

Exhibit 1

**UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS**

ALEXANDER GRINIS, MICHAEL GORDON
and ANGEL SOLIZ, on behalf of themselves
and thos similarly situated,
Petitioners,

Case No. 20-10738-GAO

v.

STEPHEN SPAULDING, Warden of
Federal Medical Center Devens, and
MICHAEL CARVAJAL, Director of
the Federal Bureau of Prisons, in their
official capacities
Respondents.

DECLARATION OF DR. JOE GOLDENSON

Pursuant to 28 U.S.C. § 1746, I, Dr. Joe Goldenson, declare as follows:

1. I am a medical physician with 33 years of experience in correctional health care. For 28 years, I worked for Jail Health Services of the San Francisco Department of Public Health. For 22 of those years, I served as the Director and Medical Director. In that role, I provided direct clinical services, managed public health activities in the San Francisco County jail, and administered the correctional health enterprise, including its budget, human resources services, and medical, mental health, dental, and pharmacy services.
2. I served as a member of the Board of Directors of the National Commission on Correctional Health Care for eight years and was past President of the California chapter of the American Correctional Health Services Association. In 2014, I received the Armond Start Award of Excellence from the Society of Correctional Physicians, which recognizes its recipient as a representative of the highest ideals in correctional medicine.
3. For 35 years, I held an academic appointment as an Assistant Clinical Professor at the University of California, San Francisco.
4. I have worked extensively as a correctional health medical expert and court monitor. I have served as a medical expert for the United States District Court for the Northern District of California for 25 years. I am currently retained by that Court as a medical expert in *Plata v. Newsom*, Case No. 3:01-cv-01351 (N.D. Cal.), to evaluate medical care provided to inmate patients in the California Department of Correctional Rehabilitation. I have also served as a medical expert and monitor at Cook County Jail

in Chicago and Los Angeles County Jail, at other jails in Washington, Texas, and Florida, and at prisons in Illinois, Ohio, and Wisconsin.

5. A true and correct copy of my current curriculum vitae is attached as Exhibit A to this declaration.

I. General Conditions of COVID-19

6. COVID-19 is a serious disease that has reached pandemic status. As of April 14, 2020, there are at least 1,848,439 confirmed cases of COVID-19 worldwide, including 553,822 confirmed cases in the United States. At least 117,217 people have died, including 21,972 in the United States.¹ These numbers have been increasing at an alarmingly rapid rate, reflecting the exponential growth of infections. Because these numbers include only laboratory confirmed cases, they likely understate the actual number of cases and deaths. Most medical and public health experts agree that the situation, which is already dire, will continue to worsen over the coming weeks to months.
7. COVID-19 is a highly contagious respiratory illness. The Centers for Disease Control and Prevention (“CDC”) estimates that the reproduction rate of the virus, the R0, is 2.4-3.8, meaning that each newly infected person is estimated to infect on average 3 additional persons. Only the great influenza pandemic of 1918 is thought to have higher infectivity.
8. COVID-19 is transmitted between persons in close proximity (within about six feet) by airborne droplets released by infected individuals when they cough, speak, or sneeze. The droplets can survive in the air for up to three hours. It may also be possible for an individual to become infected by touching a surface or object that has the virus on it and then touching his or her own mouth, nose, or possibly eyes. Infected droplets can survive on surfaces for variable lengths of time, ranging from up to four hours on copper, to 24 hours on cardboard, to 2-3 days on plastic or stainless steel.
9. Signs and symptoms of COVID-19 may appear 2 to 14 days after exposure and may include fever, cough, and shortness of breath or difficulty breathing.
10. A significant number of infected individuals do not exhibit symptoms. This poses a significant public health problem, because asymptomatic individuals—either before the onset of symptoms or because no symptoms will ever manifest—can nevertheless transmit the disease to others. According to the CDC, up to 25 percent of people

¹ World Health Organization, Coronavirus disease (COVID-19) Situation Dashboard, <https://who.sprinklr.com/> (accessed Apr. 14, 2020).

infected with COVID-19 will remain asymptomatic.² These asymptomatic and mildly symptomatic individuals can, and do, transmit the virus, contributing to its rapid spread.

