). The *Kumar* court applied the *Youngberg* civil commitment standard to the immigration detention context, which asks whether "defendants' conduct was 'such a substantial departure from accepted professional judgment, practice, or standards in the care and treatment of this plaintiff.'" *Youngberg v. Romeo*, 457 U.S. 307, 314 (1982). There can be *no* professional medical or penological judgment that could reasonably support the continued detention of elderly and/or medically compromised individuals in immigration detention in crowded, precarious conditions that subject them to a certain risk of contagion, illness or death.

to "cruel and unusual," the Due Process Clause protects individuals in detention from *any* punishment. Therefore, persons in civil immigration detention are entitled to "more considerate treatment and conditions of confinement than criminals whose conditions of confinement are designed to punish." *Youngberg*, 457 U.S. at 322.

A condition of detention amounts to impermissible punishment when "it is not reasonably related to a legitimate goal," if it is "excessive" in relation to a legitimate goal," or if it is otherwise "arbitrary or purposeless"—a court permissibly may infer that the purpose of the governmental action is punishment that may not constitutionally be inflicted upon detainees qua detainees." *Bell v. Wolfish*, 441 U.S. 520, 539 (1979); *Hare*, 74 F.3d at 640. To make this showing, an individual in detention need not demonstrate the defendant's subjective or malicious intent to punish. *Shepherd v. Dallas Cty.*, 591 F.3d 445, 452 (5th Cir. 2009). "[E]ven where a State may not want to subject a detainee to inhumane conditions of confinement or abusive jail practices, its intent to do so is nevertheless presumed when it incarcerates the detainee in the face of such known conditions and practices." *Hare*, 74 F.3d at 644. "A pervasive pattern of serious deficiencies" that subjects an individual in detention to the risk of serious injury or death likewise amounts to punishment. *Shepherd*, 591 F.3d at 454.

In *Shepherd*, the Fifth Circuit found that a "jail's evaluation, monitoring, and treatment of inmates with chronic illness was [...] grossly inadequate due to poor or non-existent procedures and understaffing of guards and medical personnel," that "serious injury and death were the inevitable results of the jail's gross inattention to the needs of inmates with chronic illness," and that this amounted to punishment. *Shepherd.*, 591 F.3d at 454. Similarly, in *Duvall*, the Fifth Circuit affirmed a jury's finding that Dallas County had an unconstitutionally punitive custom or policy when it allowed infections of Methicillin-Resistant Staphylococcus Aureus (MRSA) to be

present in a jail, and failed to take necessary measures for eradication. *Duvall v. Dallas Cty., Tex.*, 631 F.3d 203, 208-209 (5th Cir. 2011).

Given the cramped, unsanitary, and irremediable conditions in ICE detention facilities, Plaintiffs face a demonstrably substantial risk of contracting COVID-19. Once they are exposed, they are all vulnerable to severe illness or death, either because of their age, or because they have underlying medical conditions, including: asthma, heart disease, compromised immune system, chronic renal issues, liver disease, susceptibility to lung disease, and diabetes. Continued detention of Plaintiffs is an imminent threat to their lives that is clearly excessive in relation to any purported government goal, and therefore amounts to punishment.

B. Continuing Detention Constitutes Deliberate Indifference to a Substantial Risk of Serious Harm.

In addition to affirmatively imposing punitive conditions of confinement, *supra* Section II(A)(2), an official violates the Due Process Clause if the official has "acted or failed to act with deliberate indifference to the detainee's needs." *Hare*, 74 F.3d at 648.[10] Courts find deliberate indifference when a detained person can show: (1) "that he is incarcerated under conditions posing a substantial risk of serious harm," and (2) "that the official was deliberately indifferent to inmate health or safety." *Hare*, 74 F.3d at 648 (citing *Farmer v. Brennan,* 511 U.S. 825 (1994)). Under the second prong, the Fifth Circuit asks whether the official "knows that inmates face a substantial risk of serious harm and disregards that risk by failing to take reasonable measures to abate it." *Jones v. Texas Dep't of Criminal Justice*, 880 F.3d 756, 759 (5th Cir. 2018). The Fifth Circuit holds that a detained person "does not need to show that death or serious illness has yet occurred to obtain relief. He must show that the conditions pose a substantial *risk of harm*." *Gates v. Cook*,

[10] Any condition that violates the Eighth Amendment rights individuals who are in prison, necessarily amounts to punishment of individuals in civil immigration detention and thereby violates the due process rights of Plaintiffs.

376 F.3d 323, 339 (5th Cir. 2004) (emphasis added). In *Gates*, where individuals on Death Row challenged overheated temperatures as violating the Eighth Amendment, the Fifth Circuit upheld a finding that the plaintiffs faced a substantial risk of serious harm based on expert testimony substantiating a likelihood of death. *Cook*, 376 F.3d at 339. But showing a likelihood of *actual* death is not required. As the Supreme Court ruled, housing individuals in crowded conditions where they are at risk of infectious disease is unconstitutional even when it "is not alleged that the likely harm would occur immediately and even though the possible infection might not affect all of those exposed," and prison officials cannot be "deliberately indifferent to the exposure of inmates to a serious, communicable disease on the ground that the complaining inmate shows no serious current symptoms." *Helling v. McKinney*, 509 U.S. 25, 33 (1993). *See also Gates v. Collier*, 501 F.2d 1291, 1300 (5th Cir. 1974) (prison conditions, including the fact that "inmates with serious contagious diseases are allowed to mingle with the general prison population," violate the Eighth Amendment).

In light of their age and medical vulnerability, and the impossibility of enforcing appropriate social distancing and sanitation measures, *see supra*, Factual Background Sec. II-V, Plaintiffs' continued detention puts them at substantial risk of serious harm. Numerous courts across the country sitting in jurisdictions with palpable COVID-spread—only days ahead of Louisiana's—have recognized the heightened risk to individuals in detention and have ordered their release.[11] Louisiana has had the fastest COVID-19 spread rate of any region in the world. Compl. ¶97. The substantial risk of serious harm to individuals in detention is imminent.

[11] *See*, *e.g.*, *Thakker, et. al. v. Doll, et. al.,* No 1:20-cv-00480-JEJ (M.D. Pa. Mar. 31, 2020); *Fraihat v. Wolf, et. al.*, ED CV 20-00590 TJH (KSx) (C.D. Cal. Mar 30, 2020); *Coronel, et al. v. Decker*, No. 1:20-cv-02472-AJN (S.D.N.Y. Mar. 27, 2020); *Calderon v. Cronen*, No. 18-10225 (MLW), ECF. 507 (D. Mass. Mar. 26, 2020); *Umana Jovel v. Thomas Decker, et al.*, No. 1:20-cv-00308-GBD-SN (S.D.N.Y. Mar. 24, 2020); *Basank, et. al. v. Decker, et al.*, No. 1:20-cv-02518-AT, (S.D.N.Y. Mar. 26, 2020); *Xochihua-Jaimes v. Barr*, 18-71460, Doc. No. 53 (9th Cir. Mar. 23, 2020); *In the Matter of the Request to Commute or Suspend County Jail Sentences*, Case No. 84230 (N.J.

Defendants have actual knowledge of this substantial risk and are deliberately indifferent to it. The risk of COVID-19 to the health and lives of medically vulnerable individuals is front-page national and local news on a daily basis and, at this point, utterly obvious. *See Harris v. Hegmann*, 198 F.3d 153, 159 (5th Cir. 1999) ("A prison official's knowledge of a substantial risk of harm may be inferred by the obviousness of the substantial risk"). ICE's Guidance on COVID-19 recognizes these risks, and ICE's prohibition on social visitation demonstrates a recognition of the importance of social distancing.[12] Medical experts from within DHS itself have described the risk of this virus to those in immigration detention.[13] ICE has received numerous letters from experts, Members of Congress, and non-governmental organizations alerting it to the risk of COVID-19.[14] Persons in immigration detention have protested against the conditions that render them vulnerable during this pandemic.[15] The World Health Organization and the U.S. Centers for Disease Control have emphasized the risk of this disease, its infectiousness, and its severity in those with underlying medical conditions.[16] There are daily news articles about the death toll of

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Mar. 22, 2020).; *Matter of Extradition of Toledo Manrique*, No. 19 MJ 71055, 2020 WL 1307109, at *1 (N.D. Cal. Mar. 19, 2020); *United States v. Martin*, No. 19 Cr. 140-13, 2020 WL 1274857, at *2 (D. Md. Mar. 17, 2020).

[12] *ICE Guidance on COVID-19*, U.S. Immigration and Customs Enforcement, https://www.ice.gov/covid19.

[13] Catherine E. Shoichet, *Doctors warn of 'tinderbox scenario' if coronavirus spreads in ICE detention*, CNN, Mar. 20, 2020, *available at* https://www.cnn.com/2020/03/20/health/doctors-ice-detention-coronavirus/index.html.

[14] *Letter from 763 non-governmental organizations to Matthew T. Albence*, Acting Director of ICE, Mar. 19, 2020, *available at* https://www.detentionwatchnetwork.org/sites/default/files/ICE%20Response%20to%20Coronavirus%20for%20People%20Detained%20-%20Organizational%20Sign%20on%20Letter%20-%20Final.pdf; Letter from Rep. Carolyn Maloney and Rep. Jamie Raskin to Acting Secretary of DHS Chad Wolf (Mar. 11, 2020), *available at* https://oversight.house.gov/sites/democrats.oversight.house.gov/files/2020-03-11.CBM%20and%20JR%20to%20Wolf-DHS%20re%20COVID-19.pdf.

[15] Alejandro Lazo, *Protests, Hunger Strikes Erupt Over Coronavirus in Immigration Detention.* The Wall Street Journal, Mar. 27, 2020, *available at* https://www.wsj.com/articles/protests-hunger-strikes-erupt-over-coronavirus-in-immigration-detention-11585320903; Debbie Nathan, *Women in ICE Detention, Fearing Coronavirus, Make Video to Protest Unsafe Conditions*, The Intercept (Mar. 30, 2020), available at https://theintercept.com/2020/03/30/coronavirus-ice-detention/.

[16] *Information for Healthcare Professionals: COVID-19 and Underlying Conditions,* Center for Disease Control (accessed Mar. 27, 2020), *available at* https://www.cdc.gov/coronavirus/2019-ncov/hcp/underlying-conditions.html; *Coronavirus disease 2019 (COVID-19) Situation Report – 51*, World Health Organization (accessed Mar. 31, 2020), available at https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200311-sitrep-51-covid-19.pdf?sfvrsn=1ba62e57_4.

COVID-19 and its impact on those with underlying medical conditions, particularly those in detention.[17] In the face of this overwhelming evidenced Defendants continued detention of Plaintiffs amounts to deliberate indifference.

C. ICE Lacks A Constitutionally Adequate Purpose For Continued Detention.

Non-criminal confinement "constitutes a significant deprivation of liberty that requires due process protection," and, thus, the government "must have 'a constitutionally adequate purpose for the confinement.'" *Jones v. United States*, 463 U.S. 354, 361 (1983) (quoting *O'Connor v. Donaldson*, 422 U.S. 563, 574 (1975)). Accordingly, courts must ensure that the nature and duration of confinement bear "some reasonable relation to the purpose for which the individual is committed." *Jackson v. Indiana*, 406 U.S. 715, 738 (1972); *Brown v. Taylor*, 911 F.3d 235, 243 (5th Cir. 2018). Once a valid basis for detention no longer exists, substantive due process requires the state to release the person. *Foucha*, 504 U.S. at 86 (ordering petitioner's release from commitment to mental institution because there was no longer any evidence of mental illness); *accord Kansas v. Hendricks*, 521 U.S. 346, 363-64 (1997).

Continuing to detain Plaintiffs in conditions that impose a substantial risk of illness or death eviscerates any legitimate purpose for their detention. The Supreme Court has held hat immigration detention is permissible to ensure the immigrant's participation in their removal proceedings, to prevent flight, and to otherwise protect the community. *Zadvydas v. Davis,* 533 U.S. 678, 690 (2001); *Demore v. Kim*, 538 U.S. 510, 528 (2003). For individuals who are at high risk for serious illness or death from COVID-19, protection from the virus is a matter of life or

[17] *See, e.g.*, Abigail Hauslohner, Nick Miroff & Matt Zapotosky, *Coronavirus Could Pose Serious Concern in ICE Jails, Immigration Courts*, The Washington Post, Mar. 12, 2020, *available at* https://www.washingtonpost.com/immigration/coronavirus-immigration-jails/2020/03/12/44b5e56a-646a-11ea845d-e35b0234b136_story.html; Josiah Rich, Scott Allen & Mavis Noah, *We Must Release Prisoners to Lessen the Spread of Coronavirus*, The Washington Post, Mar. 17 2020, *available at* https://www.washingtonpost.com/opinions/2020/03/17/we-must-release-prisoners-lessen-spreadcoronavirus/.

death, and no adequate measures are currently in place to mitigate against these risks. If detained persons are contagious, seriously ill, or otherwise dead, participation in legal proceedings will be medically or physically impossible, in violation of procedural due process, *see infra* Section I(C). And, as explained below, there is no credible argument that community safety requires their continued detention—instead, it compels the opposite.

C. Plaintiffs Are Likely To Prevail On Their Claim That Continued Detention Violates Procedural Due Process

When a governmental action limits a fundamental due process right to be free from detention, *see Foucha*, 504 U.S. at 80, *Demore v. Kim*, 538 U.S. 510, 561 (2003) (Souter, J., dissenting) (collecting cases), *Hernandez v. Sessions*, 872 F.3d 976, 981 (9th Cir. 2017), heightened scrutiny is applied. The action will be upheld only if the government shows it is necessary to promote a compelling governmental interest, *Washington v. Glucksberg*, 521 U.S. 702, 721 (1997); *Cooper v. Oklahoma*, 517 U.S. 348, 363 (1996), and is implemented in a manner that is "carefully limited" and "narrowly focused." *Foucha*, 504 U.S. at 81. The fundamental substantive rights afforded to those in civil detention[18] mandate "strong procedural protections." *Zadvydas v. Davis*, 533 U.S. 678, 691 (2001); *Demore v. Kim*, 538 U.S. 510, 551 (Souter, J., dissenting) ("the substantive demands of due process necessarily go hand in hand with the procedural"). At a minimum, procedural due process requires the right to be heard "at a meaningful time and in a meaningful manner." *Mathews v. Eldridge*, 424 U.S. 319, 333 (1976).

Absent immediate injunctive relief, Defendants will provide either no procedural protections or wholly deficient ones. As explained, the government's only legitimate interest in Plaintiffs' continued detention—either to minimize flight risk pending removal proceedings or to

[18] Multiple courts have ruled that civilly detained individuals are afforded greater pretrial protections than their criminally-charged counterparts. *See note* 8, *supra*.

prevent danger to the community, *Zadvydas*, 533 U.S. at 690—has been eviscerated by the pandemic because the likelihood of Plaintiffs' severe illness or death renders a meaningful removal proceeding a nullity. *See supra* Factual Background Sec. II-V. At the same time, there are more "narrowly focused" means to ensure Plaintiffs' appearance in legal proceedings, which do not subject them to the dangers of detention, including supervised or conditional release[19] that would suffice to meet the government's interest without subjecting Plaintiffs to severe danger.

Nor can Plaintiffs avail themselves of any meaningful procedural protections in an already-overburdened immigration court system, one that is ill-equipped to respond to the truly exigent crisis presented by COVID-19. There is substantial evidence that detained persons in Louisiana facilities—under normal circumstances—have severe restrictions on access to counsel and the adjudicative process.[20] These restrictions have worsened; many judges postpone or simply fail to show up to their own hearings,[21] rendering an already overburdened court system dysfunctional.[22]

This is a core procedural due process violation, *Mathews v. Eldridge*, 424 U.S. 319, 333 (1976), as other courts faced with similar coronavirus spread in their respective jurisdictions have

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[19] *See, e.g.*, *Immigration: Progress and Challenges in the Management of Immigration Courts and Alternatives to Detention Program*, U.S. Government Accountability Office, Sep. 18, 2018, https://www.gao.gov/products/GAO-18-701T; *Alternatives To Detention: Improved Data Collection and Analyses Needed to Better Assess Program Effectiveness*, U.S. Government Accountability Office, (Nov. 13, 2014), https://www.gao.gov/products/GAO-15-26.

[20] Plaintiffs are held in remote facilities, often upwards of five hours away from counsel and courts, Lopez ¶ 8; Scott Decl. ¶ 6, and access to attorney-client visits are sparse, if any, Lopez Decl. ¶ 4, Scott Decl. ¶¶ 8-9, 20. The already-sparse visitation in detention centers where Plaintiffs are held is diminishing, Scott Decl. ¶ 14, Rivera Decl. ¶¶ 6-10, Giardina Decl. ¶ 4, Trostle Decl. ¶¶ 7-8 and counsel to detained noncitizens in those facilities report having to provide their own ICE-mandated medically-protective equipment, Giardina Decl. ¶ 6, or risk spreading the virus to other clients, staff, or their families. Lopez Decl. ¶ 6; Scott Decl. ¶ ¶ 13-14, 18; Axelrod Decl. ¶ 18. Meaningful attorney-client communications rarely occur due to a host of logistical nightmares—the current wait to videoconference with a client is upwards of one week—and witness interviews, document collection, and hearing preparation routinely fail for lack of accessibility. Lopez Decl. ¶ ¶ 4-5; Scott Decl. ¶ ¶ 7-8, 10; Axelrod Decl. ¶ ¶ 7, 9-10; Giardina Decl. ¶¶ 3; Villareal Decl. ¶ 16; Trostle Decl. ¶ 8.

[21] Scott Decl. ¶ 17; Huber Decl. ¶ 10.

[22] Counsel for immigrants in removal proceedings consistently report a supremely dysfunctional immigration court structure, a system exacerbated by the COVID-19 pandemic, as practitioners describe a system struggling to manage caseloads, hold timely hearings, consider relevant evidence, or even have an Immigration Judge present. Lopez Decl. ¶ 6, 7; Scott Decl. ¶¶ 15-17, 20; Axelrod Decl. ¶¶ 8, 12; Rivera Decl. ¶¶ 14-16; Giardina Decl. ¶ 5; Fernandez Decl. ¶ 9; Trostle Decl. ¶¶ 7-9.

recognized. *See Coronel v. Decker*, CV 20-2472 (AJN) at *19-20 (S.D.N.Y Mar. 27, 2020); *Jovel v. Decker*, No. CV 20-308 (GBD) (SN), 2020 U.S. Dist. LEXIS 52095, at *12-*16 (S.D.N.Y. Mar. 24, 2020). And, without immediate injunctive relief, Plaintiffs would have to attempt to safeguard their own constitutional rights before a court charged to consider only flight risk and dangerousness, not exigent threats to life and safety. *See Zadvydas*, 533 U.S. at 690; *In re Guerra*, 24 I. & N. Dec. 37, 40 (BIA 2006) (setting forth nine non-health-related factors IJ is to consider in setting bond). To safeguard Plaintiffs' procedural due process rights, this Court should order their outright release or a "narrowly focused" means to ensure future court appearances, such as supervised or conditional release. *See Reno v. Flores*, 507 U.S. 292, 343 (1993) (Stevens, J. dissenting) ("a blanket rule that simply *presumes* that detention is more appropriate than release to responsible adults is not narrowly focused on serving that interest.").

III. THE BALANCE OF THE EQUITIES AND THE PUBLIC INTEREST TILTS SHARPLY IN FAVOR OF PLAINTIFFS' RELEASE.

Where, as here, the Government is a party to the case, the third and fourth injunction factors—the balance of the equities and the public interest—merge. *Nken v. Holder*, 556 U.S. 418, 435 (2009); *El Paso Cty., Texas v. Trump*, 407 F. Supp. 3d 655, 665 (W.D. Tex. 2019). As an initial matter, the public interest is served by the protection of constitutional rights. *See Ingebretsen v. Jackson Pub. Sch. Dist.*, 88 F.3d 274, 280 (5th Cir. 1996); *Cohen v. Coahoma Co*., 805 F. Supp. 398, 408 (N.D. Miss. 1992).

