Index

COMMONWEALTH OF MASSACHUSETTS
SUPREME JUDICIAL COURT

Suffolk, ss. No. SJ-2020-0115

COMMITTEE FOR PUBLIC COUNSEL SERVICES and
MASSACHUSETTS ASSOCIATION OF
CRIMINAL DEFENSE LAWYERS,
Petitioners,

v.

CHIEF JUSTICE OF THE TRIAL COURT,
Respondent.

AFFIDAVIT OF AMY M. BELGER

I, Amy M. Belger, state the following to be true to the best of my knowledge, information and belief:

1) I am an attorney admitted to practice before the Courts of this State, and I represent indigent clients currently incarcerated in Department of Correction facilities throughout the Commonwealth.

2) I am informed by a client held in MCI-Norfolk that the 4-1 Housing Unit has been in lockdown this week awaiting the results of testing done to determine whether an inmate housed in that unit, who is now held in quarantine, is infected with the COVID-19 virus. The inmate has exhibited symptoms of illness that are consistent with symptoms exhibited by those who are currently infected with the COVID-19 virus.

3) I am further informed that the inmate under quarantine as described in ¶2 was out in the prison yard last week, with his shirt off, playing soccer with at least 20 other inmates, all of which live in numerous different housing units throughout MCI-Norfolk.

4) I am further informed that as of today, MCI-Norfolk inmates have unrestricted access to the prison yard and are allowed to play whatever close contact sports they wish to play, including basketball and soccer, and inmates from all of the different housing units comingle for these sports games. Inmates also continue to congregate in the yard in close proximity to each other, without any official directives from staff regarding the need to social distance.

5) I am further informed that every-other-day cleaning of the MCI-Norfolk prison environment consists of a staff member, and three inmates who have prison jobs,

walking through the common areas and spraying a cleaning formula. It is then left up to the inmates who do not work for the prison to physically scrub or wipe the sprayed areas with whatever they can find. There are no supplies distributed for this task.

6) I am further informed that there are hand sanitizer dispenser stations located in front of the field offices inside of MCI-Norfolk. However, those hand sanitizer dispensers are frequently empty, and even when filled, the sanitizer product contained therein does not contain alcohol. When inmates ask that empty dispensers be refilled, they are at times informed that there are no supplies available to refill the dispensers.

7) I am further informed that every Thursday, each inmate in MCI-Norfolk is provided with one bar of soap and one roll of toilet paper for the week. This provision practice was in place prior to the COVID-19 pandemic, and it has not been modified since the pandemic has happened, despite repeated and numerous requests by the inmates to staff for additional sanitary and cleaning supplies. Inmates are told that additional supplies are not available.

8) I am further informed by a client at the Massachusetts Treatment Center that he is locked into a cell with five other inmates amid an outbreak of the COVID-19 virus within the inmate population of the prison. Multiple cellmates of his are visibly ill, and they are not being tested or given any medical attention to diagnose what illnesses they may have. The size of the cell that the client is confined in with five other men, without the ability to leave other than to use the telephone, was described to me as "about three times the size of the room that you and I meet in." Based upon that information, I estimate that the size of the cell housing six adult males under the conditions as described, is roughly 36' x 24'.

9) I am further informed by a client incarcerated in MCI-Concord that the inmates are forced to eat all of their meals in the chow hall, which is a community area that serves three meals a day to the entire prison population. Inmates incarcerated in MCI-Concord are not permitted to take their meals in their cells if they wish to avoid contact with others in light of the COVID-19 pandemic. Instead, if they need to eat, MCI-Concord inmates are forced to sit elbow-to-elbow in the chow hall in close proximity one another.

10) I am further informed by a client incarcerated at the North Central Correctional Institution at Gardner ("NCCI") that although the inmates were told that they would be receiving hand sanitizer for personal use to safeguard against infection with the COVID-19 virus, no hand sanitizer has been provided to the NCCI inmates.