11. For those who exhibit symptoms, they can become severe, and can lead to hospitalization, the need for intensive care, and in some instance, death. The overall case fatality rate has been estimated to range from .3 to 3.5%, which is 5-35 times the fatality associated with influenza infection.
12. The fatality rate increases with age and for those with conditions that make them particularly susceptible to the virus. Because the primary cause of death due to COVID-19 is respiratory failure, patients with pre-existing pulmonary disease who become infected are more at risk for respiratory failure due to their underlying lung disease. Patients with pre-existing cardiac disease are at risk because cardiac output increases during severe infections. If the heart is already compromised, such an increase can exacerbate a patient's underlying heart disease. Furthermore, some patients also may have severe cardiovascular damage as a result of COVID-19 infection. Medications for certain chronic conditions, such as liver or kidney disease, can also reduce the body's ability to fight infection.
13. The CDC has determined that the following underlying conditions may increase the risk of serious COVID-19 for individuals of any age:
 - Diabetes;
 - blood disorders, such as sickle cell disease or usage of blood thinners;
 - chronic kidney disease;
 - chronic liver disease, such as cirrhosis or chronic hepatitis;
 - compromised immune systems (immunosuppression), including those caused by cancer, transplant recipients for organs or bone marrow, and HIV or AIDS;
 - current or recent pregnancy;
 - endocrine disorders;
 - metabolic disorders;
 - heart disease, such as congenital heart disease, congestive heart failure, and coronary artery disease;
 - lung disease, including asthma or chronic obstructive pulmonary disease or other chronic conditions associated with impaired lung function; and
 - neurological and neurologic and neurodevelopment conditions, including disorders of the brain, spinal cord, peripheral nerve, and muscle such as cerebral palsy, epilepsy (and other seizure disorders), stroke, intellectual disability, moderate to severe developmental delay, muscular dystrophy, or spinal cord injury.

² Apoorva Mandavilli, *Infected but Feeling Fine: The Unwitting Coronavirus Spreaders*, N.Y. Times (Mar. 31, 2020), <https://www.nytimes.com/2020/03/31/health/coronavirus-asymptomatic-transmission.html>.

14. A study of the fatality rates for patients with COVID-19 and co-morbid conditions has been found to be “13.2% for those with cardiovascular disease, 9.2% for diabetes, 8.4% for hypertension, 8.0% for chronic respiratory disease, and 7.6% for cancer.”³ This disease also “can kill healthy adults in addition to elderly people with existing health problems.”⁴
15. There is currently no medical treatment for COVID-19, other than supportive measures, and no vaccine.
16. Because there is no vaccine, there are just two ways to prevent the spread of COVID-19: physical social distancing (keeping persons separated by at least six feet) and hygiene (i.e., frequent handwashing with soap or hand sanitizer, wearing of masks, covering mouth and nose when coughing or sneezing, and cleaning and disinfecting flat and hard surfaces). Individuals must be able to practice physical social distancing for hygiene to have a meaningful impact. Reflecting this reality, as of April 7, 2020, at least 42 states had issued stay-at-home orders.⁵

II. COVID-19 in Detention Facilities

17. The risk of exposure to and transmission of infectious diseases, as well as the risk of harm from developing severe complications or death if infected,⁶ is significantly higher in jails, prisons, and detention centers than in the community.
18. While jails, prisons, and detention centers are often thought of as closed environments, this is not the case. Custody, medical, and other support staff and contractors enter and leave the facility throughout the day. New detainees arrive on a frequent basis. Since there is no effective way to screen for newly infected or asymptomatic individuals, they can unknowingly transmit COVID-19 to those housed in the facility.
19. In addition, current recommendations for social distancing, frequent hand washing, and frequent cleansing of surfaces to prevent infection and the spread of the virus are extremely difficult, if not impossible, to implement in the correctional setting. Space and resource limitations—and the resulting inability of inmates and employees to practice social distancing—make it extremely difficult to effectively quell the explosive growth of a highly contagious virus.

³ *Report of the WHO-China Joint Mission on Coronavirus Disease 2019 (COVID-19)*, World Health Organization (Feb. 28, 2020), at 12, <https://www.who.int/docs/default-source/coronaviruse/who-china-joint-mission-on-covid-19-final-report.pdf>.

