Fifth Report of the Agreement Monitoring Panel

(Chatman, et al. v. Otani, USDC Hawaii Civil No. 21-00268 JAO-KJM)

February 24, 2022

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Overview of activities since third AMP report

On February 11, 2022, the panel met by Zoom video conference with the PSD medical director, Dr. Caroline Mee. Dr. Mee discussed the medical and health services response to the ongoing surge of infections among inmates at all facilities. She explained how each individual facility had systems for identifying and monitoring individuals at higher risk for severe disease from SARS CoV2 infection. She noted challenges with cooperation with testing and said it was often due to misinformation among the inmates. On February 14, 2022, the panel met by Zoom video conference with facility leadership from OCCC, WCCC, and WCF. A similar meeting with HCF, MCCC, and KCCC leadership was held on February 15 and a third meeting with HCCC and KCF leadership was on the following day. During the meetings, facility leadership provided an overview of the response to the current surge, which, at the time of the meetings, was mirroring the community decline in infections. Common themes were application of lessons learned from prior surges; the importance of good and transparent communication among facility leadership, line staff, and inmates; seeking means to dispel misinformation; using more incentive-based approaches to overcome resistance to testing and housing moves; easing movement restrictions in isolation and quarantine housing; and the huge challenges of keeping operations going with staff absences in the already existing environment of staff shortages. The full panel met by Zoom on February 21, 2022.

This report will provide detail about PSD and facility responses to the AMP recommendations from previous reports.

Current status of COVID-19 in PSD facilities

At the submission of the 5th AMP report, the COVID-19 pandemic surge that began in early winter was experienced by all facilities and new and active infections among inmates were rapidly declining. All facilities reported existing staff shortages were exacerbated by large numbers of staff absences because of SARS CoV2 infection, noting there were times when it was necessary to hold some staff members back for 24- and even 36-hour shifts to achieve minimum coverage. Wardens and facility leadership expressed gratitude for the all-hands-on-deck cooperation by staff to ensure operations didn't suffer.

All facilities except KCF reported infections occurred among a large proportion of the inmates, challenging the cohorting needed for medical quarantine and isolation at the peak of the surge. The repeated need for establishing and maintaining cohorts often meant frequent moves that were hard on line staff and inmates as well as administering operations and housing. Each facility reported efforts to identify high-risk people and maintain surveillance of their health during exposure quarantines. The AMP was impressed by the creativity and flexibility demonstrated by the facilities in dealing with the challenges, including methods for maintaining housing records, frequent meetings to bolster communication, and identifying means of overcoming barriers. For example, at HCF, it became apparent that one of the resistances to moving by inmates was fear that a new mattress would be contaminated. Moves then commenced to include the mattress with

the inmate. KCF, which experienced its first inmate infections, was able to contain COVID-19 to two inmates. Their infections were traced to staff exposures.

No facility reported any shortage of protective equipment and sanitation supplies. The frequent need for full suits of protective gear during moves and other interactions with infected inmates was a hardship because it is uncomfortably hot. Nonetheless, good staff cooperation was reported.

Both facility and HCD staff reported symptomatic infections among inmates were the minority and generally mild, manifesting as cough without respiratory distress. Fever was infrequent. Hospitalizations during the surge were discussed with Dr. Mee. One patient with COVID-19 was transferred to the emergency room but not hospitalized. She indicated additional hospitalizations were not associated with a primary diagnosis of COVID-19. Dr. Takenaka explained that the public reporting of COVID-19 hospitalizations was according to department of health reporting criteria. Panel members could not locate the DOH reporting definition of a COVID-19 hospitalization. Following the February 21, 2022, meeting, the AMP learned there were 30 hospital admissions and 120 emergency room visits from December 1, 2021, to the time of the report. Panel members are seeking to understand the proportion of patients who had coincident SARS CoV2 infection among the admissions and emergency room visits. There were no deaths from COVID-19 during this period.

Inmate COVID-19 vaccination efforts were ongoing and the number of fully vaccinated inmates with boosters is beginning to climb. The cash incentives continued to be a primary driver of the effort. The proportion of fully vaccinated inmates in prison facilities was more than 80 and in some, more than 90 percent. The jails have lower proportions because of the population flux. Dr. Mee said that she began to track the proportion of fully vaccinated inmates among those who became infected ("breakthrough infections") but could not continue through the surge as resources became more stressed. However, the warden at WCCC reported at least 86% of the women were fully vaccinated. Among the women who became infected, the vaccinated proportion was 72%.