In addition, an injunction would also protect public health and safety, paramount considerations that weigh heavily in favor of an injunction. *See Planned Parenthood of Gulf Coast, Inc. v. Gee*, 862 F.3d 445, 472 (5th Cir. 2017); *see also Grand River Enterprises Six Nations, Ltd. v. Pryor*, 425 F.3d 158, 169 (2d Cir. 2005) (referring to "public health" as a "significant public interest"); *Pashby v. Delia*, 709 F.3d 307, 331 (4th Cir. 2013)

("the public interest in this case lies with safeguarding public health"); *Bianco v. Globus Med., Inc.*, No. 2:12-CV-00147-WCB, 2014 WL 1049067, at *11 (E.D. Tex. Mar. 17, 2014) (citing cases); *U.S. v. Barkman*, No. 3:19-cr-0052-RCJ-WGC, 2020 U.S. Dist. LEXIS 45628, at *4 (D. Nev. Mar. 17, 2020) (identifying risk of individuals carrying coronavirus into jails and noting that "[t]he men and women incarcerated at Washoe County Detention Facility are a part of our community and all reasonable measures must be taken to protect their health and safety.").

The balance of equities also strongly tilts in Plaintiffs' favor. As the Central District of California just held in ordering the release of detained children, "the public's interest in preventing outbreaks of COVID-19 among families and children in ICE or ORR custody that will infect ICE and ORR staff, spread to others in geographic proximity, and likely overwhelm local healthcare systems tips the balance of equities sharply in Plaintiffs' favor." *Flores v. Barr*, No. CV 85-4544-DMG (AGRx), ECF. 740 at 12 (C.D. Cal. Mar. 28, 2020). Because Plaintiffs present no risk to community safety, the comparative burden to the government in releasing Plaintiffs is nominal. Release not only saves the government time and money, it actually *reduces* detention center density, decreasing the chances of COVID-transmission to both detained persons and staff, and avoids correspondingly escalating medical costs. Even if it did not tangibly benefit the government, the risk of catastrophic medical consequences would still tilt the equities in Plaintiffs' favor. *See Hernandez,* 872 F.3d at 996 ("Faced with such a conflict between financial concerns and preventable human suffering, we have little difficulty concluding that the balance of hardships tips decidedly in plaintiffs' favor.").

IV. IMMEDIATE RELEASE IS THE ONLY EFFECTIVE REMEDY FOR PLAINTIFFS' UNLAWFUL DETENTION, WHICH THE COURT HAS AMPLE AUTHORITY TO ORDER.

The Court has ample authority under 28 U.S.C. § 2241, and independently under Rule 65[23] to issue the release of detained persons—a remedy that has been ordered by numerous courts across the country in recent days. Habeas invests in federal courts broad, equitable authority to "dispose of the matter as law and justice require," 28 U.S.C. § 2243, as the "very nature of the writ demands that it be administered with the initiative and flexibility." *Harris v. Nelson*, 394 U.S. 286, 292 (1969).

While it is clear in this Circuit that habeas authorizes challenges to the fact or duration of detention, there is more ambiguity about whether habeas – as compared to traditional civil rights remedies against state officials, such as 42 U.S.C. § 1983 – authorizes challenges to conditions of confinement. *See Poree v. Collins*, 866 F.3d 235, 244 (5th Cir. 2017) (observing that "the Supreme Court has not foreclosed" habeas challenges for conditions claims and "declin[ing] to address whether habeas is available only for fact or duration claims."); *Wilwording v. Swenson*, 404 U.S. 249, 251 (1971) (habeas challenging "living conditions and disciplinary measures" is "cognizable in federal habeas corpus").

In any event, this habeas petition does not challenge conditions of confinement in the way this purported distinction imagines. Plaintiffs are not seeking judicial intervention in order to alleviate harsh conditions; it is precisely because there is no judicial possibility of remediating their unconstitutional confinement that they are challenging the very *fact* of their confinement. *See Malam v. Adducci, et al.*, No. 2:20-cv-10829-JEL-APP, ECF No. 22 at p. 8 (E.D. Mich. Apr. 5, 2020) (habeas appropriate for COVID-19 release because petitioner "seeks immediate release from confinement as a result of there being no conditions of confinement sufficient to prevent

[23] *See Brown v. Plata*, 563 U.S. 493, 511 (2011) ("When necessary to ensure compliance with a constitutional mandate, courts may enter orders placing limits on a prison's population.").

irreparable constitutional injury under the facts of her case."). As such, they seek "relief from unlawful imprisonment or custody." *Pierre v. United States*, 525 F.2d 933, 935-36 (5th Cir. 1976); *see also Poree*, 866 F.3d at 244 (petition seeking transfer to facility with less restrictive conditions "properly sounds in habeas"). Habeas confers "broad discretion in conditioning a judgment granting habeas relief . . . 'as law and justice require'." *Hilton v. Braunskill*, 481 U.S. 770, 775 (1987) (quoting 28 U.S.C. § 2243). That authority includes an order of release, *Boumediene v. Bush*, 553 U.S. 723, 779 (2008), so as "to insure that miscarriages of justice . . . are surfaced and corrected." *Harris*, 394 U.S. at 291.

Separately, under Rule 65 and a court's inherent equitable authority to remedy unconstitutional government conduct, courts may issue "orders placing limits on a prison's population." *Brown v. Plata*, 563 U.S. 493, 511 (2011). *See also Duran v. Elrod*, 713 F.2d 292, 297-98 (7th Cir. 1983), *cert. denied*, 465 U.S. 1108 (1984) (affirming order releasing low-bond individuals in pretrial detention as necessary to reach a population cap); *Mobile Cty. Jail Inmates v. Purvis*, 581 F. Supp. 222, 224-26 (S.D. Ala. 1984) (exercising remedial powers to order a prison's population reduced to alleviate unconstitutional conditions.)

In the midst of this unprecedented public health crisis, numerous courts considering the plight of detained individuals have similarly ordered release. *See Xochihua-Jaimes v. Barr*, 18-71460, Doc. No. 53 (9th Cir. Mar. 23, 2020) (sua sponte release from immigration detention due to rapidly escalating health crisis); *In re Matter of Toledo Manrique*, No. 19-MJ-71055-MAG-1 (TSH), 2020 WL 1307109, at *1 (N.D. Cal. Mar. 19, 2020) ("risk that this vulnerable person will contract COVID-19 while in jail is a special circumstance that warrants bail."); *United States v. Stephens*, No. 15-cr-95 (AJN), 2020 U.S. Dist. LEXIS 47846, at *2-3 (S.D.N.Y. Mar. 18, 2020) (granting emergency motion for reconsideration of bail in light of COVID-19 pandemic); *United*

States v. Raihan, No. 20-cr-68-BMC- JO, ECF No. 20, Proc. at 10:12-19 (E.D.N.Y. Mar. 12, 2020) E.C.F. No. 20 ("[t]he more people we crowd into that facility, the more we're increasing the risk to the community"); *Manrique*, 2020 WL 1307109 at *1 (74 year-old presents "risk that this vulnerable person will contract COVID-19 while in jail [which] is a special circumstance that warrants bail").[24]

V. THE COURT SHOULD NOT REQUIRE PLAINTIFFS TO PROVIDE SECURITY PRIOR TO ISSUING A TEMPORARY RESTRAINING ORDER.

Federal Rule of Civil Procedure 65(c) provides that "[t]he court may issue a preliminary injunction or a temporary restraining order only if the movant gives security in an amount that the court considers proper to pay the costs and damages sustained by any party found to have been wrongfully enjoined or restrained." The Fifth Circuit has determined that "the amount of security required pursuant to Rule 65(c) 'is a matter for the discretion of the trial court,'" and that "the court 'may elect to require no security at all.'" *Kaepa, Inc. v. Achilles Corp.*, 76 F.3d 624, 628 (5th Cir. 1996) (quoting *Corrigan Dispatch Company v. Casa Guzman*, 569 F.2d 300, 303 (5th Cir. 1978)).

District courts routinely exercise this discretion to require no security in cases brought by indigent and/or incarcerated people. *See, e.g.*, *Cole v. Livingston*, No. 4:14-CV-1698, 2016 U.S. Dist. LEXIS 80345, at *23 (S.D. Tex. June 21, 2016) (state prisoners), *vacated on other grounds*, *Yates v. Collier*, 677 F. App'x 915 (5th Cir. 2017); *Orantes-Hernandez v. Smith*, 541 F. Supp. 351, 385 n. 42 (C.D. Cal. 1982) (detained immigrants). This Court should do the same here.

[24] Courts maintain this authority to order those detained in violation of their due process rights released, notwithstanding § 1226(c). *See Cabral v. Decker*, 331 F. Supp. 3d 255, 259 (S.D.N.Y. 2018) (collecting cases). *see also Mapp v. Reno*, 241 F.3d 221, 226 (2d Cir. 2001) (where a case presents "extraordinary circumstances . . . that make the grant of bail necessary to make the habeas remedy effective," federal courts have the inherent authority to release individuals from immigration detention pending final disposition of their claims); *Leslie v. Holder*, 865 F. Supp. 2d 627, 639 (M.D. Pa. 2012) ("extraordinary circumstances" warranting immigrant's release on habeas); *Sanchez v. Winfrey*, No. CIV.A.SA04CA0293RFNN, 2004 WL 1118718, at *3 (W.D. Tex. Apr. 28, 2004) (same).

CONCLUSION

For the foregoing reasons, Plaintiffs respectfully request that this Court grant the motion for a temporary restraining order and order their immediate release from custody.

Dated: April 14, 2020

Respectfully submitted,

/s/ William P. Quigley

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Counsel for Petitioners-Plaintiffs

CERTIFICATE OF SERVICE

I hereby certify that on April 14, 2020, I electronically filed the foregoing document and accompanying motion, exhibits, and proposed order with the Clerk of the Court using the CM/ECF system. I further certify that I spoke with AUSA Seth Reeg on the telephone and advised him of this filing on April 13, 2020, prior to its filing. In addition, I will email copies of these documents to AUSA Seth Reeg at the following email address at the U.S. Attorney's Office for the Western District of Louisiana:

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Dated: April 14, 2020

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IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF LOUISIANA

Talatu Helen Dada, et al, *Petitioners-Plaintiffs*, v. Dianne Witte, et al, *Respondents-Defendants*.	Civil Action No.:

DECLARATION OF Lydia Angela Louise Bazzano, MD, PhD, MPH, FACP

I, Lydia Bazzano, make the following declaration based on my personal knowledge and declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct.

I. Background

1. I am Dr. Lydia Angela Louise Bazzano. I am a senior physician and Executive Chair of the Ochsner Institutional Review Board at Ochsner Health System (OHS), and Professor of Epidemiology at the Tulane University School of Public Health and Tropical Medicine, where I direct the Center for Lifespan Epidemiology Research. A fellow of the American College of Physicians and Diplomate of the American Board of Internal Medicine, I did my residency training at the Beth Israel Deaconess Medical Center Internal Medicine Residency program in Boston, Massachusetts associated with the Harvard Medical School. I received my medical degree from Tulane University School of Medicine and a Master of Public Health Degree (MPH) as well as a Doctor of Philosophy (PhD) in Epidemiology from the Tulane University School of Public Health and Tropical Medicine.

2. As a professor of Epidemiology at Tulane University School of Public Health and Tropical Medicine, I teach classes in Clinical Epidemiology, which is a subfield of epidemiology focused on the issues relevant to clinical medicine. Epidemiology is commonly defined as the investigation and control of the distribution and determinants of disease in populations. Clinical epidemiology involves the application of population level principles of epidemiology to the individual care of patient in clinical medicine. In this capacity, I teach medical students in the dual degree MD/MPH and MD/PhD programs in Epidemiology, as well as students of public health in the MPH program.

3. As a Senior Physician in the Department of Internal Medicine at Ochsner Health System, I supervise residents in the Internal Medicine in the ambulatory primary care clinic. Prior to this position, from 2012 to 2014, I served as a physician in the Department of Hospital Medicine, attending patients admitted to medical units at the main campus of Ochsner Hospital, located at 1514 Jefferson Highway in New Orleans, Louisiana. In addition, I currently serve as the Executive Chair of the Ochsner Institutional Review Board, which protects the rights of human participants in clinical research.

4. I have broad expertise in the fields of Epidemiology and Internal Medicine with more than 170 peer-reviewed publications in across a range of health outcomes including but not limited to infectious, cardiovascular and metabolic diseases.

5. My CV is attached as Exhibit A.

II. COVID-19 in Louisiana

6. The novel coronavirus, officially known as SARS-CoV-2 (Coronavirus), causes a disease known as COVID-19. COVID-19 has now reached pandemic status. At the time of this

declaration, 20,595 people have been diagnosed with COVID-19 in Louisiana, 104,045people have been tested for SARS-CoV-2, 2,084 of those people have been hospitalized with 458requiring mechanical ventilation, and 840deaths reported.[1] The numbers of infection and death in the United States as a whole, and in Louisiana specifically, are likely underestimated due to the lack of test kits available.

7. The growth rate of COVID-19 cases in Louisiana has been rapid and is expected to outpace hospital bed capacity and Intensive Care Unit (ICU) capacity across the state in both urban and rural parishes.[2,3] Even the most conservative epidemiologic models of virus transmission in which only 20% of the population become infected with SARS CoV-2, indicate that the need for hospital beds, ICU beds, and ventilators for mechanical ventilation will far exceed the currently available supply, and even an augmented supply.[4]

8. The population of Louisiana has a high prevalence of co-occurring underlying medical conditions that increase vulnerability to severe disease from the virus. The CDC identified underlying medical conditions that may increase the risk of serious COVID-19 for individuals of any age, including high blood pressure, metabolic disorders (such as diabetes), heart and lung disease, and neurologic conditions. States in the Mississippi Delta region, including Louisiana, and Mississippi, lead the nation in prevalence of chronic diseases such as hypertension with age standardized prevalence of 37.5% and 40.1% of the population of each

[1] Louisiana Department of Public Health Coronavirus (COVID-19) interactive map, available at http://ldh.la.gov/Coronavirus/, accessed Mar. 30, 2020 (at noon CDT).
[2] Flattening the Curve: Taking a Look at Louisiana's Hospital Capacity https://kadn.com/flattening-the-curve-taking-a-look-at-louisianas-hospital-capacity/
[3] Louisiana governor warns New Orleans could run out of ventilators by early April https://thehill.com/policy/healthcare/489532-louisiana-governor-warns-new-orleans-could-run-out-of-ventilators-by-early
[4] How will hospitals accommodate a growing number of COVID-19 patients? Harvard Global Health Institute COVID-19 Hospital Capacity Estimates 2020 https://globalepidemics.org/

state, respectively, self-reporting hypertension compared to 28.9% nationally.[5] Similarly for diabetes, Louisiana ranks 47th in the nation with prevalence of 14.1% of the population having diabetes compared to a national prevalence of 10.9%; for cardiovascular (heart) disease 6% of the population compared to 4.2% nationally, and 5.1% of Louisiana's population has suffered stroke (neurologic disease) compared to only 3.4% nationally.[6] The percentage of Medicare enrollees with four or more chronic conditions (multiple chronic conditions) in Louisiana is 43.7% compared to 37.8% nationally. Because of this high prevalence of co-morbid conditions in the population of Louisiana (as well as other states in the Southern Mississippi Delta), vulnerability to severe disease from SARS CoV-2, requiring hospitalization and ICU level of care, as well as mechanical ventilation, is likely to be greater than in other regions or states, diabetes, and cardiovascular diseases, further taxing the limited medical infrastructure.

9. For the aforementioned reasons, the hospitalization rate and requirements for ICU level care due to severe COVID-19 are likely to be higher in Louisiana than in other states where co-occurring underlying conditions are less frequently manifested in the general population.

III. COVID-19 in Rural Louisiana

10. Rural medical infrastructure and capacity has been decreasing over time.[7] Individuals in rural parishes of Louisiana and neighboring Southern states face more barriers to fast and efficient medical care than those in urban areas due to declining medical infrastructure. Most rural hospitals have very limited ICU capacity and few ventilators as compared to hospitals

[5] Fang J, Gillespie C, Ayala C, Loustalot F. Prevalence of Self-Reported Hypertension and Antihypertensive Medication Use Among Adults Aged ≥18 Years — United States, 2011–2015. MMWR Morb Mortal Wkly Rep 2018;67:219–224 https://www.cdc.gov/mmwr/volumes/67/wr/mm6707a4.htm?s_cid=mm6707a4_w

[6] Data available at https://www.americashealthrankings.org/health-topics, accessed March 30th, 2020

[7] A Sense of Alarm as Rural Hospitals Keep Closing. New York Times. October 29, 2018. https://www.nytimes.com/2018/10/29/upshot/a-sense-of-alarm-as-rural-hospitals-keep-closing.html

and medical facilities in urban areas. Based on regional estimates of hospital capacity in Louisiana, towns in rural parishes such as Lake Charles in Calcasieu Parish and Alexandria in Rapides Parish demand for ICU and hospital beds will far outpace availability. For example, Alexandria has an estimated 20 ICU beds available regionally, however even using the best case scenario estimate of transmission (20% infected) approximately 2,002 individuals would need ICU level care due to infection which would require approximately 133 ICU beds needed in the next 6 months alone.[8] More realistic models of transmission with a 40% or 60% rate of infection project a severely insufficient hospital and ICU bed capacity in rural areas which has a very strong potential to result in a large number of excess deaths.

11. Severe COVID-19 cases that exceed rural medical capacity will require transfer to urban hospitals where ICU and mechanical ventilation capacity is expected to be higher. However, demand for hospital and ICU beds in urban areas is expected to far exceed supply as well, resulting in delays in transfer of care until beds become available, if at all.

12. Geographic transfer of patients who are infected and exhibiting severe signs of COVID-19, if possible, from rural to urban medical centers may require several days and could be associated with poorer outcomes due to the transfer itself. In addition, transfer of patients with an infectious respiratory organism that can remain airborne for significant lengths of time poses risks for transmission to medical staff and others.

IV. COVID-19 in ICE Detention Centers in Rural Louisiana

13. Community transmission is occurring across the state of Louisiana in all parishes. Staff at detention facilities are likely to become infected and transmit the infection to other staff

[8] Data available at https://globalepidemics.org/2020/03/17/2020-03-17-caring-for-covid-19-patients/ Harvard Global Health Institute, COVID-19 Hospital Capacity Estimates, accessed March 30th, 2020

and detainees. Due to the lack of systematic nationwide testing, it is likely that infections will occur and go undetected during several days of incubation, which are typically asymptomatic.

14. After SARS CoV-2 infection has occurred in a facility that is highly unlikely to be contained using the procedures outlined in the Interim Reference Sheet on 2019-Novel Coronavirus (COVID-19). Many aspects of congregative environments such as ICE detainment facilities make it difficult if not impossible to contain transmission. In Louisiana, 28 clusters of two or more linked cases have already occurred in congregative facilities, primarily nursing homes.

15. The protocol for detection and containment of COVID-19 in ICE facilities relies in part on questioning detainees about travel and sick contacts. These questions are likely to be unreliable and provide a false sense of security given the broad community-based transmission occurring in Louisiana. Staff themselves are likely exposed and bring the virus into the congregative environment during the asymptomatic period prior to fever and respiratory symptoms. Efforts to isolate detainees who have become infected are not likely to effectively contain infection because of the characteristics of the SARS CoV-2 virus and its long duration of airborne transmission due to small aerosolized particles. Only specialized negative pressure isolation rooms are documented to be effective against transmission due to small aerosolized particles.