⁴ Bill Gates, *Responding to Covid-19 – A Once-in-a-Century Pandemic?*, *The New England Journal of Medicine* (February 28, 2020), [nejm.org/doi/full/10.1056/NEJMp2003762](https://doi.org/10.1056/NEJMp2003762).

⁵ Sarah Mervosh, Denise Lu and Vanessa Swales, *See Which States and Cities Have Told Residents to Stay at Home*, *N.Y. Times*, (Apr. 7, 2020), <https://www.nytimes.com/interactive/2020/us/coronavirus-stay-at-home-order.html>

⁶ *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](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31251-0/fulltext).

20. Sufficient soap and/or hand sanitizer is often not available for prisoners and staff to wash their hands frequently enough. Housing units are commonly poorly ventilated, which facilitates the transmission of airborne illnesses such as COVID-19.
21. Most important, prisoners are housed in close, crowded quarters, often sharing bunkbeds in a single room or in open dormitories. They also share eating areas, toilets, sinks, showers, telephones and other common areas, which are commonly not disinfected adequately, especially during the current pandemic when more frequent cleaning and disinfecting are required. Food preparation and distribution is often centralized for an entire facility. Guards and other facility staff routinely have direct physical contact with prisoners, especially when handcuffing or removing handcuffs from prisoners who are entering or exiting the facility.
22. As a result of these conditions, prisoners are physically unable to practice social distancing, which CDC has identified as a “cornerstone of reducing transmission of respiratory diseases such as COVID-19.”⁷
23. Because of this, incarcerated individuals are less able to protect themselves from being exposed to and becoming infected with infectious diseases, such as COVID-19.
24. These physical conditions are especially challenging because it is well-accepted within the medical community that, due to the burden of chronic illnesses and other persistent health challenges of many of those housed in correctional facilities, incarcerated individuals are physiologically 10 years older than their chronological age. Because physiological age is more relevant when evaluating risk of complications from COVID-19, even younger incarcerated individuals could be at heightened risk of severe complications.
25. Correctional facilities largely lack the robust medical care infrastructure, including staff and resources, that would be necessary to deal with a COVID-19 outbreak.
26. Given these conditions, outbreaks of COVID-19 in jails, prisons and detention centers in the U.S. are inevitable. Releasing as many individuals as possible is important to protect the health of those incarcerated, custodial, health care, and other facility staff, and the community as a whole. Indeed, according to the World Health Organization, “enhanced consideration should be given to resorting to non-custodial measures at all stages of the administration of criminal justice, including at the pre-trial, trial and sentencing as well as post-sentencing stages.”⁸

⁷ Centers for Disease Control and Prevention, *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities*, <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html>.

⁸ World Health Organization, Regional Office for Europe, Preparedness, prevention and control of COVID-19 in prisons and other places of detention: Interim guidance (Mar. 15, 2020),

27. It is difficult to overstate the devastation that a COVID-19 outbreak can inflict on the prisoners, correctional staff and their surrounding communities. Given the conditions described above, the infection can spread rapidly within the facility. What is more, because jails and prisons lack the capacity to provide ICU treatment, prisoners with severe cases of COVID-19 must be transferred to community hospitals, further straining their already scarce resources. Finally, due to the frequent ingress and egress of employees at these facilities, an outbreak within a jail, prison, or detention center can quickly spread to surrounding communities. For example, the tuberculosis epidemic that broke out in New York City in the early 1990s began in jails and was spread to the community by jail employees who became infected and then returned home to their families and communities.

III. Risk of COVID-19 at FMC Devens

28. In making my assessment of the danger of COVID-19 at FMC Devens, I have reviewed the declarations of Alexander Grinis, Michael Gordon, and Angel Soliz. I have also reviewed the April 8, 2020 letter submitted by the United States Attorney in *United States v. James Turner*, No. 17-132.

29. My understanding is that FMC Devens is an administrative security medical center of nearly 1,000 prisoners with an adjacent minimum security satellite camp of more than 100 prisoners.

30. Based on the Grinis declaration, it is my understanding that prisoners detained in the minimum security “camp” sleep in a communal space with approximately 100 other prisoners in open 7 by 9 feet cubes that they share with 1 to 3 other prisoners in bunk beds. It is my understanding that all of the camp prisoners share 12 toilets, sinks and showers that are cleaned just twice a day. They also share 4 telephones and 5 computers that are not cleaned between uses, and eat their meals at communal tables after standing very close together to get their food. Camp prisoners work in different areas throughout the facility, including buildings outside of the camp.