Area of Disagreement

During the February 21, 2022, meeting, panel member Dr. Takenaka read the PSD Pandemic Response Plan definition for hospitalization. In a previous draft of the report, AMP members wrote: "The DOH definition of a COVID-19 hospitalization was not available and there was no additional information about the number of and reasons for other hospitalizations that occurred during the surge." The DOH definition for hospitalization is accessible at the DOH COVID-19 dashboard. Dr. Takenaka notes that there had been no formal request for data on the number of and reason for non-COVID-19 related hospitalizations prior to the February 21, 2022, discussion. After receiving clarification of the timeframe for the request, on February 23, 2022, AMP members were provided the number of hospitalizations that occurred since December 1, 2021. AMP members subsequently requested similar information for emergency room visits and were provided the number of emergency room visits that occurred since December 1, 2021. AMP members were notified that the medical

director would review and verify the reasons for hospitalizations and emergency room visits for the 150 cases. AMP members later requested: "the number of people taken to the hospital (admitted or not) who had a positive COVID test, whatever the top reason for transfer." Note that the AMP requests could require diversion of the medical director duties for a large proportion of the workweek from urgent clinical supervision and care, pandemic protocol revision and implementation, and other urgent matters. Dr. Takenaka informed AMP members about the process for COVID-19 hospitalization determinations and reporting: after reviewing the case, DOH notifies HCD when an inmate has been determined to be hospitalized for COVID-19. Dr. Takenaka reiterates the concern about AMP requests for data and information that divert limited staffing resources from clinical care and the pandemic response to data gathering and reporting. Dr. Takenaka again requests that AMP members consider requests for data or information in the context of the overall pandemic response.

Authoring Panel Member Thorburn Note

The full quote about the AMP members "later" request is: "Based on our discussion, I thought we would want to know the number of people taken to the hospital (admitted or not) who had a positive COVID test, whatever the top reason for transfer." At the February 21, 2022, meeting, panel members sought clarification of hospitalization information, including emergency room visits, provided during the meeting with Dr. Mee. After discussion of what is tabulated as a COVID-19 hospitalization during the meeting, Drs. Venters and Thorburn asked for the proportion of hospitalized and emergency room patients with coincident positive SARS CoV2 tests. Dr. Thorburn has searched the DOH website several times and been unable to find the reporting definition of COVID-19 hospitalization.

Response to recommendations

1. Conduct daily temperature and symptom checks for inmate workers who move both outside and inside of facilities. Purchase required equipment and conduct staff training.

OCCC still plans to acquire more thermometers to fully implement this recommendation. Other facilities reported thermometers and symptom checks were in place for inmates who moved out of their housing although movement was restricted for surge management in most facilities during at least some period. WCCC takes temperatures when the women leave their housing. As noted above, fever was infrequent among the infected.

2. Suspend sick call charges at least as long as COVID-19 is underway, without qualification as to the nature of the medical problem.

All sick call charges were suspended. (See the 4th AMP Report.) The WCCC warden said that his nurse noted an uptick in sick call use to obtain free medication. The AMP has requested data on any increase in sick call encounters as well as other responses to this change.

In the 3rd AMP report, PSD asserted that the greatest barriers to seeking care for COVID-19 were inmates' unwillingness to disclose symptoms and lack of cooperation with SARS CoV2 testing due to required medical isolation or quarantine should someone test positive. As noted above, the AMP heard considerable attention to the issue of barriers during our meetings with the wardens. Through meetings and other communication strategies, facilities worked to ensure needed cooperation to find infections and manage exposures. They were exploring efforts to effectively combat misinformation. Some facilities, particularly HCF, noted cooperation between health care and security staff to ensure that inmates at high risk for complications from potential SARS CoV2 infection were monitored.

Both WCF and HCF noted improved management when medical isolation and quarantine were made less restrictive. WCF provided outdoor recreation by cohort. HCF ensured daily activity outside of cells.

Area of Disagreement

Panel member Dr. Takenaka notes that the February 15, 2022, update to the CDC "Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities" does not recommend the suspension of all co-payment fees and instead reads: "Facilities should consider suspending co-pays for residents seeking medical evaluation for possible COVID-19 symptoms, to remove possible barriers to symptom reporting." Dr. Takenaka notes that the abuse of the temporary co-payment waiver program to obtain free medication among WCCC inmates is a serious concern due to the potential for suicide by overdose, which could be inadvertently caused by the temporary change in the co-payment system.