V. Specific Cases

The 16 plaintiffs in this lawsuit present with personal health characteristics that put them at high to very high risk for complications from COVID-19 should they be exposed to the virus in detention.

a. Ms. Rosabel Carrera (59, F) suffers from Diabetes, hypertension. unspecified heart issues, obesity. This person is at a very high risk for complications related to the novel coronavirus due to her co-occurring multiple chronic conditions (multi-morbidity) and obesity. Her age may increase the risk for complications. This person's age also increases the risk for complications.

b. Ms. Tatalu Helen Dada (40, F). She suffers from Asthma; Hypothyroidism, Grave's Disease, compromised immune system; Her asthma diagnosis puts her at a high risk for complications from COVID-19. The treatment for her Grave's Disease (an auto-immune condition in which the body attacks itself) may make a person immunocompromised and predispose a person for certain cancers.

c. Ms. Sonia Lemus Tejada-Dejaso (53, F) suffers from Hypertension, unspecified heart issues. This person is at a very high risk for complications related to the novel coronavirus due to her co-occurring multiple chronic conditions (multi-morbidity).

d. Ms. Matilde Flores de Saavedra (78, F). She suffers from Diabetes, hypertension. This person is at a very high risk for complications related to the novel coronavirus due to her co-occurring multiple chronic conditions (multi-morbidity). This person is at an extremely high risk for complications due to her age.

e. Mr. Suresh Kumar (37 M) is malnourished, immunocompromised, and suffers from Hep C, liver infections. This person is at a very high risk for complications related to the novel coronavirus due to his immunocompromised status. Being

malnourished significantly lowers one's immunity and would render one much more susceptible to acquiring an infection and having a harder time fighting it off.

f. Mr. Pardeep Kumar (28, M). He is malnourished, immunocompromised, and has failing kidneys. This person is at a very high risk for complications related to the novel coronavirus due to his immunocompromised status. Being malnourished lowers one's immunity and would render one much more susceptible to acquiring an infection and having a harder time fighting it off. Kidney failure in and of itself puts a person in the extremely high risk category for morbidity and mortality. Failing kidneys complicate every known medical condition and make it very difficult to treat and manage any/all medical conditions.

g. Ms. Nadira Sampath Grant (53, F) suffers from Diabetes, diabetic neuropathy. This person is at a very high risk for complications related to the novel coronavirus due to her diabetes and the diabetes complications (neuropathy) which suggest her diabetes is not under good control.

h. Ms. Griselda del Bosque (F, 59) suffers from asthma. She is at a high risk for complications related to her lung disease. This person is also at a high risk for complications due to her age.

i. Mr. Sirous Asgari (59, M). He suffers from hypertension and an unspecified respiratory condition with a history of repeat episodes of pulmonary pneumonia. This person is at high risk for complications related to the novel coronavirus due to his high-blood pressure and lung condition.

j. Mr. Hasan Saleh (62, M). He suffers from diabetes and hypertension. This person is at a very high risk for complications related to the novel coronavirus due to his co-occurring multiple chronic conditions (multi-morbidity). This person is also at a high risk for complications due to his age.

k. Mr. Rolando Alex Colon (47, M). He suffers from hypertension. This person is at high risk for complications related to the novel coronavirus due to his high-blood pressure.

l. Mr. Eduardo Devora Espinosa (34, M). He suffers from diabetes and hypertension. This person is at a very high risk for complications related to the novel coronavirus due to his co-occurring multiple chronic conditions (multi-morbidity).

m. Mr.Desmond Nkobenei (25, M). He suffers from hypertension. This person is at high risk for complications related to the novel coronavirus due to his high-blood pressure.

n. Mr. Aracelio Rodriguez (61, M) suffers from asthma. Heis at a high risk for complications related to his lung disease. This person is also at a high risk for complications due to his age.

o. Mr. Abraham Gebremedhin Gebremichael, (33, M) suffers from bradycardia. This person is at a very high risk for complications related to the novel coronavirus due to his cardiovascular disease.

p. Mr. Karthikeyan Ponnusamy (42, M) suffers from diabetes, hypertension, and a blood condition called Low Lactate Dehydrogenase.[9] This person is at a very high risk for complications related to the novel coronavirus due to his co-occurring multiple chronic conditions (multi-morbidity).

VI. Conclusion and Recommendations

16. For the reasons above, it is my professional judgment that the plaintiffs, currently in ICE's immigration detention centers in rural areas of Louisiana are at high risk of contracting SARS CoV-2 due to living in a congregative environment, and that they are much more likely to experience poor outcomes including multiorgan failure and death if they do become infected because of the shortage of rural hospital infrastructure and capacity.

17. Given transmission rates based on even the most conservative epidemiologic models, bed capacity in urban areas is likely to be far exceeded thus transfer to those hospitals will be improbable or impossible and poses risks to both the patient, health care workers, and others.

18. The recommendations of the ICE Health Service Corps embodied in Interim Reference Sheet on 2019-Novel Coronavirus (COVID-19) will not be sufficient to prevent infection in ICE detainment facilities in Louisiana where community transmission is occurring in nearly all parishes.

VII. Expert Disclosures

None.

[9] Mardani R, Ahmadi Vasmehjani A, Zali F, et al. Laboratory Parameters in Detection of COVID-19 Patients with Positive RT-PCR; a Diagnostic Accuracy Study. *Arch Acad Emerg Med*. 2020;8(1):e43. Published 2020 Apr 4.

I declare under penalty of perjury that the foregoing is true and correct.

Signature:

Date:April 12, 2020

Location: Metairie, LA

Lydia Bazzano

Exhibit A

CURRICULUM VITAE

Lydia Angela Louise Bazzano, MD, PhD, MPH
Tulane University School of Public Health and Tropical Medicine
Full Professor of Epidemiology
Ochsner Clinic Foundation
Senior Physician, Internal Medicine

CONTACT INFORMATION

Business Address: Tulane University Health Sciences Center
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1440 Canal St., Suite 2034
New Orleans, LA 70112

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1401-A Jefferson Hwy, 2nd Floor
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Business Telephone and fax: (504) 988-7323 –T office; (504) 842-3535 - O office
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Business email Address: lbazzano@tulane.edu
lbazzano@ochsner.org

Home Address: 4401 Avron Blvd.
Metairie, LA 70006

Citizenship: USA

Gender: Female

Marital Status: Married

Number of Children: Number of Children: 1

EDUCATION

Bachelor of Science Summa cum Laude (Ecology and Environmental Biology), May 1996
Newcomb College, Tulane University, New Orleans, Louisiana

Doctor of Philosophy (Epidemiology), December 2000
Tulane University School of Public Health and Tropical Medicine, New Orleans, Louisiana

Doctor of Medicine, May 2002
Tulane University School of Medicine, New Orleans, Louisiana

Master of Public Health (Epidemiology), May 2002
Tulane University School of Public Health and Tropical Medicine, New Orleans, Louisiana

POST-DOCTORAL TRAINING

June, 2002- July, 2003	Internship in Internal Medicine Department of Medicine Beth Israel Deaconess Hospital Harvard School of Medicine Boston, Massachusetts
June, 2003-July, 2005	Residency in Internal Medicine Department of Medicine Beth Israel Deaconess Hospital Harvard School of Medicine Boston, Massachusetts

LICENSURE AND CERTIFICATIONS

1996-present	Basic Life Support Certification (BLS)
2002-present	Advanced Cardiac Life Support Certification (ACLS)
2003-present	United States Medical Licensure Examination Certification
2002-2009	Massachusetts Medical Licensure
2005-present	Louisiana Medical Licensure
2005-present	Diplomate, American Board of Internal Medicine Certification
2015-present	Certified Institutional Review Board Professional (CIP)
2017-present	Diplomate, American Board of Obesity Medicine Certification

ACADEMIC APPOINTMENTS

July, 2019-	Professor of Epidemiology, Tulane University School of Public Health and Tropical Medicine
July, 2014-	Lynda B & H Leighton Steward Professorship in Nutrition Research Director, Center for Lifespan Epidemiology Research Department of Epidemiology, Tulane University School of Public Health and Tropical Medicine
January, 2013-	Senior Lecturer, University of Queensland School of Medicine Ochsner Clinical School
July, 2012	Associate Professor of Epidemiology (with Tenure), Tulane University School of Public Health and Tropical Medicine
July, 2005-2012	Assistant Professor of Epidemiology, Tulane University School of Public Health and Tropical Medicine
July, 2005-2013	Clinical Assistant Professor of Medicine, Tulane University School of Medicine
June, 2007	Adjunct Assistant Professor, Pennington Biomedical Research Center, Louisiana State University

CLINICAL PRIVLEDGES AND APPOINTMENTS

2019-	Senior Staff Physician, Internal Medicine, Ochsner Medical Center, Jefferson, LA
2012 -2019	Active Staff Physician, Internal Medicine, Ochsner Medical Center, Jefferson, LA
2005-2012	Active Staff Physician, Internal Medicine, Tulane Lakeside Hospital, Metairie, LA
2005-2012	Active Staff Physician, Internal Medicine, Tulane HCA Hospital, New Orleans, LA
2006-2012	Active Staff Physician, Internal Medicine, Medical Center of Louisiana at New Orleans, New Orleans, LA

HONORS AND AWARDS

1996	Phi Beta Kappa National Honor Society Newcomb College, Tulane University
1996	Fred R. Cagel Memorial Award in Biology Newcomb College, Tulane University
2000	Population Research Award in Epidemiology Tulane University School of Public health and Tropical Medicine

2002 Jeremiah and Rose Stamler Research Award, Finalist
American Heart Association, Council on Epidemiology and Prevention

2002 Janet M. Glasgow Memorial Achievement Citation
American Medical Women's Association
Tulane University School of Medicine

2002 Medical Student Award
American Federation for Medical Research
Tulane University School of Medicine

2002 Alpha Omega Alpha Medical Honor Society
Tulane University School of Medicine

PUBLIC POLICY ACTIVITY

2020-2025 Dietary Guidelines for Americans Advisory Committee *I have been appointed to the 2020 Committee, https://www.cnpp.usda.gov/dietary-guidelines*

2005-2015 Dietary Guidelines for Americans *My work has been cited in the Scientific Report from the Dietary Guidelines Advisory Committee in each year (2005, 2010, 2015) of guidelines over the past 15 years*

- Scientific Report of the 2015 Dietary Guidelines Advisory Committee: Advisory Report to the Secretary of Health and Human Services and the Secretary of Agriculture. U.S. Department of Agriculture, Agricultural Research Service, Washington, DC, Appendix E-2: Supplementary Documentation to the 2015 DGAC Report - Dietary Guidelines Advisory Committee. 2015. Appendix E-2.26, 27, 28: Evidence Portfolio

- Dietary Guidelines Advisory Committee. 2010. Report of the Dietary Guidelines Advisory Committee on the Dietary Guidelines for Americans, 2010, to the Secretary of Agriculture and the Secretary of Health and Human Services. U.S. Department of Agriculture, Agricultural Research Service, Washington, DC.

- Dietary Guidelines Advisory Committee. 2005. Report of the Dietary Guidelines Advisory Committee on the Dietary Guidelines for Americans, 2005, to the Secretary of Agriculture and the Secretary of Health and Human Services. U.S. Department of Agriculture, Agricultural Research Service, Washington, DC. Part D. Science Base Section 6: Selected Food Groups (Fruits and Vegetables, Whole Grains, and Milk Products)

United States Preventive Services Task Force *My work has been referenced in the following.*

- Selph S, Dana T, Blazina I, Bougatsos C, Patel H, Chou R. Screening for type 2 diabetes mellitus: a systematic review for the US Preventive Services Task Force. Annals of Internal Medicine. 2015 Jun 2;162(11):765-76.

American Heart Association/American College of Cardiology, Guidelines and Statements *My work has been referenced in all of the following guidelines and statements*

- Eckel RH, Jakicic JM, Ard JD, De Jesus JM, Miller NH, Hubbard VS, Lee IM, Lichtenstein AH, Loria CM, Millen BE, Nonas CA. 2013 AHA/ACC guideline on lifestyle management to reduce cardiovascular risk: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. Journal of the American College of Cardiology. 2014 Jul 1;63(25 Part B):2960-84.

- Smith SC, Benjamin EJ, Bonow RO, Braun LT, Creager MA, Franklin BA, Gibbons RJ, Grundy SM, Hiratzka LF, Jones DW, Lloyd-Jones DM. AHA/ACCF secondary prevention and risk reduction therapy for patients with coronary and other atherosclerotic vascular disease: 2011 update: a guideline from the American Heart Association and American College of Cardiology Foundation endorsed by the World Heart Federation and the Preventive Cardiovascular Nurses Association. Journal of the American College of Cardiology. 2011 Nov 29;58(23):2432-46.

- Goldstein LB, Adams R, Alberts MJ, Appel LJ, Brass LM, Bushnell CD, Culebras A, DeGraba TJ, Gorelick PB, Guyton JR, Hart RG. Primary prevention of ischemic stroke: A guideline from the American heart association/American stroke association stroke council: Cosponsored by the atherosclerotic peripheral vascular disease interdisciplinary working group; cardiovascular nursing council; clinical cardiology council; nutrition, physical activity, and metabolism council; and the quality of care and outcomes research interdisciplinary working group: The American academy of neurology affirms the value of this guideline. Stroke. 2006 Jun 1;37(6):1583-633.

- Hunt SA, Abraham WT, Chin MH, Feldman AM, Francis GS, Ganiats TG, Jessup M, Konstam MA, Mancini DM, Michl K, Oates JA. ACC/AHA 2005 guideline update for the diagnosis and management of chronic heart failure in the adult—summary article: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Writing Committee to Update the 2001 Guidelines for the Evaluation and Management of Heart Failure). Journal of the American College of Cardiology. 2005 Sep 20;46(6):1116-43.

- Mosca L, Appel LJ, Benjamin EJ, Berra K, Chandra-Strobos N, Fabunmi RP, Grady D, Haan CK, Hayes SN, Judelson DR, Keenan NL. Evidence-based guidelines for cardiovascular disease prevention in women. Journal of the American College of Cardiology. 2004 Mar 3;43(5):900-21.

World Health Organization *I was invited to give a presentation at a joint conference of the World Health Organization and the food and Agriculture Organization on "Effects of Fruits and Vegetables on Risk of CVD and Diabetes".*

- World Health Organization. Fruit and vegetables for health: report of a Joint FAO/WHO Workshop, 1-3 September, 2004, Kobe, Japan. Available at: http://www.fao.org/3/a-y5861e.pdf Accessed 10/28/2018

PROFESSIONAL MEMBERSHIPS AND OFFICES

1997-	Member of the American Medical Association
2003-2009	Member of the Massachusetts Medical Society
2005-	Member of the Louisiana State Medical Society
2005-	Member of the Society of General Internal Medicine
2005-	Member of the Nutrition and Epidemiology Councils, American Heart Association
2007	Fellow, American College of Nutrition
2008-2011	Elected Member, Evidence Based Medicine Task Force, Society of General Internal Medicine
2012	Member, Southern Society for Clinical Investigation
2013	Fellow, American College of Physicians
2016-	Member, American Association of University Professors
2017-2018	Board Member, American Association of University Professors, Tulane Chapter
2017-present	Elected Councilor, Executive Council, Southern Society for Clinical Investigation

NATIONAL AND INTERNATIONAL COMMITTEES

Study Section and Scientific Reviews

NIHR-CCF (National Institute for Health Research Central Commissioning Facility for UK Department of Health) Peer review for Department of Health Applied Research Program– "Delivering the Diabetes Prevention Program in a UK Community Setting," 2006

Member, National Board of Public Health Examiners 2008 Item-Writing Committee, Meetings September 28-29th, 2006 and September 10-11th,2007

Office of Dietary Supplements, National Institutes of Health, Reviewer for 2007 Annual Bibliography of Significant Advances in Dietary Supplements Research, 2007

Ad-hoc Member, Health Services Organization and Delivery (HSOD) Study Section, National Institute of Health, Center for Scientific Review, February 5-6th, 2009

Member, External Advisory Panel, Peer review for Dry Grain Pulses Collaborative Research Support Program (CRSP), Office of Agriculture, EGAT, United States Agency for International Development (USAID), October 16th, 2009

Member, Special Emphasis Panel, National Institutes of Health, Center for Scientific Review, Internet Assisted Review, February 16-18th, 2011

Member, Special Emphasis Panel reviewing applications for the RFA HL-12-004 entitled "Maximizing the scientific value of the NHLBI biologic specimen repository: Scientific opportunities (R21)", National Institutes of Health, Center for Scientific Review, November 7, 2012

Ad-hoc Member, Neurological, Aging and Musculoskeletal Epidemiology Study Section, National Institute of Health, Center for Scientific Review**,** June 13th-14th, 2013

Ad-hoc Member, Neurological, Aging and Musculoskeletal Epidemiology Study Section, National Institute of Health, Center for Scientific Review, October 15th-16th, 2015

Member, Contract Review Panel, National Institute of Child Health and Human Development, Center for Scientific Review, ZHD1 DSR-K (DD), August 23rd, 2016.

Ad hoc Member, Cancer, Heart, and Sleep Epidemiology Study Section - A (CHSA), National Institute of Health, Center for Scientific Review, October 27th-29th, 2016

Ad hoc Member, Neurological, Aging and Musculoskeletal Epidemiology Study Section, National Institute of Health, Center for Scientific Review, February 5th-6th, 2018

Regular Appointed Member, Neurological, Aging and Musculoskeletal Epidemiology Study Section, National Institute of Health, Center for Scientific Review, July 1, 2018 - 2022

SERVICE

Journal Reviewer

American Journal of Clinical Nutrition
British Journal of Nutrition
Nutrition, Metabolism & Cardiovascular Disease
American Journal of Epidemiology
Annals of Neurology
Annals of Internal Medicine
Canadian Medical Association Journal
Circulation
Diabetes Care

Epidemiology
Hypertension
JAMA (Journal of the American Medical Association)
JAMA Internal Medicine
Journal of the American College of Nutrition
Kidney International
Lancet
Nature
Public Library of Science (PLoS) One
Public Library of Science (PLoS) Medicine
Stroke
Science

Journal Editorial Boards

2011-present Nutrition Metabolism and Cardiovascular Disease

Academic Committees

2005-present Member, Tulane MD/MPH Advisory Committee

2008-2010 Chair, Tulane MD/MPH Advisory Committee

2006-2008 Member, Tulane SPH&TM Culminating Exam Committee

2008, 2017 Chair, Tulane Epidemiology Faculty Search Committee (Cardiovascular Epidemiology)

2009-2012 Member, Program Committee, Tulane Interdisciplinary PhD in Aging Studies

2009-2014 Alternate Member, Tulane University Biomedical Institutional Review Board

2017-2018 Secretary, General Faculty, Tulane School of Public Health & Tropical Medicine

2018-2021 Senator, Tulane University Senate (3 year term)

2012-present Steering Committee Member, Building Interdisciplinary Research Careers in Women's Health (BIRCWH)

2014-present Ochsner Institutional Review Board, Chair Panel A

2014-present Chair, Bogalusa Heart Study Steering Committee, Tulane University

2019-present Advancement, Promotion and Tenure Committee, Tulane School of Public Health & Tropical Medicine

Other Committees

2011-2012 Alternate Member, New Orleans VA Institutional Review Board

CONSULTANCIES

2017-2020 Mizkan Ltd – consultancy to provide scientific and clinical input in the design and operation of a clincal trial examining the effects of a vinegar beverage on blood pressure in black and white men and women with pre-hypertension as defined in the most recent national guidelines.

2015-2016 Wellness and Nutrition Advisory Board (WNAB) – consultancy organized by Sabra Dipping Company to advise the company regarding scientific advances in nutrition which provide a strategic opportunity to promote healthy dietary patterns incorporating hummus and other Sabra products.