31. Based on the Gordon declaration, it is my understanding that prisoners detained in the H-B unit sleep in 65 open cubicles that they share with another prisoner in a bunk bed. It is my understanding that the prisoners detained in the H-B unit share 4 toilets, 6 urinals and 6 shower stalls, as well as a single sink to clean cooking and eating utensils. They also share 4 phones and 5 computers that are not cleaned between uses, and eat their meals at tables of 4 or 5 people after standing inches from each other to get their food. Correctional staff move between the different units. Several prisoners in this unit leave the unit several times a week to go the dialysis facility on the compound.

32. Based on the Soliz declaration, it is my understanding that the approximately 120 prisoners detained in the J-B unit sleep in 2 man cells with a sink and toilet. They share

http://www.euro.who.int/__data/assets/pdf_file/0019/434026/Preparedness-prevention-and-control-of-COVID-19-in-prisons.pdf.

12 showers that are usually dirty, and also share 4 phones and 5 computers that are not cleaned between uses. Prisoners in the J-B unit eat in their unit after they pick up their meals in the dining hall; they also stand in line together to receive their medications.

33. All of the declarants emphasize that new prisoners continue to enter their unit and that it is impossible for them to maintain six feet of distance from other individuals in their unit.
34. In my professional judgment, FMC Devens is a tinder-box that is waiting to explode with a surge of COVID-19 infections. The facility has a high-number of medically vulnerable individuals living in conditions where they are unable to practice any kind of meaningful physical distancing or maintain proper hygiene. The failure to routinely clean bathrooms and surfaces like phones and computers after every use creates a perfect pathway for the transmission of the virus. The facility is not a closed environment, with correctional officers and new prisoners arriving regularly, and many people circulating amongst the units for jobs and medical treatment. And most important, the current population levels and physical structures do not allow prisoners or correctional officers to follow CDC's recommendation to maintain six feet of distance between themselves.
35. I have reviewed the United States Attorney's description in *Turner* of the steps they have taken at FMC Devens in light of the pandemic, and in my professional opinion it is clearly not enough to mitigate the risk of a surge of COVID-19 infections at the facility.
36. Given the high percentage of individuals who are asymptomatic either during the early stages of infection, or throughout their entire period of infection, FMC Devens' limited "screening" procedures of taking individuals' temperatures will not prevent the infection from infiltrating the facility.
37. What is more, while the letter describes some additional hygiene procedures— such as the use of a disinfectant "known to be active against COVID-19" and the distribution of soap and three masks per month to prisoners—physical distancing is the most important element of preventing the transmission of the disease. Even under the "modified lockdown" at FMC Devens, prisoners are completely unable to successfully implement physical distancing at the current population levels and design capacity of the facilities. Until they are able to consistently do so, no other efforts will meaningfully decrease the risk of COVID-19 infection.

IV. Conclusion

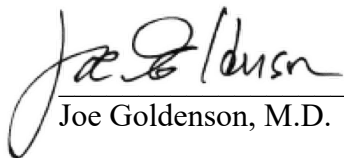
38. For the reasons above, it is my professional opinion that persons currently detained at FMC Devens are at significantly greater risk of contracting COVID-19 than if they were permitted to shelter in place in their home communities. If infected, they are at increased risk of suffering severe complications and outcomes, including death.

39. It is my public health recommendation that in order to meaningful decrease the risk of COVID-19 infections at FMC Devens, the facility must reduce the prisoner population sufficiently to ensure social distancing and permit personal hygiene in compliance with CDC guidelines.

40. It is my professional opinion that it is unnecessary and harmful to automatically quarantine asymptomatic prisoners for two weeks in solitary confinement in the Special Housing Unit (“SHU”) prior to release. Even solitary confinement in the facility cannot prevent the spread of infection due to ongoing contact with staff members. What is more, such confinement is unnecessarily traumatic and punitive for the prisoners. Instead, the Bureau of Prisons should work to ensure that prisoners are released to a place where they can maintain medically appropriate isolation for at least 14 days.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed this 14th day of April 2020.