11) I am further informed that NCCI inmates are being housed in housing units with thirty men in a unit, and my client informs me that many of the men in his housing unit are elderly. The housing units are organized into two-man cells; two men are

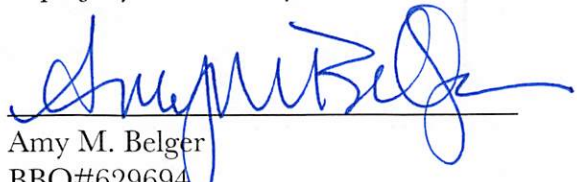
confined together in cells so small that they cannot stand side-by-side without touching each other. My client describes his cell to be "the size of a closet out there."

12) I am further informed that NCCI inmates are forced to eat "elbow-to-elbow" in the chow hall. They are not permitted to keep personal distance from each other in the chow hall, although they are aware of the six-foot social distancing health precaution that is being urged on all citizens of the Commonwealth.

13) I further state that the information to follow is a true copy of a message sent to me via electronic mail by a client that is currently incarcerated in the Souza Baranowski Correctional Center:

> *"The virus situation is not being dealt with well in here, and i feel like this population are very much sitting ducks. Almost no measures are being taken in here to protect us concretely on the units: there is zero education about the virus and precautions that should be taken, there is no hand sanitizer being issued for inmates to use, there are no hygiene and disinfecting cleaning protocols being carried out on the units (e.g. wiping down with disinfectant all publicly touched surfaces multiple times per day, maybe even issuing N-95 masks, etc.) , kitchen inmates who have come in contact with infected kitchen C.O. (c.o. was sent home) were then sent back to my unit and just walk around socializing like nothing happened!? This is really unbelievable, because if nothing happened, then why was the infected C.O. sent home (rhetorical question)?! This population is at particularly high risk, not least because we live right on top of each other.*
>
> *I'm asserting that even in this setting of prison, much much more can, should, and must be done. A useless memo from the commissioner was posted (dated 3.20.20), riddled with lies (e.g. that we get hand sanitizer and disinfecting protocols are being carried out on the units, and a covid-19 pamphlet was distributed for education, etc.), and useless advice such as "don't fist bump or shake hands", "if you feel anxious about the disease put in a sick slip to talk to mental-health" (who aren't even here!?), etc.!? Please let someone know."*

Signed under the pains and penalties of perjury this 25th day of March, 2020.



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COMMONWEALTH OF MASSACHUSETTS
SUPREME JUDICIAL COURT

Suffolk, ss. SJC-12926

COMMITTEE FOR PUBLIC COUNSEL SERVICES and
MASSACHUSETTS ASSOCIATION OF
CRIMINAL DEFENSE LAWYERS,
Petitioners,

v.

CHIEF JUSTICE OF THE TRIAL COURT,
Respondent.

AFFIDAVIT OF CARRIE BURKE

I, Carrie Burke, state the following to be true to the best of my knowledge, information and belief:

1. I am the Director of Social Services Advocacy for the Public Defender Division of the Committee for Public Counsel Services (CPCS). As Director of Social Services Advocacy, I oversee all operations and functions of the Social Services Advocates (SSAs) in this division, including but not limited to: engaging in upper management decision making and policy-setting, providing direct supervision and training to SSA Supervisors and staff SSAs, and assisting CPCS's General Counsel with legislative and policy advocacy on behalf of CPCS. I have been in this role since December 2019. Prior to that time, I was a Supervising SSA for 7 years, and an SSA in the Boston office for 2 years. In total I have been employed by CPCS for 10.5 years. I am a Licensed Independent Clinical Social Worker in good standing in the State of Massachusetts. I received a Masters' Degree in Social Work from Boston College School of Social Work.

2. First, it is worth stating clearly that many of our clients who are incarcerated have available housing and community supports already in place for when they are released. Based on my experience working with

incarcerated clients, the belief that our prisons and jails are overwhelmingly filled with individuals who are without meaningful support from or ties to the communities that they lived in prior to their incarceration is inaccurate. The great majority of CPCS's incarcerated clients have families, friends, and community ties that provide viable support to them upon their release, and are not referred to SSAs. SSA support is sought primarily for and provided to those who demonstrate the highest need—who do not otherwise have supports already in place through their own networks.