2007-2009 Bean Expert Advisory Panel (BEAN) – consultancy organized by Bush Beans. The Panel is composed of 11 nationally renowned food and nutrition, health, and culinary experts who advise on ways to help Americans achieve the 2005 Dietary Guidelines recommendation to consume 3 cups per week of legumes, such as beans, as part of a healthy diet

TEACHING

Current

Course Director	EPID 6420 Clinical Epidemiology (Tulane University School of Public Health and Tropical Medicine, 2007-present)
Course Director	EPID 6430 Clinical and Translational Research Methods (Tulane University School of Public Health and Tropical Medicine, 2018-present)
Lecturer	EPID 790 Advanced Epidemiology Methods (Tulane University School of Public Health and Tropical Medicine, 2008-2011)
Lecturer	EPID 6220 Cardiovascular Disease Epidemiology (Tulane University School of Public Health and Tropical Medicine, 2000-2002, 2005-present)
Lecturer	EPID 6500 Nutritional Epidemiology (Tulane University School of Public Health and Tropical Medicine, 2017-present)

Lecturer	SPHU 3200 Nutrition and Chronic Disease (Tulane University School of Public Health and Tropical Medicine, 2015-present)

Past

Course Director	EPID 6220 Cardiovascular Disease Epidemiology (Tulane University School of Public Health and Tropical Medicine, 2009-2012)
Lecturer	EPID 6430 Clinical and Translational Research Methods (Tulane University School of Public Health and Tropical Medicine, 2015-2017)

Students Advised Each Year by Level of Degree

Master Students (by year of graduation or expected)

2007	Kristina Lewis (MD/MPH) Jeffrey Wolters (MD/MPH) Hannan Natalia (MD/MPH) Ulana Pogribna (MD/MPH)
2008	Melissa DeVito (MD/MPH) Kyle Fargen (MD/MPH) Mary McDonald (MD/MPH) Jeannie Rhee (MD/MPH) Ajay Tejwanti (MD/MPH) Michael Tees (MD/MPH)
2009	Eduardo Castro-Echeverry (MD/MPH) Joseph Prows (MD/MPH) James Lukens (MPH) Margaret Jones (MD/MPH) Katherine Kerisit (MD/MPH) Jason Collins (MPH) Bridgette Collins-Burrow (MPH) Nedret Copur (MPH) Houman Dahi (MPH) Christiane Hadi (MPH) Julie Kumata (MPH) T C Narumanchi (MPH) Supat Thammasitboon (MPH) Aggarwal, Shivang (MPH)
2010	Jordan Awerbach (MD/MPH) Kelly Lafaro (MD/MPH) Oni Olirunde (MS) Eric Richter (MS-CR)

	Sindjuja Marupudi (MPH)
	Alina D. Fotino (MPH)
2011	Aaron Boojindasum (MD/MPH)
	Jordan Hoffman (MD/MPH)
	Edward Mannina (MD/MPH)
	Ashley Nitschke (MD/MPH)
	Snow Petersen (MD/MPH)
	Tina Wang (MD)
	Brian Zwecker (MD/MPH)
	Jerome Crowley (MD/MPH)
	Supat Thommasitboon (MPH)
2012	David Bateman (MD/MPH)
	Daniel Bourgeois III (MD/MPH)
	Joanne So (MD/MPH)
	Thomas Jan (MD/MPH)
	Kutaiba Al-Shebeeb (MPH)
	Palwasha Anwari (MPH)
	Cassandra J. Heiselman (MPH)
2013	Kayleen Bailey (MD/MPH)
	David German (MD/MPH)
	Michael R. Halstead (MD/MPH)
	Marsha Smith (MD/MPH)
2014	Mohamed H. Eloustaz (MD/MPH)
	Cary T. Grayson (MD/MPH)
	Nicole Jackson (MD/MPH)
	Erica Jones (MD/MPH)
	Jessica Langston (MD/MPH)
	Simon Christopher Lim (MD/MPH)
	Tianming Liu (MD/MPH)
	Daniel Reid (MD/MPH)
	Rebecca Reimers (MD/MPH)
	Lucy Witt (MD/MPH)
	Elliot S. Brannon (MPH/PeaceCorp)
	Kenny L. Wang (MPH)
	Babalola Olayiwola (MPH)
2015	Maeh Al-Shawaf (MPH)
	Nkechi Mbaebie (MPH)
	Oduche Igboechi (MD/MPH)
	Anita Madison (MD/MPH)
	William (Cameron) McGuire (MD/MPH)
	Brigid Avendido (MD/MPH)
	Ngoc Ly (MD/MPH)
2016	Brian Burkett (MD/MPH)

Chad Bush (MD/MPH)
Erin Dawson (MD/MPH)
Brian Duffell (MD/MPH)
Michelle Fleshner (MD/MPH)
Emily Harkins (MD/MPH)
Haley Johnson (MD/MPH)
Jason Ohlstein (MD/MPH)
Stacey Ullman (MD/MPH)
Aktar Faisal (MPH)
Sarah Ali (MPH)

2017 Alexandra Haugh (MD/MPH)
Kelly Jensen (MD/MPH)
Meghan McGwier (MD/MPH)
Shoshana Newman-Gerhardt (MD/MPH)
Hunter Smith (MD/MPH)

2018 Brigid Adviento (MD/MPH)
Christopher Carr (MD/MPH)
Thomas Flowers (MD/MPH)
Zachary Koretz (MD/MPH)
Gregory Minutillo (MD/MPH)
William Preston (MD/MPH)
Christopher Schmitt (MD/MPH)
David Swift (MD/MPH)
Natalie Fortune (MS)

2019 Kionna Henderson (MPH)
Peng Cheng (MPH)

2020 Kyle Arnold (MD/MPH)
Hannah Bernstein (MD/MPH)

Doctoral Dissertation Committees (Member and Chaired)

Dissertation Committees (Chair)

Angela M. Thompson, MPH
PhD in Epidemiology 2012
"Impact of Hurricane Katrina on Medication Adherence and Health Care Facility Utilization among Hypertensive Veterans"
Current Position: Epidemiologist at Centers for Disease Control and Prevention, Atlanta, Georgia

Tian Hu, BM, MPH
PhD in Epidemiology 2015
"Nutritional Factors in the Progression of Chronic Kidney Disease"

Current Position: Post-doctoral fellow at University of Minnesota, School of Public Health, Division of Epidemiology and Community Health, Minneapolis, Minnesota

Ben Pollock, MPH
PhD in Epidemiology 2017
"Cardiovascular Risk Mobility: A Novel Application of Economic Theory to Characterize Life Course Cardiovascular Risk"
Current Position: Epidemiologist, Mayo Clinic, Jacksonville, Florida

Patrick Stuchlik, MS
PhD in Epidemiology 2018
"Childhood and Young Adult Predictors of Cognitive Function in Middle Age: Evidence from the Bogalusa Heart Study"
Current Position: Post-doctoral Fellow, University of California San Francisco, San Francisco, California

Dissertation Committee (Member)

Tanika Kelly, MPH 2008
PhD in Epidemiology: Chair, Jiang He, MD, PhD
"Genetic Variants and the Salt-Sensitivity of Blood Pressure in the Genetic Epidemiology Network of Salt-Sensitivity"
Current Position: Associate Professor of Epidemiology, Tulane University SPHTM

Angela Shen, MPH 2011
Executive ScD in Health Systems Management: Chair, Mahmud Khan, PhD
"An Economic Evaluation for the Introduction of a Future HIV Vaccine"
Current Position: Affiliate Faculty, Drexel University, Dornsife School of Public Health, Consultant - Vaccines and Immunizations, Captain (retired) US Public Health Service

Christopher Anderson, MPH, Expected 2020
PhD in Epidemiology: Chair, Jeanette Gustat, PhD
"The Built Environment, Health Contexts and Health States in the Bogalusa Heart Study Population"

Xiang Li, MPH Expected 2020
PhD in Epidemiology: Chair, Lu Qi, MD, PhD

Jovia Nierenberg, MPH Expected 2020
PhD in Epidemiology: Chair, Tanika Kelly, PhD

PUBLICATIONS

Peer-reviewed Publications

1. He J, Ogden LG, Vupputuri S, **Bazzano LA**, Loria C, Whelton PK. Dietary sodium intake and subsequent risk of cardiovascular diseases in overweight U.S. men and women. JAMA. 1999; 282:2027-2034.

2. He J, **Bazzano LA**. Effects of lifestyle modification on treatment and prevention of hypertension. Current Opinion in Nephrology and Hypertension. 2000; 9:267-271.

3. He J, Ogden LG, **Bazzano LA**, Vupputuri S**,** Loria C, Whelton PK. Risk factors for congestive heart failure in US men and women: NHANES I Epidemiologic Follow-up Study. Arch Intern Med. 2001;161:996-1002

4. Butt AA, Dascomb KK, DeSalvo KB, **Bazzano L**, Kissinger PJ, Szerlip HM. Human Immunodeficiency Virus infection in elderly patients. Southern Medical Journal. 2001; 94:397-400.

5. **Bazzano LA**, He J, Ogden LG, Vupputuri S, Loria C, Myers L, Whelton PK. Dietary potassium intake and risk of stroke in US men and women: NHANES I Epidemiologic Follow-up Study. Stroke. 2001; 32:1473-1480.

6. **Bazzano LA**, He J, Ogden LG, Vupputuri S, Loria C, Myers L, Whelton PK. Legume consumption and risk of coronary heart disease in US men and women: NHANES I Epidemiologic Follow-up Study. Arch Intern Med. 2001; 161(21):2573-8.

7. **Bazzano LA**, He J, Ogden LG, Vupputuri S, Loria C, Myers L, Whelton PK. Dietary Intake of folate and risk of stroke in US men and women: NHANES I Epidemiologic Follow-up Study. Stroke. 2002; 33:1183-1189.

8. **Bazzano LA**, He J, Ogden LG, Vupputuri S, Loria C, Myers L, Whelton PK. Fruit and vegetable intake and cardiovascular disease mortality in US adults: the National Health and Nutrition Examination Survey I Epidemiologic Follow-up Study. Am J Clin Nutr. 2002;76:93-9

9. **Bazzano LA**, He J, Ogden LG, Vupputuri S, Loria C, Myers L, Whelton PK. Agreement on nutrient intake between NHANES I and ESHA Food Processor databases. Am J Epidemiol. 2002; 156:78-85.

10. He J, Ogden LG, **Bazzano LA**, Vupputuri S, Loria C, Whelton PK. Dietary sodium intake and incidence of congestive heart failure in overweight US men and women: First National Health and Nutrition Examination Survey Epidemiologic Follow-up Study. Arch Intern Med. 2002; 162:1619-1624.

11. **Bazzano LA**, He J, Muntner P, Vupputuri S, Whelton PK. Relationship between cigarette smoking and novel risk factors for cardiovascular disease in the United States. Ann Intern Med. 2003; 138:891–897.

12. **Bazzano LA**, Serdula MK, Liu S. Dietary intake of fruits and vegetables and risk of cardiovascular disease. Curr Atheroscler Rep. 2003; 5: 492-499.

13. Vupputuri S, He J, Muntner P, **Bazzano LA**, Whelton PK, Batuman V. B Blood lead level is associated with elevated blood pressure in blacks. Hypertension. 2003;41:463-8.

14. **Bazzano LA**, He J, Ogden LG, Vupputuri S, Loria C, Myers L, Whelton PK. Dietary fiber intake and reduced risk of coronary heart disease in US men and women. Arch Intern Med. 2003; 163:1897-1904.

15. Vupputuri S, Batuman V, Muntner P, **Bazzano LA**, Lefante JJ, Whelton PK, He J. Effect of blood pressure on early decline in kidney function among hypertensive men. Hypertension. 2003; 42:1144-1149.

16. Vupputuri S, Batuman V, Muntner P, **Bazzano LA**, Lefante JJ, Whelton PK, He J. The risk for mild kidney function decline associated with illicit drug use among hypertensive men. Am J Kidney Dis. 2004; 43:629-35.

17. **Bazzano LA**, Serdula MK, Liu S. Prevention of type 2 diabetes by diet and lifestyle modification. J Am Coll Nutr. 2005; 24: 310-319.

18. **Bazzano LA**, Song Y, Bubes V, Good CK, Manson JE, Liu S. Dietary intake of whole and refined grain breakfast cereals and weight gain in men. Obes Res. 2005; 13:1952-1960.

19. **Bazzano LA**, Reynolds K, Holder K, He J. Effect of folate supplementation on risk of cardiovascular diseases: a meta-analysis of randomized controlled trials. JAMA. 2006; 296:2720-2726.

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pressure on blood pressure in obstructive sleep apnea. Hypertension. 2007; 50: 1-7

21. He J, Reynolds K, Chen J, Chen CS, Duan X, Reynolds R, **Bazzano LA,** Whelton PK, Gu D. Cigarette smoking and erectile dysfunction among Chinese men without clinical vascular disease. Am J Epidemiol. 2007; 166:803-809.

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24. Wildman RP, Gu D, Muntner P, Wu X, Reynolds K, Duan X, Chen CS, Huang G, **Bazzano LA**, He J. Trends in overweight and obesity in Chinese adults: 1991 to 1999-2000. Obesity. 2008; 16:1448-1453.

25. **Bazzano LA**, Li TY, Joshipura KJ, Hu FB. Fruit, vegetable and fruit juice intake and development of diabetes in women. Diabetes Care. 2008; 31:1311-1317.

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29. Riccioni G, **Bazzano LA**, Bucciarelli T, Mancini B, di Ilio E, D'Orazio N. Rosuvastatin reduces intima-media thickness in hypercholesterolemic subjects with asymptomatic carotid artery disease: the Asymptomatic Carotid Atherosclerotic Disease in Manfredonia (ACADIM) Study. Expert Opin Pharmacother. 2008; 9: 2403-8.

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31. Riccioni G, Capra V, D'Orazio N, Bucciarelli T, **Bazzano LA**. Leukotriene modifiers in the treatment of cardiovascular diseases. J Leukoc Biol. 2008; 84:1374-8.

32. Riccioni G, Bucciarelli T, D'Orazio N, Palumbo N, di Illio E, Corradi F, Penneli A, **Bazzano LA**. Plasma antioxidants and asymptomatic carotid atherosclerotic disease. Ann Nutr Metab. 2008; 53:86-90.

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55. Thompson AM, Zhang Y, Tong W, Xu T, Chen J, Zhao L, Kelly TN, Chen C-S, **Bazzano LA**, He J. Association of inflammation and endothelial dysfunction with metabolic syndrome, prediabetes and diabetes in adults from Inner Mongolia, China. BMC Endocrine Disorders 2011;11:16.

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78. Zhang T, Li S, **Bazzano L**, He J, Whelton P, Chen W.Trajectories of Childhood Blood Pressure and Adult Left Ventricular Hypertrophy: The Bogalusa Heart Study. Circulation. 29 Jun 2018;137(Suppl_1): AP097.

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84. Hu T, Sinaiko A, Woo J, Burns T, Steinberger J, **Bazzano L**, Urbina E, Zhang N, Magnussen C, Venn A, Juonala M. Abstract P207: An Interpretation-Friendly Approach for Model Comparison of Risk Scores for Adult Obesity in the International Childhood Cardiovascular Cohort (I3c) Consortium. AHA Epidemiology Meeting 2018.

85. Khoury M, Khoury P, Hu T, Widome R, **Bazzano L**B, Burns TL, Daniels SR, Dwyer T, Ikonen J, Juonala M, Kähönen M. Abstract P055: Evaluating the Impact of the New Pediatric Clinical Practice Guideline on the Prevalence of Pediatric Hypertension and Associations With Adult Hypertension: The International Childhood Cardiovascular Cohort (i3C) Consortium. Circulation. 2019 Mar 5;139(Suppl_1):AP055.

86. Cleland V, Tian J, Buscot MJ, Magnussen C, **Bazzano LA**, Burns TL, Daniels SR, Dwyer T, Jacobs DR, Juonala M, Prineas RJ. Abstract MP66: Body Mass Index Trajectories From Childhood to Adulthood: Evidence From the International Childhood Cardiovascular Cohort (i3C) Consortium. Circulation. 2019 Mar 5;139(Suppl_1):AMP66.

87. Shi M, **Bazzano LA**, He J, Gu X, Li C, Li S, Yaffe K, Kinchen JM, Stuchlik P, Mi X, Nierenberg JL. Novel serum metabolites associate with cognition phenotypes among Bogalusa Heart Study participants. Aging (Albany NY). 2019 Jul 31;11(14):5124.

88. Chukwurah QC**, Bazzano L**. Body types and association with depressive symptoms among older adults: Findings from NHANES 2013-2016. Innovation in Aging. 2019 Nov;3(Suppl 1): S270.

89. Razavi AC, Fernandez Alonso C, Kelly TN, He J, Potts KS, Whelton SP, **Bazzano LA**. Pooled Cohort Equations-Derived Heart Failure Risk Score Predicts Cardiovascular and all-cause mortality in US adults: The NHANES III Follow-Up Study. Circulation. 2019 Nov 19; 140 (Suppl_1): A17113-.

90. Razavi AC, Wong ND, Budoff MJ, **Bazzano LA**, Kelly TN, He J, Fernandez Alonso C, Lima JA, Polak JF, Mongraw-Chaffin ML, Szklo M. Predictors of Healthy Arterial Aging in Persons with metabolic syndrome and diabetes: The Multi-Ethnic Study of Atherosclerosis. Circulation. 2019 Nov 19; 140 (Suppl_1): A15034.

91. Fernandez C, Razavi A, Barshop R, Guo Y, **Bazzano LA**. Life course determinants of adult diastolic function: Insights from the Bogalusa Heart Study. Circulation. 2019 Nov 19; 140 (Suppl_1): A17257.

92. Guo Y, Fernandez C, Razavi A, Barshop R, **Bazzano LA**. Impact of excessive birth weight on body Mass Index Growth Trajectories Over the Life Course: The Bogalusa Heart Study. Circulation. 2019 Nov 19;140(Suppl_1): A17241.

93. Razavi AC, Fernandez C, **Bazzano LA**, He J, Krousel-Wood MA, Nierenberg J, Shi M, Li C, Mi X, Li S, Kinchen J. Abstract P1125: Serum Metabolite 1-Methylhistidine, a Marker of Red Meat and Poultry Consumption, Independently Associates With Increases in Systolic and Diastolic Blood Pressure in Middle-Aged Adults. Hypertension. 2019 Sep; 74(Suppl_1): AP1125.

Other - Doctoral Dissertation

Bazzano LA. Diet and the Risk of Cardiovascular Disease among U.S. Adults. Tulane University School of Public Health and Tropical Medicine, New Orleans, LA. Doctor of Philosophy, 2000.

PRESENTATIONS

Invited Presentations and Workshops

1. "A Big-Picture Snapshot of Pasta and its Partners on the Plate". Invited presentation: Nutrition Science, Pasta Meals, and the Healthy Mediterranean Diet. Oldways Preservation Trust, Rome, Italy. February 16-18, 2004.

2. "Health Effects of Fruits and Vegetables on Risk of CVD and Diabetes". Invited presentation: Joint World Health Organization-Food and Agriculture Organization Workshop on Fruits and Vegetables, Kobe, Japan. June 23-25, 2004.

3. "Health Aspects of Vegetables and Fruits: Scientific Evidence for 5-a-day". Invited presentation: 10th Annual Karlsruhe Nutrition Congress, Karlsruhe, Germany. October 15-17, 2006.

4. "Micronutrients in Cardiovascular Disease: Current Recommendations". Invited presentation: 48th Annual Meeting of the American College of Nutrition, Orlando, FL. September 27-30, 2007.

5. "Epidemiological Evidence for the Effects of Fruits and Vegetables on Cardiovascular Disease and Diabetes". Seminar presented to faculty and staff of Pennington Biomedical Research Center, Baton Rouge, LA, May 9, 2007.