Joe Goldenson, M.D.

Exhibit A

CURRICULUM VITAE

JOE GOLDENSON, MD

BERKELEY, CA 94703

EDUCATION

Post Graduate Training

February 1992	University of California, San Francisco, CPAT/APEX Mini-Residency in HIV Care
1979-1980	Robert Wood Johnson Fellowship in Family Practice
1976-1979	University of California, San Francisco Residency in Family Practice

Medical School

1973-1975	Mt. Sinai School of Medicine, New York M.D. Degree
1971-1973	University of Michigan, Ann Arbor

Undergraduate Education

1967-1971	University of Michigan, Ann Arbor B.A. in Psychology
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PROFESSIONAL EXPERIENCE

Practice Experience

1993-2015	Director/Medical Director Jail Health Services San Francisco Department of Public Health
1991-1993	Medical Director Jail Health Services San Francisco Department of Public Health
1990-1991	Chief of Medical Services, Hall of Justice Jail Health Services San Francisco Department of Public Health
1987-1990	Staff Physician Jail Health Services San Francisco Department of Public Health
1980-1987	Sabbatical
1975-1976	Staff Physician United Farm Workers Health Center, Salinas, CA

Consulting

6/16-8/19	Consultant to Los Angeles Department of Health Services re: provision of health care services in the LA County Jail
4/02-Present	Federal Court Medical Expert, <i>Plata v. Newsome</i> , Class Action Lawsuit re: prisoner medical care in California State Prison System
6/14-9/14	Medical expert for the Illinois Department of Corrections and the ACLU of Illinois
6/10-12/13	Federal Court appointed Medical Monitor, <i>U.S.A. v. Cook County, et al.</i> , United States District Court for the Northern District of Illinois, No. 10 C 2946, re: medical care in the Cook County Jail
6/08-6/12	Member, <i>Plata v. Schwarzenegger</i> Advisory Board to the Honorable Thelton E. Henderson, U.S. District Court Judge
5/08-9/09	Medical Expert for ACLU re Maricopa County Jail, Phoenix, AZ
1/08	Member of the National Commission on Correctional Health Care's Technical Assistance Review Team for the Miami Dade Department of Corrections
9/07-1/10	Federal Court appointed Medical Expert, <i>Herrera v. Pierce County, et al.</i> , re: medical care at the Pierce County Jail, Tacoma, WA
8/06-8/12	State Court Appointed Medical Expert, <i>Farrell v. Allen</i> , Superior Court of California Consent Decree re medical care in the California Department of Juvenile Justice
6/05	Member of Technical Assistance Review Team for the Dallas County Jail
11/02-4/03	Medical Expert for ACLU re Jefferson County Jail, Port Townsend, Washington
4/02-8/06	Federal Court Medical Expert, <i>Austin, et. al vs Wilkinson, et al</i> , Class Action Law Suit re: Prisoner medical care at the Ohio State Penitentiary Supermax Facility
1/02-3/02	Consultant to the Francis J. Curry, National Tuberculosis Center re: <i>Tuberculosis Control Plan for the Jail Setting: A Template (Jail Template)</i> ,
8/01-4/02	Medical Expert for ACLU re Wisconsin Supermax Correctional Facility, Boscobel, WI
7/01-4/02	Medical Expert for Ohio Attorney General's Office re Ohio State Prison, Youngstown, OH
1/96-1/14	Member and Surveyor, California Medical Association Corrections and Detentions Health Care Committee
5/95-6/08	Medical Expert for the Office of the Special Master, <i>Madrid vs Alameida</i> , Federal Class Action Law Suit re: Prisoner medical care at the Pelican Bay State Prison Supermax Facility
3/98-12/98	Member, Los Angeles County Department of Public Health Jail Health Services Task Force

2/98 Medical Expert, Department of Justice Investigation of Clark
County Detention Center, Las Vegas, Nevada
6/94 Surveyor, National Commission on Correctional Health Care,
INS Detention Center, El Centro, CA

Work Related Committees

1/14 to present Member, Editorial Advisory Board, *Correctional Health Care Report*

10/11 to 5/19 Member, Board of Directors of the National Commission on Correctional Health Care

5/07-10/12 Liaison to the CDC Advisory Council for the Elimination of Tuberculosis (ACET) from the National Commission on Correctional Health Care