Dr. Takenaka reiterated an earlier concern, as cited in the previous AMP report, about diverting limited staff resources from clinical care to data gathering and reporting activities. On February 21, 2022, AMP panel members "requested data on any increase in sick call encounters as well as other responses to this change." Dr. Takenaka cautions: a review of trends in sick-call encounter data would likely result in confirmation bias, regardless of the direction of the trend in data. Dr. Takenaka reported that the health care division intended to review the co-pay suspension program at the completion of the two-month period. Dr. Takenaka also mentioned other potential modifications to the co-payment program (e.g., reinforcement for prosocial behavior), that were being examined prior to the pandemic.

3. Identify offices near/on housing areas wherever possible for clinical encounters with computers that have electronic medical record access.

The project is ongoing but the needed resources directed to the surge response meant that there is nothing to report since the 4th AMP Report.

4. Institute monthly town halls in housing areas to discuss vaccination and consider structured vaccine education encounters for all high-risk patients who remain unvaccinated.

The cash incentive program is generating good results in encouraging vaccination. As the report was being written, PSD reported that more than 1,000 inmates have received

boosters. Dr. Mee explained that vaccination status is noted in the medical records and health care providers counsel unvaccinated high-risk patients during health care visits.

5. Adopt a uniform policy regarding screening, quarantine and testing of people who have outside court and medical appointments that follows CDC guidelines and limits possible and/or perceived disincentives to receiving care.

Dr. Mee reported that she was unaware of refusals of transport to outside medical appointments. Dr. Takenaka said routine quarantine after transportation to medical appointments is considered low risk for infection transmission and will be eliminated in the revised PRP. The AMP plans to review the revised draft PRP during the next month.

HCCC reported that, as a result of meetings with the courts, some previously required court transportation had been reduced.

6. Take a broad approach to both testing and contact tracing, so that individual quads or subparts of housing areas are considered part of the same potential exposure and include roving staff, inmate workers, and supervisors as well as individuals identified by inmate movement records in contact tracing and testing after new cases are identified.

Testing since the 4th AMP report focused on surge management and was assisted by both Project Vision and the National Guard. Facilities reported that, once infection was identified among the existing inmate population (as opposed to infected new arrivals from the community), broad-based testing of the entire facility commenced and continued every three to seven days as new infections were identified. Dr. Mee and several wardens noted that an important outreach message was the risk of infection was not worth the potential benefit of remaining in their current housing. Understanding these inmate concerns about the consequences of testing and identifying infections helped the facilities find messages and strategies to improve cooperation with testing.

OCCC reported ongoing challenges in implementing COVID-19 screening and monitoring efforts in the Annex housing areas.

7. Follow CDC guidance to identify and treat post-COVID symptoms and disability, including among those who initially had mild or no symptoms.

Dr. Mee reported that infected inmates with associated high-risk conditions received priority attention until recovery. Sick call request will be used if inmates have post-COVID symptoms or disability. Drs. Venters and Thorburn continue to urge more systematic approaches to follow up, such as a routine screening of anyone infected at a month or some such interval after recovery or negative test. The panel discussed that this recommendation is most applicable to the prison facilities among inmates who will remain in the care of PSD health services.

Area of Disagreement

Panel member Dr. Takenaka previously described the department's systematic approach (protocol) addressing the timing of follow-up for post-COVID conditions involving the

presence of comorbidities and the highest level of acute COVID-19 illness severity, which interacted with age to determine the care path. The department's post-COVID-19 follow-up practices were consistent with CDC guidance and the UpToDate review on "COVID-19: Evaluation and management of adults following acute viral illness." Due to the recently updated UpToDate review, the Health Care Division has been modifying protocols accordingly.

Dr. Takenaka disagrees with AMP members' recommendation for "routine screening of anyone infected at a month or some such interval after recovery or negative test." CDC guidance and the UpToDate review do not support the AMP members' recommendation. CDC guidance remains unchanged since June 14, 2021; CDC "General Clinical Considerations: Evaluating and Caring for Patients with Post-COVID Conditions: Interim Guidance," reads: "Patients with asymptomatic infection to moderate illness might benefit from follow-up within 3–4 weeks from initial infection if they experience ongoing or new symptoms." In the February 2022 UpToDate revision, the presence of comorbidities and age have been replaced by the presence of persistent symptoms in the mild to moderate acute illness category in determining the follow-up care path. The follow-up protocol for asymptomatic and severe/hospitalized patients remains unchanged.