6. "Folic Acid Supplementation: A Tale of Two Studies" Invited presentation: Internal Medicine Grand Rounds, Tulane University Department of Medicine, New Orleans, LA, January 30th, 2008.

7. "Folic Acid Supplementation and Cardiovascular Disease: State of the Art Update." Invited presentation: Southern Regional Meetings, New Orleans, LA, February 12-14, 2009.

8. "Folic Acid Supplementation in Cardiovascular Disease" Invited presentation: Cardiology Grand Rounds, Tulane University Department of Medicine, Division of Cardiology, New Orleans, LA, March 4, 2009.

9. "What's New in the Art and Science of Teaching Evidence-based Medicine (EBM)?: A 2008 Update for Teachers of EBM". Workshop presented at the 32nd Annual Meeting of the Society of General Internal Medicine, Miami Beach, FL, May 15, 2009. CME Offered

10. "Folic Acid Intervention Studies". Invited Presentation: Max-Rubner Institute Conference, Karlsruhe, Germany. October 11-13, 2009.

11. "Trials of Folic Acid Supplementation in Cardiovascular Disease". Invited Presentation: China Heart Congress and International Heart Forum, Beijing, China. August 12-15, 2010.

12. "Low Carbohydrate Diet and Cardiovascular Disease Risk Factors". Seminar presented to faculty and staff of Pennington Biomedical Research Center, Baton Rouge, LA, May 24, 2012.

13. "Management of Cardiovascular Disease Risk Post-MI and in my Chest Pain (Rule Out) Patients". Invited Presentation: 13th Annual Southern Hospital Medicine Conference, Atlanta, GA. October 24-27, 2012.

14. "Management of Acute Hypertension in the Hospital" Invited Presentation: 14th Annual Southern Hospital Medicine Conference, New Orleans, LA. November 7-9th, 2013.

15. "Fat Is Not the Enemy: Why High Fat Diets May Be Good for Your Waistline and Your Heart" Invited Presentation: Distinguished Lecture Health Sciences Research Day, Tulane University, New Orleans, LA, March 26th, 2015.

16. "Low Carbohydrate Diets, Weight Loss and Heart Health" Invited Presentation: Rutgers University Department of Nutrition. New Brunswick, NJ. April 16th, 2015.

17. "Overview of the Bogalusa Heart Study and Recent Results" Invited Presentation: University of Alabama Birmingham, Department of Epidemiology. Birmingham, AL. May 6th, 2015.

18. Moderator, American Heart Association Epidemiology Conference, Life-course Epidemiology Session, Thursday, March 22nd, 2018, New Orleans, LA.

CURRENT RESEARCH GRANT PARTICIPATION

Role:	Site PI (Subcontract from Northwestern University at Chicago)
Project:	**PROmote weight loss in obese PAD patients to preVEnt mobility loss: the PROVE Trial**
Period of Support:	04/01/2019- 03/31/2024
Funding Source:	NIH/NHLBI (UG3HL141729)
Funding Level:	$3,019,993
Principal Investigator:	Mary McGrae McDermott, MD
Objectives:	The proposed study will randomize 212 participants with peripheral arterial disease (PAD) and BMI > 28 kg/m^2 to one of two groups: weight loss + exercise (WL+EX) vs. exercise alone (EX). Participants will be randomized at three field centers: Northwestern University, University of Minnesota, and Tulane. Our primary outcome is change in six-minute walk distance at 12-month follow-up. Secondary outcomes are change in six-minute walk distance at 6-month follow-up, walking exercise adherence, and change in physical activity, patient-reported walking ability (measured by the Walking Impairment Questionnaire), and quality of life (measured by the SF12 Physical Component Score).

Role:	Principal Investigator
Project:	**Lifespan Cardiovascular Risk Exposures and Alzheimer-related Brain Health: The Bogalusa Heart Study**
Period of Support:	07/01/2019-06/30/2024
Funding Source:	NIH/NIA (2R01AG041200)
Funding Level:	$3,715,021.00
Principal Investigator:	Lydia Bazzano, MD, PhD (contact PI) MPI: Owen Carmichael, PhD
Objectives:	The proposed study will examine how cardiovascular risk factors (CVRF) and cumulative exposure to CVRF across the life-course influence Alzheimer-related indicators of brain health including performance on a standardized neurocognitive battery, transcranial doppler ultrasound, cerebral blood flow and oxygenation, 3T brain MRI and, in a subset, amyloid PET scanning, among participants in the Bogalusa Heart Study.

Role:	Principal Investigator
Project:	**Early Life Glycemic Status and Alzheimer's Disease Neuroimaging Markers in Middle Age: The Bogalusa Heart Study**
Period of Support:	12/01/2018-11/30/2023
Funding Source:	NIH/NIA (R01AG062309)
Funding Level:	$3,608,663
Principal Investigator:	Lydia Bazzano, MD, PhD (contact PI) MPI: Owen Carmichael, PhD
Objectives:	This project will use neuroimaging and cognitive testing to explore long-term cognitive outcomes among Bogalusa Heart Study participants associated with high-normal early-life mean fasting plasma glucose, as well as Alzheimer's Disease-related neurobiological substrates for these outcomes in a subset of participants will also undergo 3T brain MRI and amyloid PET.
Role:	Principal Investigator

Project:	**A Novel Research Infrastructure Enabling Life-course Studies of Healthy Aging**
Period of Support:	08/15/2018-07/31/2023
Funding Source:	NIH/NIA R21/R33 Phased Innovation Award (R21AG057983)
Funding Level:	$2,743,499
Principal Investigator:	Lydia Bazzano, MD, PhD (contact PI) MPI: Elaine Urbina, Jessica Woo
Objectives:	The overall objective of this proposal is to develop and enhance a novel research infrastructure that will advance the science of aging in the area of early life and childhood protective factors that contribute to "successful" aging. In the R21 phase, we will catalog and consolidate biorepositories across three cohorts, and in the R33 phase, we will demonstrate the feasibility of remote measurement methods.

Role:	Principal Investigator
Project:	**The Role of Vascular Aging in Cognitive and Physical Function**
Period of Support:	09/01/2012-11/30/2018 No Cost Extension
Funding Source:	NIA (R01AG041200)
Funding Level:	$ 2,399,927
Principal Investigator:	Lydia A. Bazzano, MD, PhD
Objectives:	This project will examine the role of vascular aging, lifestyle and diet in maintenance of cognitive and physical performance by recruiting 1,257 participants in the Bogalusa Heart Study who will undergo cognitive function, physical function and cardiovascular risk factor examination at baseline and again 2 years later at follow- up.

Role:	Principal Investigator
Project:	**A tRial of the idEal proteiN systEm versus loW fAt diet for weight Loss: RENEWAL**
Period of Support:	01/01/2018-12/31/2019
Funding Source:	Ideal Protein of America, Inc.
Funding Level:	$432,125

Principal Investigator:	Lydia A. Bazzano, MD, PhD
Objectives:	RENEWAL is a randomized controlled clinical trial examining the effects of a restricted carbohydrate, optimal protein (Ideal Protein) diet as compared to a guideline-based, low-fat, restricted calorie diet on changes in body weight, composition, traditional and CVD risk factors.
Role:	Co-Investigator
Project:	**Tulane Building Interdisciplinary Research Careers in Women's Health (BIRCHW)**
Period of Support:	09/26/2002-07/31/2023
Funding Source:	NIH/ K12HD043451
Funding Level:	$2,693,710
Principal Investigator:	Marie Krousel-Wood, MD
Objectives:	The Tulane BIRCWH Program provides mentored career development for junior faculty to increase the number of highly trained independent investigators in sex/ gender differences and women's health in the field of cardiovascular and related diseases.
Role:	Co-Investigator (Subcontract from Children's Hospital Medical Center)
Project:	**Childhood CV Risk and Adult CVD Outcomes: an International Long-term Follow-up**
Period of Support:	12/01/2014-11/30/2019
Funding Source:	NIH/NHLBI (R01HL121230)
Funding Level:	$10,561,912
Principal Investigator:	Jessica Woo, PhD
Objectives:	This research is a multicenter study of international longitudinal cohort studies (Bogalusa, Louisiana; Minneapolis, Minnesota; Muscatine, Iowa; Cincinnati, Ohio; Princeton, Ohio; Australia and Finland). The study leverages the existing collaborative structure to assess the relation of childhood and adolescent cardiovascular risk factors to adult endpoints.
Role:	Co-Investigator
Project:	**Tulane COBRE for Clinical and Translational Research in Cardiometabolic Diseases**
Period of Support:	03/10/2016-02/28/2021
Funding Source:	NIH/NIGM (P20GM109036)
Funding Level:	$13,330,930
Principal Investigator:	Jiang He, MD, PhD
Objectives:	The overall objective of this COBRE application is to increase the quality and quantity of clinical, translational and implementation research in cardiometabolic diseases at Tulane University. Role:
Role:	Site PI (Subcontract from Northwestern University at Chicago)
Project:	**Improve PAD Performance with Metformin: The PERMET Trial**
Period of Support:	03/01/2018-11/30/2019
Funding Source:	NIH/NHLBI (R01HL131771)
Funding Level:	$2,974,184

Principal Investigator:	Mary McGrae McDermott
Objectives:	The PERMET trial is a placebo controlled double-blind randomized clinical trial to establish whether metformin (2,000 mgs daily) improves and/or prevents decline in walking performance in people with peripheral artery disease (PAD).
Role:	Site PI (Subcontract from Northwestern University at Chicago)
Project:	**TELmisartan plus EXercise to improve functioning in PAD: The TELEX Trial**
Period of Support:	03/01/2018-04/30/2019
Funding Source:	NIH/NHLBI (R01HL126117)
Funding Level:	$2,933,532
Principal Investigator:	Mary McGrae McDermott
Objectives:	TELEX is a randomized controlled clinical trial designed to establish whether telmisartan improves walking performance in people with peripheral artery disease (PAD). The TELEX trial will also determine whether telmisartan plus supervised exercise improves walking performance more than either therapy alone.
Role:	Co-investigator
Project:	**The Roles of the Microbiome and Metabolome in Vascular Aging**
Period of Support:	09/01/2016-05/31/2019 (NCE)
Funding Source:	NIH/NIA (R21AG051914)
Funding Level:	$263,375
Principal Investigator:	Tanika Kelly, PhD
Objectives: vascular	To identify gut bacterial communities and metabolites influencing aging among 300 Bogalusa Heart Study participants. These findings may also be used to advance clinical and public health practice through the development of novel therapies for CVD and promotion of healthy aging.

PAST RESEARCH GRANT PARTICIPATION

Role:	Principal Investigator
Project:	**Lifespan Cardiovascular Exposures and Risk of Brain Injury in the Bogalusa Heart Study**
Period of Support:	1/01/2017 – 12/31/2018
Funding Source:	Louisiana Clinical and Translational Science Center - Pilot Project
Funding Level:	$50,000
Principal Investigator:	Lydia Bazzano, MD, PhD
Objectives:	The goals of this project are to collect 3TMRI measures of brain health from members of the Bogalusa Heart Study, and to assess relationships between lifespan exposures to cardiovascular risk
Role:	Co-Investigator

Project:	**Linking Health and Environmental Outcomes to Dietary Behaviours in the United States**
Period of Support:	10/01/2015-08/31/2017
Funding Source:	Wellcome Trust (106854/Z/15/Z)
Funding Level:	$624,997
Principal Investigator:	Diego Rose, PhD
Objectives:	The project aims to improve our understanding of how dietary choices influence health and environmental outcomes, and how such choices can be modified through public policy.

Role:	Co-Investigator (Subcontract via Louisiana Public Health Institute)
Project:	**PCORnet Bariatric Study**
Period of Support:	10/01/2015-09/30/2017
Funding Source:	PCORI OBS150530683
Funding Level:	$4,568,390
Principal Investigator:	David Arterburn, MD, MPH
Objectives:	The main goal of this comparative effectiveness research study is to provide accurate estimates of the 1-, 3-, and 5-year benefits and risks of the three main surgical treatment options for severe obesity.

Role:	Co-Investigator
Project:	**Long-Term Burden of Maternal Cardiovascular Risk Factors and Birth Outcomes**
Period of Support:	08/05/2012-06/30/2017
Funding Source:	NIH/NICHD (R01HD069587)
Funding Level:	$1,538,429
Principal Investigator:	Emily Harville, PhD
Objectives:	The overall objective with this project is to determine the relationship between pre-pregnancy cardiovascular risk, from childhood through early adulthood, and birth outcomes.

Role:	Co-Investigator
Project:	**Childhood Secondhand Smoke and Longitudinal Cardiovascular Risk Profile**
Period of Support:	09/17/2012-06/30/2015
Funding Source:	NIEHS (R01ES021724)
Funding Level:	$1,203,299
Principal Investigator:	Wei Chen, MD, PhD
Objectives:	The major goal is to study childhood secondhand smoke exposure and its impact on cardiovascular disease risk from childhood to adulthood within a black-white population using a longitudinal cohort.

Role:	Subcontract, Co-Investigator
Project:	**South American Center of Excellence in Cardiovascular Health**
Period of Support:	06/08/2009-06/07/2014
Funding Source:	NHLBI (HHSN268200900029C)
Funding Level:	$5,270,206

Principal Investigator:	Adolpho Rubenstein, MD
Objectives:	The objective of the South American Center of Excellence in Cardiovascular Health (SACECH) is to establish a cohort in the Southern Cone of Latin America in order to (1) estimate the prevalence, distribution, and secular trend of major CVD and risk factors in the Southern Cone, (2) examine the association between traditional and novel CVD risk factors and incidence, (3) assess the burden of CVD, and (4) identify future interventions
Role:	Co-Investigator
Project:	**Clinical Center for Prospective Cohort Study of CRI**
Period of Support:	09/28/2001-04/30/2013
Funding Source:	NIDDK (U01DK060963)
Funding Level:	$4,402,718
Principal Investigator:	Jiang He, MD, PhD
Objectives:	The major goals of this project are to examine risk factors for the progression of renal disease and development of cardiovascular disease in patients with chronic renal insufficiency.
Role:	Co-Investigator
Project:	**Research Training in Gene-Environment Interaction in China**
Period of support:	07/01/2012─06/30/2017
Funding source:	Fogarty International Center (D43 TW009107)
Funding level:	$1,343,470
Principal Investigator:	Jiang He, MD, PhD
Objectives:	This joint training program of the Tulane University and Tropical Medicine and the Chinese Academy of Medical Sciences and Peking Union Medical College, and the National Center for Cardiovascular Diseases of China aimed to provide research training in gene-environment interaction in chronic diseases across the lifespan in China.
Role:	Co-Investigator
Project:	**Comprehensive Approach for Hypertension Prevention and Control in Argentina**
Period of support:	04/01/2012 –03/31/2017
Funding source:	NHLBI (1U01HL114197-01)
Funding level:	$2,218,017
Principal Investigator:	Jiang He, MD, PhD
Objectives:	The overall objectives of the proposed cluster randomized trial are to test whether a comprehensive intervention program within a national public primary care system will improve hypertension prevention and control among uninsured hypertensive patients and their families in Argentina.
Role:	Principal Investigator
Project:	**Heritability and Genome-wide Linkage of Lipid Phenotypes**
Period of Support:	09/15/2008-06/30/2012
Funding Source:	NHLBI (K08HL091108)

Funding Level:	$458,800
Principal Investigator:	Lydia A. Bazzano, MD, PhD
Objectives:	The overall objectives of the proposed study are to investigate familial correlations, heritability, and major gene effects for serum lipid and lipoprotein phenotypes and investigate the role of quantitative trait loci by conducting genome-wide linkage analyses using 407 microsatellite markers.

Role:	Junior Faculty Investigator
Project:	**Tulane COBRE in Hypertension and Renal Biology**
Period of Support:	09/2007-08/2012
Funding Source:	NCRR (P20RR017659)
Funding Level:	$12 million
Principal Investigator:	Louis Gabriel Navar, PhD
Objectives:	The objectives are to provide an enriched mentoring environment to junior faculty investigators so that they can achieve independent status and national competitiveness and to augment and strengthen biomedical research capacity at Tulane University Health Sciences Center and the State of Louisiana in hypertension and associated renal and cardiovascular disease.

Role:	Co-Investigator
Project:	**Sodium Sensitivity and Risk of Hypertension**
Period of Support:	07/01/2007-07/31/2012
Funding Source:	NHLBI (R01HL087263)
Funding Level:	$2,834,971
Principal Investigator:	Jiang He, MD, PhD
Objectives:	The major objectives are to examine the relationship between blood pressure responses to dietary sodium and the risk of hypertension and to examine the association between biological candidate genes and the risk of hypertension.

Role:	Principal Investigator
Project:	**Impact of Hurricane Katrina on Medication Adherence and Health Care Facility Utilization among Veterans**
Period of Support:	11/15/2006-11/15/2011
Funding Source:	Tulane University Research Enhancement Fund-Phase II
Funding Level:	$45,000
Principal Investigator:	Lydia A. Bazzano, MD, PhD
Objectives:	This project evaluates adherence of hypertensive veterans to medication regimens and use of health care facilities before and after Hurricane Katrina

Role:	Primary Care Physician
Project:	**Primary Care Access Stabilization Grant**
Period of Support:	09/2007-09/2010
Funding Source:	Louisiana Public Health Institute

Funding Level:	$1,962,232
Principal Investigator:	L. Lee Hamm, MD
Objectives:	The objective of this project is to restore and expand access to primary care in the greater New Orleans area in the wake of Hurricane Katrina and its aftermath.

Role:	Co-Principal Investigator
Project:	**Comparison of Efficacy and Safety of NPH Insulin and Glargine Insulin**
Period of Support:	03/15/2007-06/15/2007
Funding Source:	Eli Lilly & Co.
Funding Level:	$22,452
Principal Investigator:	Lydia A. Bazzano, MD, PhD and Lizheng Shi, PharmD, PhD
Objectives:	The major objective of this project is to perform meta-analysis to examine treatment effects, hypoglycemia, glycosylated hemoglobin, weight gain and doses between Neutral Protamine Hagedorn (NPH) insulin and glargine insulin among person with type II diabetes.

Role:	Junior Faculty Scholar
Project:	**Building Interdisciplinary Research Careers in Women's Health**
Period of Support:	07/01/2005-06/30/2007
Funding Source:	ODS/NICHD (K12HD43451)
Funding Level:	$449,993
Principal Investigator:	Paul K. Whelton, MD, MSc.
Objectives:	This grant is designed to promote research and the transfer of research findings to clinical care that will benefit the health of women.

Declaration of Dr. Jaimie Meyer

Pursuant to 28 U.S.C.§ 1746, I hereby declare as follows:

I. Background and Qualifications

1. I am Dr. Jaimie Meyer, an Assistant Professor of Medicine at Yale School of Medicine and Assistant Clinical Professor of Nursing at Yale School of Nursing in New Haven, Connecticut. I am board certified in Internal Medicine, Infectious Diseases and Addiction Medicine. I completed my residency in Internal Medicine at NY Presbyterian Hospital at Columbia, New York, in 2008. I completed a fellowship in clinical Infectious Diseases at Yale School of Medicine in 2011 and a fellowship in Interdisciplinary HIV Prevention at the Center for Interdisciplinary Research on AIDS in 2012. I hold a Master of Science in Biostatistics and Epidemiology from Yale School of Public Health.

2. I have worked for over a decade on infectious diseases in the context of jails and prisons. From 2008-2016, I served as the Infectious Disease physician for York Correctional Institution in Niantic, Connecticut, which is the only state jail and prison for women in Connecticut. In that capacity, I was responsible for the management of HIV, Hepatitis C, tuberculosis, and other infectious diseases in the facility. Since then, I have maintained a dedicated HIV clinic in the community for patients returning home from prison and jail. For over a decade, I have been continuously funded by the NIH, industry, and foundations for clinical research on HIV prevention and treatment for people involved in the criminal justice system, including those incarcerated in closed settings (jails and prisons) and in the community under supervision (probation and parole). I have served as an expert consultant on infectious diseases and women's health in jails and prisons for the UN Office on Drugs and Crimes, the Federal Bureau of Prisons, and others. I also served as an expert health witness for the US Commission on Civil Rights Special Briefing on Women in Prison.