12/04-3/06 Member of the CDC Advisory Council for the Elimination of Tuberculosis (ACET) Ad Hoc Working Group on the *Prevention and Control of Tuberculosis in Correctional and Detention Facilities: Recommendations from CDC* (MMWR 2006; 55(No. RR-9))

6/03-8/03 Member of the Advisory Panel for the Francis J. Curry National Tuberculosis Center and National Commission on Correctional Health Care, 2003: *Corrections Tuberculosis Training and Education Resource Guide*

3/02-1/03 Member of the Advisory Committee to Develop the *Tuberculosis Control Plan for the Jail Setting: A Template (Jail Template)*, Francis J. Curry, National Tuberculosis Center

6/01-1/15 Director's Cabinet
San Francisco Department of Public Health

3/01 Consultant to Centers for Disease Control on the Prevention and Control of Infections with Hepatitis Viruses in Correctional Settings (MMWR 2003; 52(No. RR-1))

9/97-6/02 Member, Executive Committee of Medical Practice Group, San Francisco Department of Public Health

3/97-3/02 American Correctional Health Services Association Liaison with American Public Health Association

3/96-6/12 Chairperson, Bay Area Corrections Committee (on tuberculosis)

2/00-12/00 Medical Providers' Subcommittee of the Office-based Opiate Treatment Program, San Francisco Department of public Health

12/98-12/00 Associate Chairperson, Corrections Sub-Committee, California Tuberculosis Elimination Advisory Committee

7/94-7/96 Advisory Committee for the Control And Elimination of Tuberculosis, San Francisco Department of Public Health

6/93-6/95 Managed Care Clinical Implementation Committee, San Francisco Department of Public Health

2/92-2/96 Tuberculosis Control Task Force, San Francisco Department of Public Health

3/90-7/97 San Francisco General Hospital Blood Borne Pathogen Committee

1/93-7/93

Medical Staff Bylaws Committee, San Francisco Department of
Public Health

ACADEMIC APPOINTMENT

1980-2015 Assistant Clinical Professor
University of California, San Francisco

PROFESSIONAL AFFILIATIONS

Society of Correctional Physicians, Member of President's Council, Past-Treasurer and
Secretary
American Correctional Health Services Association, Past-President of California
Chapter
American Public Health Association, Jails and Prison's Subcommittee
Academy of Correctional Health Professionals

PROFESSIONAL PRESENTATIONS

Caring for the Inmate Health Population: A Public Health Imperative, Correctional Health
Care Leadership Institutes, July 2015
Correctional Medicine and Community Health, Society of Correctional Physicians Annual
Meeting, October, 2014
Identifying Pulmonary TB in Jails: A Roundtable Discussion, National Commission on
Correctional Health Care Annual Conference, October 31, 2006
A Community Health Approach to Correctional Health Care, Society of Correctional
Physicians, October 29, 2006
Prisoners the Unwanted and Underserved Population, Why Public Health Should Be in Jail,
San Francisco General Hospital Medical Center, Medical Grand Rounds, 10/12/04
TB in Jail: A Contact Investigation Course, Legal and Administrative Responsibilities, Francis
J. Curry National Tuberculosis Center, 10/7/04
Public Health and Correctional Medicine, American Public Health Association Annual
Conference, 11/19/2003
Hepatitis in Corrections, CA/NV Chapter, American Correctional Health Services
Association Annual Meeting, 1/17/02
Correctional Medicine, San Francisco General Hospital Medical Center, Medical Grand
Rounds, 12/16/02
SuperMax Prisons, American Public Health Association Annual Conference, 11/8/01
Chronic Care Programs in Corrections, CA/NV Chapter, American Correctional Health
Services Association Annual Meeting, 9/19/02
Tuberculosis in Corrections - Continuity of Care, California Tuberculosis Controllers
Association Spring Conference, 5/12/98
HIV Care Incarcerated in Incarcerated Populations, UCSF Clinical Care of the AIDS Patient
Conference, 12/5/97
Tuberculosis in Correctional Facilities, Pennsylvania AIDS Education and Training Center,
3/25/93

Tuberculosis Control in Jails, AIDS and Prison Conference, 10/15/93

The Interface of Public Health and Correctional Health Care, American Public Health Association Annual Meeting, 10/26/93

HIV Education for Correctional Health Care Workers, American Public Health Association Annual Meeting, 10/26/93

PUBLICATIONS

Structure and Administration of a Jail Medical Program. Correctional Health Care: Practice, Administration, and Law. Kingston, NJ: Civic Research Institute. 2017.