8. PSD needs to continue to vigorously engage at central level and support its individual facility administrators to engage with the Hawaii Paroling Authority, courts, and other local officials, agencies, and partners to attempt to reduce the influx of new detained people as a means to ensure adequate COVID-19 response, particularly during periods of ongoing transmission.

PSD administration, as well as facility wardens, continue to engage with other agencies, particularly the courts, on managing intake to improve population pressures. HCCC and KCCC are the two facilities facing the severest strain. There have been several communications with the Big Island courts but issues continue, such as low-bail admissions and 48-hour detentions. There is also concern that, as the surge diminishes, delayed admissions will be sent for intake, exacerbating crowding. The KCCC warden is in regular communication with the courts and PSD administration is committed to supporting the efforts. Both HCCC and KCCC wardens noted that per diem judges may be the most frequent users of detention in lieu of postponement or alternatives.

9. Continue to remove departmental administrative barriers to inmate placements and intra-facility transfers. House inmates based on health and custodial safety.

Intra-facility movement was restricted by the surge. As noted in previous reports, PSD has eliminated several administrative barriers to transfers and inmates have been identified for moves that will resume once transfers are safe from a health standpoint. A large transfer from HCCC is scheduled during the week of February 21.

There is a requirement that inmates who fly be fully vaccinated. This requirement should be monitored because it could result in a barrier to vaccination acceptance.

10. Prioritize completion of installation of the isolation containers that have been purchased for all facilities.

Due to the surge, there has been no change is the status of availability of isolation container housing since the 4th report. The containers were quadruple occupied at HCCC throughout the surge. The shower is not yet complete at HCCC but is scheduled for construction. Containers are also in use at MCCC.

11. Consider requiring that inmates who transfer to Waiawa and Kulani Correctional Facilities be vaccinated.

This recommendation remains under consideration by PSD.

12. Because of increased risk for death, ensure high-risk patients are identified at the outset of any outbreak or large-scale health event and receive a higher level of attention during population symptom monitoring with the goal of intervening when early warning symptoms present.

Dr. Mee explained that high-risk patients are identified and monitored by each facility health care and security staff to ensure adequate observation.

13. Create a more robust mortality review process that focuses on potential system improvements by noting deficiencies in care as well as areas for improvement after each death, with an additional pooled or joint review for deaths from outbreaks and other large-scale health events.

No inmate deaths were reported during the period between reports, which encompassed the current surge. As noted in the 4th AMP report, the regular mortality review process during quarterly health care meetings will resume once the meetings are re-started. Drs. Venters and Thorburn continue to recommend, based on the panel's review of COVID case mortality reviews, strengthening the process to ensure shortfalls in care, especially as they relate to system issues, are identified to contribute to the process of quality improvement.

Areas of concern

The majority of the panel continues to be concerned about the lack of a systematic approach to post-COVID monitoring and strengthening of the mortality review process.

Area of Disagreement

Panel member Dr. Takenaka references the area of disagreement in item 7 above concerning post-COVID conditions. Dr. Takenaka does not disagree with the notion for ongoing improvement in the mortality review process, as continuous quality improvement is essential for effective health care delivery. Dr. Takenaka also comments that the focus on the mortality review process misses the overall effort and progression of interventions that have occurred as a result of updated information provided by the CDC and other entities as more has been learned about the virus throughout the pandemic. Since the occurrence of COVID-related deaths during the first outbreak at HCF, there have been numerous layers of preventative efforts implemented, which have reduced instances of severe illness and death, as evidenced by the recent clusters at each of the eight facilities. Vaccine availability, booster administration, and identification of high-risk inmates are mentioned in report. But,

there has been no mention of other layers of protection that have been implemented, as COVID-19 information and CDC/DOH guidance have evolved, such as the department's efforts to establish systems for the use of monoclonal antibodies and antiviral medication as interventions for the prevention of severe illness and death, installation of portable HEPA filtration units at all facilities, expansion of in-reach health care services, advancements in the medication for opioid use disorder program, efforts to increase treatment for Hepatitis C through an Opt-Out Screening project and 340B program approval, and efforts to increase medical and nursing services through contract and appropriation of funds.

Recommendations

Continue to monitor operational and procedural mandates that become obstacles to care and treatment and work with staff and inmates to identify means of minimizing the barriers.

Next steps

The panel will review the draft PRP revisions. There will be warden and facility Zoom video conference meetings on March 9 and 11, 2022. The AMP will hold a meeting on March 22, 2022, to prepare its final report to be submitted by the end of March 2022.

Signed on behalf of the AMP members

Kim Marie Thorburn, MD, MPH

February 24, 2022