3. I have written and published extensively on the topics of infectious diseases among people involved in the criminal justice system including book chapters and articles in leading peer-reviewed journals (including Lancet HIV, JAMA Internal Medicine, American Journal of Public Health, International Journal of Drug Policy) on issues of prevention, diagnosis, and management of HIV, Hepatitis C, and other infectious diseases among people involved in the criminal justice system. In making the following statements, I am not commenting on the particular issues posed this case. Rather, I am making general statements about the realities of persons in detention facilities, jails and prisons.

4. My C.V. includes a full list of my honors, experience, and publications, and it is attached as Exhibit A.

5. I was paid $1,000 for my time drafting an earlier version of this report filed in another case. I subsequently prepared this version of the report without receiving payment for my services.

6. I have not testified as an expert at trial or by deposition in the past four years.

II. Heightened Risk of Epidemics in Jails and Prisons

7. The risk posed by infectious diseases in jails and prisons is significantly higher than in the community, both in terms of risk of transmission, exposure, and harm to individuals who become infected. There are several reasons this is the case, as delineated further below.

8. Globally, outbreaks of contagious diseases are all too common in closed detention settings and are more common than in the community at large. Prisons and jails are not isolated from communities. Staff, visitors, contractors, and vendors pass between communities and facilities and can bring infectious diseases into facilities. Moreover, rapid turnover of jail and prison populations means that people often cycle between facilities and communities. People often need to be transported to and from facilities to attend court and move between facilities. Prison health is public health.

9. Reduced prevention opportunities: Congregate settings such as jails and prisons allow for rapid spread of infectious diseases that are transmitted person to person, especially those passed by droplets through coughing and sneezing. When people must share dining halls, bathrooms, showers, and other common areas, the opportunities for transmission are greater. When infectious diseases are transmitted from person to person by droplets, the best initial strategy is to practice social distancing. When jailed or imprisoned, people have much less of an opportunity to protect themselves by social distancing than they would in the community. Spaces within jails and prisons are often also poorly ventilated, which promotes highly efficient spread of diseases through droplets. Placing someone in such a setting therefore dramatically reduces their ability to protect themselves from being exposed to and acquiring infectious diseases.

10. Disciplinary segregation or solitary confinement is not an effective disease containment strategy. Beyond the known detrimental mental health effects of solitary confinement, isolation of people who are ill in solitary confinement results in decreased medical attention and increased risk of death. Isolation of people who are ill using solitary confinement also is an ineffective way to prevent transmission of the virus through droplets to others because, except in specialized negative pressure rooms (rarely in medical units if available at all), air continues to flow outward from rooms to the rest of the facility. Risk of exposure is thus increased to other people in prison and staff.

11. Reduced prevention opportunities: During an infectious disease outbreak, people can protect themselves by washing hands. Jails and prisons do not provide adequate opportunities to exercise necessary hygiene measures, such as frequent handwashing or use of alcohol-based sanitizers when handwashing is unavailable. Jails and prisons are often under-resourced and ill-equipped with sufficient hand soap and alcohol-based sanitizers for people detained in and working in these settings. High-touch surfaces (doorknobs, light switches, etc.) should also be cleaned and disinfected regularly with bleach to prevent virus spread, but this is often not done in jails and prisons because of a

lack of cleaning supplies and lack of people available to perform necessary cleaning procedures.

12. Reduced prevention opportunities: During an infectious disease outbreak, a containment strategy requires people who are ill with symptoms to be isolated and that caregivers have access to personal protective equipment, including gloves, masks, gowns, and eye shields. Jails and prisons are often under-resourced and ill-equipped to provide sufficient personal protective equipment for people who are incarcerated and caregiving staff, increasing the risk for everyone in the facility of a widespread outbreak.

13. Increased susceptibility: People incarcerated in jails and prisons are more susceptible to acquiring and experiencing complications from infectious diseases than the population in the community.[1] This is because people in jails and prisons are more likely than people in the community to have chronic underlying health conditions, including diabetes, heart disease, chronic lung disease, chronic liver disease, and lower immune systems from HIV.

14. Jails and prisons are often poorly equipped to diagnose and manage infectious disease outbreaks. Some jails and prisons lack onsite medical facilities or 24-hour medical care. The medical facilities at jails and prisons are almost never sufficiently equipped to handle large outbreaks of infectious diseases. To prevent transmission of droplet-borne infectious diseases, people who are infected and ill need to be isolated in specialized airborne negative pressure rooms. Most jails and prisons have few negative pressure rooms if any, and these may be already in use by people with other conditions (including tuberculosis or influenza). Resources will become exhausted rapidly and any beds available will soon be at capacity. This makes both containing the illness and caring for those who have become infected much more difficult.

15. Jails and prisons lack access to vital community resources to diagnose and manage infectious diseases. Jails and prisons do not have access to community health resources that can be crucial in identifying and managing widespread outbreaks of infectious diseases. This includes access to testing equipment, laboratories, and medications.

16. Jails and prisons often need to rely on outside facilities (hospitals, emergency departments) to provide intensive medical care given that the level of care they can provide in the facility itself is typically relatively limited. During an epidemic, this will not be possible, as those outside facilities will likely be at or over capacity themselves.

17. Health safety: As an outbreak spreads through jails, prisons, and communities, medical personnel become sick and do not show up to work. Absenteeism means that facilities can become dangerously understaffed with healthcare providers. This increases a number of risks and can dramatically reduce the level of care provided. As health systems inside facilities are taxed, people with chronic underlying physical and mental health conditions and serious medical needs may not be able to receive the care they need for these

[1] *Active case finding for communicable diseases in prisons*, 391 The Lancet 2186 (2018), https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31251-0/fulltext.

conditions. As supply chains become disrupted during a global pandemic, the availability of medicines and food may be limited.

18. Safety and security: As an outbreak spreads through jails, prisons, and communities, correctional officers and other security personnel become sick and do not show up to work. Absenteeism poses substantial safety and security risk to both the people inside the facilities and the public.

19. These risks have all been borne out during past epidemics of influenza in jails and prisons. For example, in 2012, the CDC reported an outbreak of influenza in 2 facilities in Maine, resulting in two inmate deaths.[2] Subsequent CDC investigation of 995 inmates and 235 staff members across the 2 facilities discovered insufficient supplies of influenza vaccine and antiviral drugs for treatment of people who were ill and prophylaxis for people who were exposed. During the H1N1-strain flu outbreak in 2009 (known as the "swine flu"), jails and prisons experienced a disproportionately high number of cases.[3] Even facilities on "quarantine" continued to accept new intakes, rendering the quarantine incomplete. These scenarios occurred in the "best case" of influenza, a viral infection for which there was an effective and available vaccine and antiviral medications, unlike COVID-19, for which there is currently neither.

III. Profile of COVID-19 as an Infectious Disease[4]

20. The novel coronavirus, officially known as SARS-CoV-2, causes a disease known as COVID-19. The virus is thought to pass from person to person primarily through respiratory droplets (by coughing or sneezing) but may also survive on inanimate surfaces. People seem to be most able to transmit the virus to others when they are sickest but it is possible that people can transmit the virus before they start to show symptoms or for weeks after their symptoms resolve. In China, where COVID-19 originated, the average infected person passed the virus on to 2-3 other people; transmission occurred at a distance of 3-6 feet. Not only is the virus very efficient at being transmitted through droplets, everyone is at risk of infection because our immune systems have never been exposed to or developed protective responses against this virus. A vaccine is currently in development but will likely not be able for another year to the

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[2] *Influenza Outbreaks at Two Correctional Facilities — Maine, March 2011*, Centers for Disease Control and Prevention (2012), https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6113a3.htm.

[3] David M. Reutter, *Swine Flu Widespread in Prisons and Jails, but Deaths are Few*, Prison Legal News (Feb. 15, 2010), https://www.prisonlegalnews.org/news/2010/feb/15/swine-flu-widespread-in-prisons-and-jails-but-deaths-are-few/.

[4] This whole section draws from Brooks J. Global Epidemiology and Prevention of COVID19, COVID-19 Symposium, Conference on Retroviruses and Opportunistic Infections (CROI), virtual (March 10, 2020); *Coronavirus (COVID-19)*, Centers for Disease Control, https://www.cdc.gov/coronavirus/2019-ncov/index.html; Brent Gibson, *COVID-19 (Coronavirus): What You Need to Know in Corrections*, National Commission on Correctional Health Care (February 28, 2020), https://www.ncchc.org/blog/covid-19-coronavirus-what-you-need-to-know-in-corrections.

general public. Antiviral medications are currently in testing but not yet FDA-approved, so only available for compassionate use from the manufacturer. People in prison and jail will likely have even less access to these novel health strategies as they become available.

21. Most people (80%) who become infected with COVID-19 will develop a mild upper respiratory infection but emerging data from China suggests serious illness occurs in up to 16% of cases, including death.[5] Serious illness and death is most common among people with underlying chronic health conditions, like heart disease, lung disease, liver disease, and diabetes, and older age.[6] Death in COVID-19 infection is usually due to pneumonia and sepsis. The emergence of COVID-19 during influenza season means that people are also at risk from serious illness and death due to influenza, especially when they have not received the influenza vaccine or the pneumonia vaccine.

22. The care of people who are infected with COVID-19 depends on how seriously they are ill.[7] People with mild symptoms may not require hospitalization but may continue to be closely monitored at home. People with moderate symptoms may require hospitalization for supportive care, including intravenous fluids and supplemental oxygen. People with severe symptoms may require ventilation and intravenous antibiotics. Public health officials anticipate that hospital settings will likely be overwhelmed and beyond capacity to provide this type of intensive care as COVID-19 becomes more widespread in communities.

23. COVID-19 prevention strategies include containment and mitigation. Containment requires intensive hand washing practices, decontamination and aggressive cleaning of surfaces, and identifying and isolating people who are ill or who have had contact with people who are ill, including the use of personal protective equipment. Jails and prisons are totally under-resourced to meet the demand for any of these strategies. As infectious diseases spread in the community, public health demands mitigation strategies, which involves social distancing and closing other communal spaces (schools, workplaces, etc.) to protect those most vulnerable to disease. Jails and prisons are unable to adequately provide social distancing or meet mitigation recommendations as described above.

24. The time to act is now. Data from other settings demonstrate what happens when jails and prisons are unprepared for COVID-19. News outlets reported that Iran temporarily

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[5] *Coronavirus Disease 2019 (COVID-19): Situation Summary*, Centers for Disease Control and Prevention (March 14, 2020), https://www.cdc.gov/coronavirus/2019-ncov/summary.html.

[6] *Clinical course and risk factors for mortality of adult inpatients with COVID-19 in Wuhan, China: a retrospective cohort study.* The Lancet (published online March 11, 2020), https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30566-3/fulltext

[7] *Coronavirus Disease 2019 (COVID-19): Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease*, Centers for Disease Control and Prevention (March 7, 2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html.

released 70,000 prisoners when COVID-19 started to sweep its facilities.[8] To date, few state or federal prison systems have adequate (or any) pandemic preparedness plans in place.[9] Systems are challenged to respond to COVID-19 guidelines that are modified on a near-daily basis. It may be impossible to adequately respond to the COVID-19 pandemic, while also respecting the rights and dignity of people who are incarcerated.

IV. Possible Risks of COVID-19 in ICE Detention Facilities

25. Based on my experience working on public health in jails and prisons, I can make the following general statements about how the COVID-19 outbreak will interact with and exacerbate conditions that may exist in some detention centers.

26. Any delays in access to care that already exist in normal circumstances will only become worse during an outbreak, making it especially difficult for the facilities to contain any infections and to treat those who are infected.

27. Failure to provide individuals with continuation of the treatment they were receiving in the community, or even just interruption of treatment, for chronic underlying health conditions will result in increased risk of morbidity and mortality related to these chronic conditions.

28. Failure to provide individuals adequate medical care for their underlying chronic health conditions results in increased risk of COVID-19 infection and increased risk of infection-related morbidity and mortality if they do become infected.

29. People with underlying chronic mental health conditions need adequate access to treatment for these conditions throughout their period of detention. Failure to provide adequate mental health care, as may happen when health systems in jails and prisons are taxed by COVID-19 outbreaks, may result in poor health outcomes. Moreover, mental health conditions may be exacerbated by the stress of incarceration during the COVID-19 pandemic, including isolation and lack of visitation.

30. Failure to keep accurate and sufficient medical records will make it more difficult for facilities to identify vulnerable individuals in order to both monitor their health and protect them from infection. Inadequate screening and testing procedures in facilities increase the widespread COVID-19 transmission.

31. Language barriers will similarly prevent the effective identification of individuals who are particularly vulnerable or may have symptoms of COVID-19. Similarly, the failure to

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[8] *Iran temporarily releases 70,000 prisoners as coronavirus cases surge*, Reuters (March 9, 2020), https://www.reuters.com/article/us-health-coronavirus-iran/iran-temporarily-releases-70000-prisoners-as-coronavirus-cases-surge-idUSKBN20W1E5.

[9] Luke Barr & Christina Carrega, *State prisons prepare for coronavirus but federal prisons not providing significant guidance, sources say*, ABC News (March 11, 2020), https://abcnews.go.com/US/state-prisons-prepare-coronavirus-federal-prisons-providing-significant/story?id=69433690.

provide necessary aids to individuals who have auditory or visual disabilities could also limit the ability to identify and monitor symptoms of COVID-19.

32. Facilities with a track record of neglecting individuals with acute pain and serious health needs under ordinary circumstances are more likely to be ill-equipped to identify, monitor, and treat a COVID-19 epidemic.

33. Similarly, facilities with a track record of failing to adequately manage single individuals in need of emergency care are more likely to be seriously ill-equipped and under-prepared when a number of people will need urgent care simultaneously, as would occur during a COVID-19 epidemic.

34. For individuals in facilities that have experienced these problems in the past, the experience of an epidemic and the lack of care while effectively trapped can itself be traumatizing, compounding the trauma of incarceration.

V. Conclusion and Recommendations

35. Reducing the size of the population in jails and prisons can be crucially important to reducing the level of risk both for those within those facilities and for the community at large. As such, from a public health perspective, it is my recommendation that individuals who can safely and appropriately remain in the community not be placed in ICE detention facilities at this time. I also recommend that individuals who are already in these facilities should be evaluated for release.

36. This is more important still for individuals with preexisting conditions (e.g., heart disease, chronic lung disease, chronic liver disease, suppressed immune system, diabetes) or who are over the age of 65.

37. Health in jails and prisons is community health. Protecting the health of individuals who are detained in and work in these facilities is vital to protecting the health of the wider community.

I declare under penalty of perjury that the foregoing is true and correct.

March 23, 2020
New Haven, Connecticut

Dr. Jaimie Meyer

CURRICULUM VITAE

Name: Jaimie P. Meyer, M.D., M.S.

Education:

B.A.	Dartmouth College (Anthropology) 2000
M.D.	University of Connecticut 2005
M.S.	Yale School of Public Health (Biostatistics and Epidemiology) 2014

Career/Academic Appointments:

2005-08	Intern and Resident, Internal Medicine, NY Columbia Presbyterian Hospital, New York, NY
2008-11	Clinical and Research Fellow, Infectious Diseases, Yale University, New Haven, CT
2010-12	Postdoctoral Fellow, Center for Interdisciplinary Research on AIDS, Yale School of Public Health, New Haven, CT
2012-14	Instructor, Infectious Diseases (AIDS Program), Yale School of Medicine, New Haven, CT
2014-present	Assistant Professor, Infectious Diseases (AIDS Program), Yale School of Medicine, New Haven, CT
2015-present	Clinical Assistant Professor, Division of Primary Care/Health Systems in Nursing, Yale School of Nursing, New Haven, CT

Clinical Positions Held & Other Employment:

1999	Spanish Medical Interpreter, Boston Children's Hospital, Boston, MA
2000-01	Research Assistant, UCSF Immunogenetics and Transplantation Laboratory, San Francisco, CA
2010-12	Infectious Diseases Attending (per diem), Hospital of Saint Raphael, New Haven, CT
2009-15	Infectious Diseases Clinician, York Women's Correctional Institution, Niantic, CT
2015-	HIV Clinician, Nathan Smith Clinic, New Haven, CT
2018-	Faculty, Contemporary Management of HIV, Clinical Care Options

Board and other Certifications:

American Board of Internal Medicine, Internal Medicine, 2008, 2018
American Board of Internal Medicine, Infectious Diseases, 2010
American Board of Preventive Medicine, Addiction Medicine, 2018
DATA 2000 DEA X waiver to prescribe Buprenorphine, 2010
REMS Certified implanter and prescriber for Probuphine, 2016

Professional Honors & Recognition

A) <u>International/National/Regional</u>

2018	Selected as Early Career Reviewer, NIH Center for Scientific Review
2017	Doris Duke Charitable Foundation Scholar

2016 Fellow, American College of Physicians
2016 NIH Health Disparities Loan Repayment Award Competitive Renewal
2016 Selected for AAMC Early Career Women Faculty Professional Development Seminar
2014 NIH Health Disparities Loan Repayment Program Award
2014 NIDA Women & Sex/Gender Differences Junior Investigator Travel Award
2014 International Women's/Children's Health & Gender Working Group Travel Award
2014 Patterson Trust Awards Program in Clinical Research
2013 Thornton Award for Clinical Research
2011 Bristol Myers-Squibb Virology Fellows Award
2006 John N. Loeb Intern Award
2005 Connecticut State Medical Society Award
2005 American Medical Women's Association Citation
2000 Hannah Croasdale Senior Award, Dartmouth College
1998 Palaeopitus Senior Leadership Society Inductee, Dartmouth College

B) University
2014 Fellow, Women's Faculty Forum Public Voices Thought Leadership Program

PROFESSIONAL SERVICE

Journal Service:
Reviewer
2012-present (In alphabetical order): *Addiction Sci and Clin Pract, Addictive Behav Reports, AIDS Care, AIMS Public Health, American Journal on Addictions, American Journal of Epidemiology, American Journal of Public Health, Annals Internal Medicine, BMC Emergency Medicine, BMC Infectious Diseases, BMC Public Health, BMC Women's Health, Clinical Infectious Diseases, Critical Public Health, Drug and Alcohol Dependence, Drug and Alcohol Review, Epidemiologic Reviews, Eurosurveillance, Health and Justice (Springer Open), International Journal of Drug Policy, International Journal of Prisoner Health, International Journal of STDs and AIDS, International Journal of Women's Health, JAIDS, JAMA Internal Medicine, Journal of Family Violence, Journal of General Internal Medicine, Journal of Immigrant and Minority Health, Journal of International AIDS Society, Journal of Psychoactive Drugs, Journal of Urban Health, Journal of Women's Health, Open Forum Infectious Diseases, PLoS ONE, Public Health Reports, University of Wisconsin-Milwaukee Research Growth Initiative, Social Science and Medicine, SpringerPlus, Substance Abuse Treatment Prevention and Policy, Women's Health Issues, Yale Journal of Biology and Medicine*

2019-present Section Editor: Sex and Gender Issues, *Journal of the International Association of Providers of AIDS Care (JIAPAC)*

Grant Service:
Reviewer:
2020 Doris Duke Charitable Foundation Physician Scientist Fellowship Award
2019 NIH RFA-DA-19-025 HEAL Initiative: Justice Community Opioid Innovation Network (JCOIN) Clinical Research Centers