Structure and Administration of a Jail Medical Program – Part II. Correctional Health Care Report. Volume 16, No. 2, January-February 2015.

Structure and Administration of a Jail Medical Program – Part I. Correctional Health Care Report. Volume 16, No. 1, November-December 2014.

Pain Behind Bars: The Epidemiology of Pain in Older Jail Inmates in a County Jail. Journal of Palliative Medicine. 09/2014; DOI: 10.1089/jpm.2014.0160

Older jail inmates and community acute care use. Am J Public Health. 2014 Sep; 104(9):1728-33.

Correctional Health Care Must be Recognized as an Integral Part of the Public Health Sector, Sexually Transmitted Diseases, February Supplement 2009, Vol. 36, No. 2, p.S3-S4

Use of sentinel surveillance and geographic information systems to monitor trends in HIV prevalence, incidence, and related risk behavior among women undergoing syphilis screening in a jail setting. Journal of Urban Health 10/2008; 86(1):79-92.

Discharge Planning and Continuity of Health Care: Findings From the San Francisco County Jail, American Journal of Public Health, 98:2182–2184, 2008

Public Health Behind Bars, Deputy Editor, Springer, 2007

Diabetes Care in the San Francisco County Jail, American Journal of Public Health, 96:1571-73, 2006

Clinical Practice in Correctional Medicine, 2nd Edition, Associate Editor, Mosby, 2006.

Tuberculosis in the Correctional Facility, Mark Lobato, MD and Joe Goldenson, MD, Clinical Practice in Correctional Medicine, 2nd Edition, Mosby, 2006.

Incidence of TB in inmates with latent TB infection: 5-year follow-up. American Journal of Preventive Medicine. 11/2005; 29(4):295-301.

Cancer Screening Among Jail Inmates: Frequency, Knowledge, and Willingness Am J Public Health. 2005 October; 95(10): 1781–1787

Improving tuberculosis therapy completion after jail: translation of research to practice. Health Education Research. 05/2005; 20(2):163-74.

Incidence of TB in Inmates with Latent TB Infection, 5-Year Follow-up, American Journal of Preventive Medicine, 29(4), 2005

Prevention and Control of Infections with Hepatitis Viruses in Correctional Settings, Morbidity and Mortality Reports, (External Consultant to Centers for Disease Control), Vol. 52/No. RR-1 January 24, 2003

Randomized Controlled Trial of Interventions to Improve Follow-up for Latent

Tuberculosis Infection After Release from Jail, Archives of Internal Medicine, 162:1044-1050, 2002

Jail Inmates and HIV care: provision of antiretroviral therapy and Pneumocystis carinii pneumonia prophylaxis, International Journal of STD & AIDS; 12: 380-385, 2001

Tuberculosis Prevalence in an urban jail: 1994 and 1998, International Journal of Tuberculosis Lung Disease, 5(5):400-404, 2001

Screening for Tuberculosis in Jail and Clinic Follow-up after Release, American Journal of Public Health, 88(2):223-226, 1998

A Clinical Trial of a Financial Incentive to Go to the Tuberculosis Clinic for Isoniazid after Release from Jail, International Journal of Tuberculosis Lung Disease, 2(6):506-512, 1998

AWARDS

Armond Start Award of Excellence, Society of Correctional Physicians, 2014

Award of Honor, San Francisco Board of Supervisors, 2014

Award of Honor, San Francisco Health Commission, 2014

Certificate of Appreciation, San Francisco Public Defender's Office, 2014

Certificate for Excellence in Teaching, California Department of Health Services, 2002

Employee Recognition Award, San Francisco Health Commission, July 2000

Public Managerial Excellence Award, Certificate of Merit, San Francisco, 1997

LICENSURE AND CERTIFICATION

Medical Board of California, Certificate #A32488

Fellow, Society of Correctional Physicians

Board Certified in Family Practice, 1979-1986 (Currently Board Eligible)