Professional Service for Professional Organizations

2016-present Fellow, American College of Physicians

2016-present Member, AAMC Group on Women in Medicine and Science (GWIMS)
2013-2016 Member, American College of Physicians
2013-present Member, InWomen's Network, NIDA International Program
2011-present Member, American Medical Women's Association
2011-present Member, Connecticut Infectious Disease Society
2009-present Member, American Society of Addiction Medicine
2008-present Member, Infectious Disease Society of America
2005-present Member, American Medical Association
2005-2008 Member, New York State Medical Society

Yale University Service

2019-present Core Faculty, Program in Addiction Medicine
2017-present Affiliated Faculty, Arthur Liman Center for Public Interest Law, Yale Law School
2016-present Leadership Council, Women's Faculty Forum, Yale University
2015-2016 Steering Committee, US Health and Justice Course, Yale School of Medicine
2014-present Yale Internal Medicine Traditional Residency Intern Selection Committee
2013-present Women in Medicine at Yale Mentoring Program
2013-present Women in Science at Yale Mentoring Program
2012-present Affiliated Scientist, Center for Interdisciplinary Research on AIDS
2009-2011 Preclinical Clerkship Tutor, Yale School of Medicine

Individual Mentorship
2020 Zoe Sernyak, Yale University: Summer internship
2020 Caroline Wortman, Cornell University: Summer internship
2020 Chevaughn Wellington, Quinnipiac School of Medicine: Capstone Project Advisor
2019 Callie Ginapp, Yale School of Medicine: Research Mentor
2019 Alissa Haas, Yale School of Public Health (EMD): Research mentor
2019 Emily Bail, Yale School of Nursing: APRN Clinical mentor
2018 Camila Odio, Yale Internal Medicine Residency Program: Research mentor
2018 Zoe Adams, Yale School of Medicine: Research mentor
2018 Yilu Qin, Yale Primary Care Residency Program, HIV Training Track: Research mentor
2018 Kaitlin Erickson, Yale School of Nursing: APRN Clinical mentor
2017-2019 Emily Hoff, Yale School of Medicine: Research mentor, Thesis mentor
2017 Lindsay Eysenbach, Yale School of Medicine: Research mentor, Summer project on Syringe Service Program
2017 Megan Carroll, Yale School of Public Health: M.S. Thesis advisor (Biostatistics)
2016-2020 Britton Gibson, Yale School of Public Health and Quinnipiac School of Medicine: Research mentor
2016 Ronnye Rutledge, Yale School of Medicine: MHS Thesis advisor; awarded IDSA Education and Research Foundation 2015 Medical Scholarship and Yale School of Medicine Medical Student Research Fellowship; earned School and Departmental Honors for Thesis
2015 Kelsey Loeliger, Yale Schools of Medicine and Public Health: M.D./Ph.D. Dissertation committee

2014 Javier Cepeda, Yale School of Public Health: Ph.D. Research advisor/mentor
2014 Audrey Fritzinger, Yale PA Program: Thesis advisor; Received Honors for thesis
2014 Cecilia Dumouchel, Yale College: Summer internship
2014 Joan Chi-How, Yale School of Medicine: Internship
2014 Michelle Fikrig, Oberlin College: Summer internship
2014 Madison Breuer, Southern Connecticut State University: Internship

Public Service

2020 Expert Consultant on COVID-19 Preparedness in Vermont Department of Corrections: Vermont Office of the Defender General, Prisoner Rights' Office
2020 Expert Consultant on COVID-19 in Jails and Prisons: New York ACLU and Bronx Defenders, *Onosamba-Ohindo, et al. v. Barr et al., Case No. 20-cv-0290 (W.D.N.Y.).*
2020 Expert Consultant on COVID-19 in Jails and Prisons: New York ACLU and Bronx Defenders, *Velesaca v. Wolf et al., Case No. 20-cv-1803 (S.D.N.Y.).*
2019 Consultant on Medication Assisted Treatment in Prisons, Vermont Department of Corrections, Addiction Health Services
2019 Expert Witness for Women in Prison Briefing, U.S. Commission on Civil Rights
2018 Consultant for SAMHSA State Targeted Response-Technical Assistance Consortium to address the opioid crisis, American Academy of Addiction Psychiatry
2017 Consultant on HIV Care in Prisons, United Nations Office on Drugs and Crime
2017 Scientific Advisory Board, HIV Prevention and Treatment in Cis-Gendered Women, Gilead Sciences, Inc.
2016 Consultant on Women's Health, Female Offenders Unit, Federal Bureau of Prisons
2002 "Medicine as a Profession" Fellow, Soros Open Society Institute
1999 Volunteer Spanish Medical Interpreter, Boston Children's Hospital
1998 Honorary Service Fellow, Costa Rican Humanitarian Foundation

Research Support

Ongoing Research Support

ACTIVE
Investigator Sponsored Award (M161462) PI: Meyer 7/1/2017-6/30/2020 1.8 calendar
Gilead Sciences, Inc. $81,151 (FY1 Directs)
Delivering HIV Pre-Exposure Prophylaxis to Networks of Justice-Involved Women
Description: To leverage risk networks of CJ-involved women as a means of delivering PrEP and to evaluate the acceptability and feasibility of strategically delivering PrEP to network members.

Clinical Scientist Development Award PI: Meyer 7/1/17-6/30/20 3.0 calendar
Doris Duke Clinical Foundation $149,959 (FY1 Directs)

Developing and Testing the Effect of a Patient-Centered HIV Prevention Decision Aid on PrEP uptake for Women with Substance Use in Treatment Settings
Description: 1) To adapt a patient-centered HIV prevention decision aid to women with substance use entering treatment for substance use disorders. 2) Building on findings from Aim 1, to pilot test the effect of the adapted decision-aid intervention on PrEP uptake among women with substance use entering treatment for substance use disorders.

1 R21 DA042702-01A1 PI: Meyer 8/1/2017–7/31/2020 (NCE) 1.20 calendar
NIH/NIDA $129,673 (FY1 Directs)
Prisons, Drug Injection and the HIV Risk Environment in Kyrgyzstan
Description: We propose to generate qualitative data from interviews with prisoners and prison staff and triangulate it with quantitative data from MATLINK within an analytical HIV risk environment framework which aims to: 1. Describe the individual-environment interactions that shape within-prison drug-related HIV risk practices and health expectations post-release; and 2. Measure how within-prison risk and other factors within the prison environment mediate engagement with OAT both within prison and after release.

H79 TI080561 PI: Meyer 11/30/2018–11/29/2023 1.20 calendar
SAMHSA $389,054 (FY1 Directs)
CHANGE: Comprehensive Housing and Addiction Management Network for Greater New Haven
We will expand and enhance the local implementation of a community infrastructure that integrates housing, behavioral health, and addiction treatment services for highly vulnerable populations at-risk for or living with HIV (PARLWH), by virtue of their involvement in criminal justice (CJ) systems and/or engagement in sex work. The target population for CHANGE is CJ-involved PARLWH in New Haven, Connecticut who experience co-occurring homelessness, psychiatric, and substance use disorders.

Pilot Project Award mPI: Willie, Meyer 10/01/19-09/30/20 0.24 calendar
Center for Interdisciplinary Research on AIDS (CIRA) $29,993
Optimizing PrEP's Potential in Non-Clinical Settings: Development and Evaluation of a PrEP Decision Aid for Women Seeking Domestic Violence Services
This Type II hybrid effectiveness-implementation study seeks to adapt an existing PrEP decision aid to intimate partner violence (IPV)-exposed women seeking domestic violence services at two major Connecticut service agencies. This study will: provide support for a PrEP decision aid that addresses the HIV prevention needs of IPV-exposed women; use implementation science to increase PrEP uptake; include DV agencies in intervention development and implementation; and improve understanding of PrEP scale-up by addressing implementation factors in the community settings that serve IPV-exposed women.

R01 MH121991 mPI: Meyer, Sullivan 01/01/2020-11/30/2024 1.8 calendar
NIMH $374,816 (FY1 Directs)
Identifying Modifiable Risk and Protective Processes at the Day-Level that Predict HIV Care Outcomes among Women Exposed to Partner Violence
The main purpose of this study is to understand how exposure to intimate partner violence (IPV) affects women's abilities to self-manage their HIV on a daily basis (i.e., adhere to antiretroviral medication), engage in longitudinal HIV care, and achieve and

sustain viral suppression. The project aims to build awareness of the IPV-health association and inform strategies/resources to promote resilience.

UNDER REVIEW:
R01 MH124533 PI: Meyer 07/01/2020-06/30/2025 3.6 calendar
NIMH $577,894 (FY1 Directs)
TelePrEP+ for Women in Criminal Justice Systems
This study is designed to test an active facilitation strategy (ePrEP) for scaling up PrEP, an evidence-based practice, in two distinct settings (Connecticut and Alabama) for a key population of women involved in criminal justice systems. We will randomize justice-involved, PrEP-eligible women across two sites (CT and AL) to receive ePrEP or standard of care. Using a Type I Hybrid Efficacy-Implementation framework, we will evaluate individual-level (PrEP initiation and 6-month retention) and organizational-level outcomes important for ePrEP scalability and sustainability across diverse contexts.

Inmate Health Services 2019 (Clinical Services Contract) PI: Meyer
10/01/2019-09/30/2022 0.96
Connecticut Department of Corrections $436,899
Yale Center of Excellence in Prison Health
We will create a Yale Center of Excellence in Prison Health that will provide specialty e-consultation, staff development, and quality assurance programs for the CT Department of Correction (DOC) in the areas of Behavioral Health, Transitional care, and Infectious Diseases, which are the largest cost centers for DOC healthcare. We will additionally provide outpatient specialty telehealth services in key areas, including: Cardiology, Endocrinology, and Rheumatology. We focus on regional healthcare delivery (RFPs 2 and 4), acknowledging that the majority of people in these facilities will return home to the greater New Haven area, enabling continuity of care and serving as a regional hub.

Inmate Health Services 2019 (Clinical Services Contract) PI: Meyer
10/01/2019-09/30/2022 0.96
Connecticut Department of Corrections $250,805
Yale HIV in Jails Program
The current proposal seeks to reinvigorate and improve upon the HIV in Prisons Program to deliver high quality, cost-effective HIV care and Infectious Disease consultations to PWH in each of Connecticut's jails (Hartford CC in RFP Region 1; New Haven CC in RFP Region 2; Bridgeport CC in RFP Region 3; Corrigan Radgowski CC and York CI in RFP Region 4).

<u>Completed Research Support</u>
K23 DA033858 PI: Meyer 7/1/2012 – 11/30/2017 9.0 calendar
NIH/NIDA $153,529 (FY1 Directs)
Evaluating and Improving HIV Outcomes in Community-based Women who Interface with the Criminal Justice System
The major goal of this project is to inform, adapt and test an intervention that will improve HIV treatment outcomes for community-based women who interface with the criminal justice system, either after release from jail or during community supervision.

Patterson Trust Awards Program in Clinical Research PI: Meyer 1/31/14-10/30/15

Disentangling the Effect of Gender on HIV Treatment and Criminal Justice Outcomes

Bristol Myers-Squibb HIV Virology Fellowship Award PI: Meyer 9/1/11-6/30/13

NIMH T32 MH020031 PI: Ickovics 7/2/10-6/30/12
Interdisciplinary HIV Prevention Training Program, Yale University School of Epidemiology and Public Health, Center for Interdisciplinary Research on AIDS
Role: Research Scientist

NIAID T32 AI007517 PI: Quagliarello 6/30/09-7/1/10
Training in Investigative Infectious Disease, Yale University School of Medicine, Section of Infectious Disease
Role: Research Scientist

Publications

Peer-Reviewed Journals

Azar M, Springer S, **Meyer J,** Altice F. A Systematic Review of the Impact of Alcohol Use Disorders on HIV Treatment Outcomes, Adherence to Antiretroviral Therapy and Health Care Utilization. Drug and Alcohol Dependence 2010, 112: 178–193. *PMID 20705402. PMCID: PMC2997193*

Meyer J, Springer S, Altice F. Substance Abuse, Violence, and HIV in Women: A Literature Review of the SAVA Syndemic. Journal of Women's Health 2011, 20(7). *PMID 21668380. PMCID: PMC3130513*

Chen N, **Meyer J,** Springer S. Advances in the Prevention of Heterosexual Transmission of HIV/AIDS among Women in the United States. Infectious Disease Reports, Special Issue: Women and Infectious Diseases 2011; 3: e6. *doi: 10.4081/idr.2011.e6. PMID: 23745166. PMCID: PMC3671603*

Meyer J, Chen N, Springer S. HIV Treatment in the Criminal Justice System: Critical Knowledge and Intervention Gaps. AIDS Research and Treatment 2011; 2011:680617. *PMID 21776379. PMCID: PMC3137962*

Springer S, Spaulding A, **Meyer J,** Altice F. Public Health Implications for Adequate Transitional Care for HIV-Infected Prisoners: Five Essential Components. Clinical Infectious Disease 2011; 53(5): 469-479. *PMID 21844030 PMCID: PMC3156144.*

Chen N, **Meyer J,** Bollinger R, Page K. HIV Testing and Prevention Behaviors among Latinos in Baltimore City. Journal of Immigrant and Minority Health. 2012 Jan 20 (Epub). *PMID: 22262410. PMCID: PMC3389229*

Meyer J, Qiu J, Chen N, Larkin G, Altice F. Emergency Department Use by Released Prisoners with HIV: An Observational Longitudinal Study. PLoS ONE 2012; 7(8): e42416. *PMID: 22879972 PMCID: 3411742*

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Meyer J, Wickersham J, Fu J, Brown S, Sullivan T, Springer S, Altice F. Partner Violence and Health among HIV-Infected Jail Detainees. International Journal of Prisoner Health 2013; 9(3): 124-141. *DOI: 10.1108/IJPH-03-2013-0011. PMID: 24376468 PMCID: PMC3873166.*

Althoff A, Zelenev A, **Meyer J**, Fu J, Brown S, Vagenas P, Avery A, Cruzado J, Spaulding A, Altice F. Correlates of Retention in HIV Care after Release from Jail: Results from a Multi-site Study. AIDS and Behavior 2013 Oct;17 Suppl 2:156-70. *PMID: 23161210. PMCID: 3714328.*

Chen N, **Meyer J**, Avery A, Draine J, Flanigan T, Lincoln T, Spaulding A, Springer S, Altice F. Adherence to HIV Treatment and Care among Previously Homeless Jail Detainees. AIDS Behav. 2013 Oct;17(8):2654-66. doi: 10.1007/s10461-011-0080-2. *PMID: 22065234. PMCID: PMC3325326*

Williams C, Kim S, **Meyer J,** Spaulding A, Teixeira P, Avery A, Moore K, Altice F, Simon D, Wickersham J, Murphy-Swallow D, Ouellet L. Gender Differences in Baseline Health, Needs at Release, and Predictors of Care Engagement among HIV-positive Clients Leaving Jail. AIDS and Behavior 2013 Oct;17 Suppl 2:195-202 *PMID: 23314801 PMCID: PMC3758427*

Chitsaz E, **Meyer JP**, Krishnan A, Springer SA, Marcus R, Zaller N, Jordan AO, Lincoln T, Flanigan TP, Porterfield J, Altice FL. Contribution of Substance Use Disorders on HIV Treatment Outcomes and Antiretroviral Medication Adherence Among HIV-infected Persons Entering Jail. AIDS and Behavior 2013 Oct;17 Suppl 2:118-27. doi: 10.1007/s10461-013-0506-0 *PMID: 23673792. PMCID: PMC3818019*

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Meyer J, Zelenev A, Wickersham J, Williams C, Teixiera P, Altice F. Gender Disparities in HIV Treatment Outcomes Following Release From Jail: Results From a Multicenter Study. American Journal of Public Health. 2014 Mar; 104(3): 343-41. *NIHMS: 581757. PMID: 24432878. PMC3953795.*

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Boyd A, Song D, **Meyer J**, Altice F. Emergency Department Use among HIV-Infected Released Jail Detainees. J Urban Health. 2014 Oct 21. [Epub ahead of print] *PMID: 25331820. PMC4338130*

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Meyer J, Cepeda J, Taxman F, Altice F. Sex-Related Disparities in Criminal Justice and HIV Treatment Outcomes: A Retrospective Cohort Study of HIV-infected Inmates. American Journal of Public Health: 2015 Sep;105(9):1901-10. doi: 10.2105/AJPH.2015.302687. Epub 2015 Jul 16. NIHMS677862. PMID: 26180958. PMC4529767

Meyer J, Womack J, Gibson B. Beyond the Pap Smear: Gender-Responsive HIV Care for Women. Yale J Biol Med (Focus Issue: Sex and Gender Health). 2016 Jun; 89(2): 193–203. PMCID: PMC4918880

Bernardo R, Streiter S, Tiberio P, Rodwin B, Mohareb A, Ogbuagu O, Emu B, **Meyer J.** Photo Quiz: A Peripheral Blood Smear in a Ugandan Refugee. Journal of Clinical Microbiology. 2017 December 55(12): 3313-3314.

Peasant C, Sullivan T, Weiss N, Martinez I, **Meyer J.** Beyond the Syndemic: Condom Negotiation and Use among Women Experiencing Partner Violence. AIDS Care. 2016 Sep 2:1-8. PMID: 27590004. PMCID: PMC5291821.

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violence on condom negotiation and condom use among college women in non-casual sexual partnerships. Women & Health: 2017 Apr 12:1-15. PMID: 28402194.

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Shrestha R, Karki P, Altice F, Huedo-Medina T, **Meyer J**, Madden L, Copenhaver M. Correlates of willingness to initiate pre-exposure prophylaxis and the likelihood of practicing safer drug- and sex-related risk behaviors among high-risk drug users on methadone treatment. Drug and Alcohol Dependence*:* 2017 Apr 1;173:107-116. doi: 10.1016/j.drugalcdep.2016.12.023. Epub 2017 Feb 2. PMID: 28214391. PMCID: PMC5366273.

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Hoff E, Marcus R, Bojko M, Makarenko I, Mazhnaya A, Altice F, **Meyer J.** The effects of opioid-agonist treatments on HIV risk and social stability: A mixed methods study of women with opioid use disorder in Ukraine. J Substance Abuse Treatment 83 (2017) 36–44. NIHMS 914022. PMC5726590.

Harada K, Heaton H., Chen J., Vazquez M, **Meyer J.** Herpes zoster vaccine-associated Primary Varicella Infection in an Immunocompetent Host: Case Report and Literature Review. BMJ Case Rep. 2017 Aug 22;2017. pii: bcr-2017-221166. PMID: 28830902. NIHMS 913803. PMC5624100.

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Meyer J. The Sustained Harmful Health Effects of Incarceration for Women Living with HIV. J Womens Health (Larchmt). 2019 Aug;28(8):1017-1018. doi: 10.1089/jwh.2019.7940. Epub 2019 Jul 29. PMID: 31355697.

Olson B, Vincent W, **Meyer J,** Kershaw T, Sikkema K, Heckman T, Hansen N. Depressive Symptoms, Physical Symptoms, and Health-Related Quality of Life among Older Adults with HIV. Qual Life Res. 2019 Aug 24. doi: 10.1007/s11136-019-02271-0. PMID: 31446515.

Hoff E, Adams Z, Dasgupta A, Goddard D, Sheth S, **Meyer J.** Reproductive Health Justice and Autonomy: A systematic review of pregnancy planning intentions, needs, and interventions among women involved in US criminal justice systems. J Women's Health: *Under revision*.

Qin L, Price C, Puglisi L, Rutledge R, Madden L, **Meyer J.** Women's Decision-Making about PrEP for HIV Prevention in Drug Treatment Contexts. J Int Assoc Provid AIDS Care. 2020;19:2325958219900091. PMID: 31918605

Hoff E, Rutledge R, Gibson B, Price C, Gallagher C, Maurer K, **Meyer J.** PrEP for Women across the Criminal Justice Continuum in Connecticut: Implications for Policy and Practice. J Corr Healthcare: *In press. NIHMS 1573821*

Manuscripts in Submission

Muthulingham D, Clemons T, Marcus R, **Meyer J,** Yonkers K**.** Pregnancy as Peril for Women with Addiction: Public Health, not Punishment. AJPH: *Under review.*

Rich K, Loeliger K, Chandra D, Muthulingam D, Althoff K, Gallagher C, **Meyer J,** Altice F. Elevated Mortality Risk after Release from Prisons and Jails: Implications for Targeting At-Risk Persons. JAIDS: *Under review.*

Rich K, Eysenbach L, Joslin S, Marcus R, Brothers S, **Meyer J,** Altice F. Evaluation of a "One-Stop-Shop": An innovative treatment and prevention program that integrates harm reduction and primary care services for people who inject drugs. J Urban Health*: Under review.*

Barber D, Kempner T, Pasalar S, Borne D, Eysenbach L, Quinn E, Rajabiun S, **Meyer J.** Effects of a Multisite Medical Home Intervention on Emergency Department Use among Homeless People with HIV. J Healthcare Poor and Underserved*: Under review.*

Meyer J, Franco-Paredes C, Parmar P, Yasin F, Gartland M. COVID-19 and the Coming Plague in U.S. Immigration Detention Centers. NEJM: *Under review.*

Manuscripts in Preparation

Meyer J, Flash C, Gonzalez N, Pan A, Yuan Y, Rajabiun S. The Intersecting Effect of Gender and Race on Housing and HIV Outcomes in a Multisite Medical Home Project. *To submit to AJPH.*

Culbert G, Azbel L, Bachireddy C, Kurmanalieva A, Rhodes T, Altice F, **Meyer J**. A Qualitative Study of Diphenhydramine Injecting in Kyrgyz Prisons and Implications for Harm Reduction Efforts. *To submit to Harm Reduction J.*

Hoff E, Adams Z, Hass A, Dasgupta A, Goddard D, Sheth S, **Meyer J.** Reproductive Health Needs of Women at Risk of HIV in Connecticut. *To submit to J Women's Health.*

Meyer J, Shrestha R, Shenoi S, Wickersham J, Altice F. Potential and Challenges of Same Day PrEP for Key Populations. *To submit to Lancet HIV.*

Meyer J, Price CR, Tracey D, Madden L, Elwyn G, Altice F. Development and Efficacy of a PrEP Decision Aid for Women in Drug Treatment. *To submit to JSAT.*

Book Chapters

Meyer J, Altice F. HIV in Injection and Other Drug Users. Somesh Gupta, Bhushan Kumar, eds. *Sexually Transmitted Infections* 2nd ed. New Delhi, India: Elsevier, 2012: 1061-80. ISBN 978-81-312-2809-8.

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Mohareb A, Tiberio P, Mandimika C, Muthulingam D, **Meyer J.** Infectious Diseases in Underserved Populations. Onyema Ogbuagu, Gerald Friedland, Merceditas Villanueva, Marjorie Golden, eds. *Current Diagnosis and Treatment- Infectious Diseases*. McGraw-Hill Medical 2016.

Shrestha R, McCoy-Redd B, **Meyer J.** Pre-Exposure Prophylaxis (PrEP) for People Who Inject Drugs (PWID). Brianna Norton, Ed. *The Opioid Epidemic and Infectious Diseases.* Elsevier 2019.

Other Publications and Reports

Paul J (maiden surname). Bullous Pemphigoid in a Patient with Psoriasis and Possible Drug Reaction. Connecticut Medicine 2004 Nov-Dec; 68(10):611-5.

Meyer J *for United Nations Office on Drugs and Crime.* HIV and AIDS in Places of Detention. A toolkit for policymakers, programme managers, prison officers, and health care providers in prison settings. Vienna, Austria.

Other Media Communications

Gender differences in the treatment outcomes of HIV-infected jail detainees. Outbreak News this Week, WTAN 1340 Clearwater. Interviewed by Robert Herriman [radio] Tampa, Florida, February 8, 2014.

Caring for Justice-Involved Women. The Fortune Society Reentry Education Project Detailing Kit. New York City Department of Health and Mental Hygiene. October 2014.

"Safe" Sex with IUDs Is Not Safe Enough. Ms. Magazine Online. Posted December 8, 2014. http://msmagazine.com/blog/2014/12/08/safe-sex-with-iuds-is-not-safe-enough/

Women's Health Behind Bars- Not so Black and Orange. Huffington Post. Posted December 18, 2014. http://www.huffingtonpost.com/jaimie-meyer/womens-health-behind-bars-not-so-black-and-orange_b_6308892.html

Opioid use in women is not just 'a fetus problem'. Boston Globe. Posted February 19, 2015. http://www.bostonglobe.com/opinion/2015/02/19/opioid-use-women-not-just-fetus-problem/8tTFfEtn4mOJ1K75rxEXPI/story.html

Distinct Challenges Affect Women's HIV Treatment Outcomes After Jail. NIDA Notes. Posted May 12, 2015. http://www.drugabuse.gov/news-events/nida-notes/2015/05/distinct-challenges-affect-womens-hiv-treatment-outcomes-after-jail

Caring for the dying, behind bars. Boston Globe. Posted online May 21, 2015; in print May 24, 2015. http://www.bostonglobe.com/opinion/2015/05/21/caring-for-dying-inmates/WNispkkTY8MoI6zYP8tSRO/story.html

Video abstract. AJPH Talks. Posted online July 28, 2015. http://ajphtalks.blogspot.com/

Invited Conference Presentations & Published Abstracts

Adherence to HIV treatment and care among previously homeless jail detainees. IAPAC HIV Treatment and Adherence Conference. Miami, Florida. May 2011.

Emergency Department Use by Released Prisoners with HIV. Connecticut Infectious Disease Society Annual Symposium. Orange, Connecticut. May 2011.

Effects of Intimate Partner Violence on HIV and Substance Abuse in Released Jail Detainees. 5th Academic and Health Policy Conference on Correctional Health. Atlanta, Georgia. March 2012.

Frequent Emergency Department Use among Released Prisoners with HIV: Characterization Including a Novel Multimorbidity Index. IDWeek: Infectious Diseases Society of America Annual Meeting. San Diego, California. October 2012.

Correlates of Retention in HIV Care after Release from Jail: Results from a Multi-site Study. IDWeek: Infectious Diseases Society of America Annual Meeting. San Diego, California. October 2012.

Women Released from Jail Experience Suboptimal HIV Treatment Outcomes Compared to Men: Results from a Multi-Center Study. Conference on Retroviruses and Opportunistic Infections (CROI). Atlanta, Georgia. March 2013.

Women Released from Jail Experience Suboptimal HIV Treatment Outcomes Compared to Men: Results from a Multi-Center Study. Connecticut Infectious Disease Society Annual Meeting. Orange, Connecticut. May 2013.

Women Released from Jail Experience Suboptimal HIV Treatment Outcomes Compared to Men: Results from a Multi-Center Study. HIV Intervention and Implementation Science Meeting. Bethesda, Maryland. September 2013.

Longitudinal Treatment Outcomes in HIV-Infected Prisoners and Influence of Re-Incarceration. Conference on Retroviruses and Opportunistic Infections (CROI). Boston, Massachusetts. March 2014.

Longitudinal Treatment Outcomes in HIV-Infected Prisoners and Influence of Re-Incarceration. Connecticut Infectious Disease Society Annual Meeting. Orange, Connecticut. May 2014.

Gender Differences in HIV and Criminal Justice Outcomes. College on Problems in Drug Dependence (CPDD). San Juan, Puerto Rico. June 2014.

Gender Differences in HIV and Criminal Justice Outcomes. International Women's and Children's Health and Gender Working Group. San Juan, Puerto Rico. June 2014.

Violence, Substance Use, and Sexual Risk among College Women. International Women's and Children's Health and Gender Working Group. Phoenix, Arizona. June 2015.

Evidence-Based Interventions to Enhance Assessment, Treatment, and Adherence in the Chronic Hepatitis C Care Continuum. International Harm Reduction Conference. Kuala Lumpur, Malaysia. October 2015.

Beyond the Syndemic: Condom Negotiation and Use among Women Experiencing Partner Violence (Oral presentation). CDC National HIV Prevention Conference. Atlanta, Georgia. December 2015.

An Event-level Examination of Successful Condom Negotiation Strategies among College Women. International Women's and Children's Health and Gender Working Group. Palm Springs, California. June 2016.

Where rubbers meet the road: HIV risk reduction for women on probation (Oral presentation). 2017 Annual Meeting of the Society for Applied Anthropology. Santa Fe, New Mexico. April 2017.

A Mixed Methods Evaluation of HIV Risk among Women with Opioid Dependence in Ukraine. International Women's and Children's Health and Gender Working Group. Montreal, Canada. June 2017.

Assessing Receptiveness to and Eligibility for PrEP in Criminal Justice-Involved Women. International Women's and Children's Health and Gender Working Group. Montreal, Canada. June 2017.

A Mixed Methods Evaluation of HIV Risk among Women with Opioid Dependence in Ukraine. NIDA International Forum. Montreal, Canada. June 2017.

Late breaker: Predictors of Linkage to and Retention in HIV Care Following Release from Connecticut, USA Jails and Prisons. International AIDS Society (IAS) Meeting. Paris, France. July 2017.

Predictors of Linkage to and Retention in HIV Care Following Release from Connecticut, USA Jails and Prisons (Oral presentation). IDWeek: Annual Meeting of Infectious Diseases Society of America. San Diego, CA. October 2017.

The New Haven syringe services program. 2017 Connecticut Public Health Association Annual Conference. Plantsville, CT. October 2017.

Assessing Concurrent Validity of Criminogenic and Health Risk Instruments among Women on Probation in Connecticut. 11th Academic and Health Policy on Conference on Correctional Health. Houston, TX. March 2018.

From prison's gate to death's door: Survival analysis of released prisoners with HIV. 2018 Conference on Retroviruses and Opportunistic Infections (CROI). Boston, MA. March 2018.

HIV and Drug Use among Women in Prison in Azerbaijan, Kyrgyzstan and Ukraine. NIDA International. San Diego, CA. June 2018.

Methadone Maintenance Therapy Uptake, Retention, and Linkage for People who Inject Drugs Transitioning From Prison to the Community in Kyrgyzstan: Evaluation of a National Program. 22nd International AIDS Conference. Amsterdam, Netherlands. 23-27 July 2018.

HIV risk perceptions and risk reduction strategies among prisoners in Kyrgyzstan: a qualitative study. 22nd International AIDS Conference. Amsterdam, Netherlands. 23-27 July 2018.

Service needs and access to care among participants in the New Haven Syringe Services Program (SA-15). 12th National Harm Reduction Conference. New Orleans, LA. October 2018.

Oral presentation: New Haven Syringe Service Program: A model of integrated harm reduction and health care services. American Public Health Association (APHA) Annual Meeting. San Diego, California. November 2018.

PrEP Eligibility and HIV Risk Perception for Women across the Criminal Justice Continuum in Connecticut. 12th Academic and Health Policy on Conference on Correctional Health. Las Vegas, Nevada. March 2019.

Released to Die: Elevated Mortality in People with HIV after Incarceration. 2019 Conference on Retroviruses and Opportunistic Infections (CROI). Seattle, Washington. March 2019.

Impact of Trauma and Substance Abuse on HIV PrEP Outcomes among Women in Criminal Justice Systems. Symposium: "Partner Violence: Intersected with or Predictive of Substance Use and Health Problems among Women." Behaviors across Diverse Populations: Innovations in Science and Practice, APA Collaborative Perspectives on Addiction Annual Meeting. Providence, Rhode Island. April 2019.

Uniquely successful implementation of methadone treatment in a women's prison in Kyrgyzstan. 11th International Women's and Children's Health and Gender (InWomen's) Group. San Antonio, Texas. June 2019.

Diphenhydramine Injection in Kyrgyz Prisons: A Qualitative Study Of A High-Risk Behavior With Implications For Harm Reduction. 2019 NIDA International Forum. San Antonio, Texas. June 2019.

Decision-Making about HIV Prevention among Women in Drug Treatment: Is PrEP Contextually Relevant? 14th International Conference on HIV Treatment and Prevention Adherence. Miami, Florida. June 2019.

Punitive approaches to pregnant women with opioid use disorder: Impact on health care utilization, outcomes and ethical implications. CPDD 81st Annual Scientific Meeting. San Antonio, Texas. June 2019.

How does methadone treatment travel? On the 'becoming-methadone-body' of Kyrgyzstan prisons. Harm Reduction International. Porto, Portugal. May 2019.

Effects of a Multisite Medical Home Intervention on Emergency Department Use among Unstably Housed People with Human Immunodeficiency Virus. Society for Academic Emergency Medicine (SAEM) New England Regional Meeting (NERDS). Worcester, Massachusetts. March 2019.

Preliminary Findings from a Novel PrEP Demonstration Project for Women Involved in Criminal Justice Systems and Members of their Risk Networks. 37th Annual Connecticut Infectious Disease Society Conference. New Haven, Connecticut. May 2019.

Decision-Making about HIV Prevention among Women in Drug Treatment: Is PrEP Contextually Relevant? American College of Physicians (ACP) Connecticut Chapter Scientific Meeting. Hartford, Connecticut. October 2019.

Oral presentation: Decision-Making about HIV Prevention among Women in Drug Treatment: Is PrEP Contextually Relevant? SGIM New England Regional Meeting. Boston, Massachusetts. November 2019.

Workshop presentation: Treatment of Women's Substance Use Disorders and HIV Prevention During and Following Incarceration. Association for Justice-Involved Female Organizations Conference 2019. Atlanta, Georgia. December 2019.

Oral presentation: Can an interactive aid modify decisional preference for HIV pre-exposure prophylaxis (PrEP) among women seeking domestic violence services? description of a novel collaborative program and preliminary findings. National Conference on Health and Domestic Violence (NCHDV). Chicago, Illinois. March 2020.

Oral presentation: A Novel PrEP Demonstration Project for Justice-Involved Women and Members of their Risk Networks. 13th Academic and Health Policy Conference on Correctional Health. Raleigh, North Carolina. April 2020.

Impact of Motherhood Identity on Women's Substance Use and Engagement in Treatment Across the Lifespan. International Women's and Children's Health and Gender (InWomen's) Group. Hollywood, Florida. June 2020.

Invited Lectures/Seminars

Yale School of Medicine Affiliated

"HIV 101": Yale Affiliated Hospital Program, Greenwich Hospital Internal Medicine Residency Conference. March 2011.

"Clostridium Difficile": Yale Affiliated Hospital Program, Greenwich Hospital Internal Medicine Residency Conference. April 2013.

"Community-Acquired Infections." Student Microbiology Workshop, Yale University School of Medicine. September 2013.

"Hospital Associated Infections." Student Microbiology Workshop, Yale University School of Medicine. September 2014.

"Microbiology of the Central Nervous System." Student Microbiology Seminar. Yale University School of Medicine, Physician Associate Program. October 2014.

"Fever of Unknown Origin": Yale Affiliated Hospital Program, Greenwich Hospital Grand Rounds. January 2015.

"HIV and Women": Yale Affiliated Hospital Program, Greenwich Hospital Grand Rounds. May 2015.

"Clinical Care of HIV+ Women." Nathan Smith Clinic Lecture Series. May 2015.

"Implicit Bias and incarceration." Yale School of Medicine Pre-clinical clerkship seminar. September 2015.

Incarceration and Health Disparities." US Health and Justice course, Yale School of Medicine, Physician Assistant Program, and Yale School of Nursing. November 2015.

"Fever of Unknown Origin": Yale Affiliated Hospital Program, Danbury Hospital Teaching Rounds. January 2016.

"Management of Substance Use Disorders." Yale Affiliated Hospital Program, Greenwich Hospital Teaching Rounds. February 2016.

"Management of Substance Use Disorders." Yale Affiliated Hospital Program, Bridgeport Hospital Resident Teaching Rounds. June 2016.

"Clostridium Difficile Infection." Yale Affiliated Hospital Program, Norwalk Hospital Resident Conference. October 2016.

"Management of Substance Use Disorders." Yale Affiliated Hospital Program, Bridgeport Hospital Resident Teaching Rounds. November 2016.

"Mass Incarceration: Film and Panel Discussion." Yale Department of Psychiatry, Psychiatry and Film Series. December 2016.

"HIV 101." Yale Affiliated Hospital Program, Bridgeport Hospital Noon Conference. May 2017.

"HIV in the Criminal Justice System." Yale Affiliated Hospital Program, Danbury Hospital Noon Conference. June 2017.

"Management of Substance Use Disorders." Yale Affiliated Hospital Program, Norwalk Hospital Teaching Rounds. October 2017.

"Management of Substance Use Disorders." Yale Affiliated Hospital Program, Bridgeport Hospital Noon Conference. March 2018.

"HIV prevention for justice-involved women." Addiction Medicine Grand Rounds. May 2018.

"Diagnosis and Management of Urinary Tract Infections." Yale Affiliated Hospital Program, Norwalk Hospital Teaching Rounds. November 2018.

"Bacteremia." Yale Medicine Residency Program Resident Noon Conference. March 2019.

"Clostridium Difficile." Yale Affiliated Hospital Program, Norwalk Hospital Teaching Rounds. October 2019.

Invited small group facilitator. "Taking a Substance Use History." Session delivered as a required component of the Interprofessional Longitudinal Clinical Experience (ILCE) course delivered to all first-year Yale medical, nursing and PA students. Yale School of Nursing. November 1, 2019.

Non-Yale School of Medicine Affiliated

"HIV and Addiction": Rhode Island Chapter of the Association of Nurses in AIDS Care, 7th Annual Education Day. September 2010.

"Incarceration as Opportunity: Prisoner Health and Health Interventions": Yale College Class of 1960 Criminal Justice Symposium. May 2013.

"Trends and obstacles associated with healthcare for incarcerated or recently incarcerated women." Arthur Liman Public Interest Program, Yale Law School. October 2015.

"Incarceration as Opportunity: Prisoner Health and Health Interventions." New England AIDS Education Training Center, Dartmouth Geisel School of Medicine. April 2016.

"Trends in HIV Prevention: Integration of Biomedical and Behavioral Approaches." Connecticut Advanced Practice Registered Nurse Society Annual Meeting. April 2016.

"Topics in Infectious Diseases." Evolutionary Medicine course, Frank H. Netter School of Medicine, Quinnipiac University. October 2016.

"Optimizing the HIV Care Continuum for People Who Use Drugs: Strategies to Address Health Disparities." Clinical Directors Network Webinar. January 2017.

"HIV prevention for justice-involved women." Frank H. Netter School of Medicine Faculty Seminar Series. March 2018.

Plenary: "Intersection of the HIV and Opioid Epidemics." CCO Annual HIV and Hepatitis Symposium: Regional Workshops and Annual Update 2018. Washington, DC. April 2018.

"HIV prevention and treatment for women involved in criminal justice systems." CT HIV/AIDS Identification and Referral task force (CHAIR), Center for Interdisciplinary Research on AIDS (CIRA). Yale School of Public Health. May 2018.

Discussant: "Research on Women who Use Drugs: Knowledge and Implementation Gaps and A Proposed Research Agenda." Workshop on Women in Addictions Ten Years On, College of Problems on Drug Dependence. San Diego, CA. June 2018.

"PrEP Awareness among Special Populations of Women and People who Use Drugs." Clinical Directors Network Webinar. October 2018.

Panelist and Expert Witness: "An Analysis of Women's Health, Personal Dignity and Sexual Abuse in the US Prison System." US Commission on Civil Rights, Briefing on Women in Prison: Seeking Justice Behind Bars. Washington, DC. February 2019.

Faculty: "A Grassroots Approach to Weed out HIV and HCV in Special OUD Populations" (Live Webcast). CME Outfitters. September 2019.

"PrEP in Special Populations: PrEP in People who Inject Drugs." New England AIDS Education Training Center Annual Primary Care Conference. Hartford, CT. March 2020.