3. Second, for those who do require assistance, numerous services are available to help released individuals continue to receive substantive use disorder and mental health services upon release:

    a. Substance use disorder services

        i. Individuals who are receiving medication-assisted treatment (MAT) or who wish to begin MAT are still able to access this medication MAT upon release. During this national emergency, the Substance Abuse and Mental Health Services Administration (SAMSHA) has exercised its authority to exempt in-person physical evaluation before a practitioner can prescribe buprenorphine (Suboxone) maintenance treatment to a new patient; instead, such prescriptions can now be provided via telehealth. BMC-OBAT is available to help provide buprenorphine prescriptions to individuals upon release and to connect individuals to local prescribers. With respect to methadone, the state and federal government have taken several steps to increase ease of access to this medication during the national emergency. Governor Baker's March 23, 2020 order designated Office Treatment Programs (OTPs), which provide methadone treatment, as essential services that "shall continue to operate brick and mortar facilities during this two-week time period."[1] The Bureau of Substance Addiction Services (BSAS) has informed all state OTPs that, "OTPs must continue admitting new patients."[2] Although new patients cannot begin methadone treatment without a physical evaluation, SAMHSA has approved

[1] See https://www.mass.gov/doc/covid-19-essential-services/download.

[2] See https://www.abhmass.org/images/msdp/annoucements/COVID-19/COVID-19-OTP-BSAS_guidance_FINAL_31820201.pdf

telemedicine to treat existing patients once they begin receiving methadone.[3] Based on a request by BSAS, SAMHSA has also allowed take home dosing of methadone of up to 14 and 28 days in certain circumstances.[4]

ii. While it is true that many residential treatment services are not currently admitting new patients, it should be noted that many individuals with substance use disorder do not require residential level care, and can be well served by outpatient providers. As with any clinical care, the level of treatment should be matched with the individual client need. Furthermore, some residential programs *are* continuing to accept referrals and admit new patients based on bed availability, and with additional screening. To my knowledge these services include, but may not be limited to, Recovery Centers of America, Spectrum Programming, Spectrum Young Adult Program, and Victory/New Victories. Detox centers remain available to those in need of detox support. AdCare Hospital is also admitting new clients for detox-only residential treatment. Additional programs continue to accept referrals, subject to varying waitlists, including Shiloh House, Wyman Reentry, Dimock Women's Renewal, Bridge House, Steps 2 Solutions, Men's Hello House, and Pathways.

iii. Moreover, outpatient treatment services remain available, either on a one-to-one basis or through telehealth (groups have been suspended at this time). To my knowledge thus far, some of these programs include AdCare Boston, AdCare Quincy, AdCare Worcester, Arbour Green Street, Spectrum Health Services, The Counseling and Psychotherapy Center, and NFI. In Western Mass., available providers include ServiceNet and Center for Human Development (CHD), which offer individual therapy by phone or video call, and Clinical Support Options (CSO), offering telehealth services in addition to its crisis and respite services which remain open.

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[3] See https://www.samhsa.gov/sites/default/files/faqs-for-oud-prescribing-and-dispensing.pdf.

[4] See https://www.abhmass.org/images/msdp/annoucements/COVID-19/COVID-19-OTP-BSAS_guidance_FINAL_31820201.pdf.

b. Mental health services:

i. Individual outpatient therapy and telecounseling remain active and accessible services. Available providers include Arbour Green Street, NFI, Spectrum, The Counseling and Psychotherapy Center, ServiceNet, CHD, and CSO (as described in more detail above).

c. Other resources:

i. Many more services have been made available on-line to promote safe access during this public health crisis. Such services include online AA and NA meetings and online recovery meetings through SMART Recovery, Everyday Miracles, and The Recovery Project.

ii. PAATHS, the triage and referral service operated by the Boston Public Health Commission is still in operation during the day at Boston Medical Center, as is the Department of Public Health's Bureau of Substance and Alcohol Services (BSAS) helpline. Both of these organizations can assist individuals in locating available treatment in their area.

d. Comparative services in custody:

i. Finally, if concerns about available services in the community weigh against a person's release, the above-named services must be considered against the backdrop of what services are, and are *not*, currently available for clients who remain in custody.

ii. Only seven county facilities and three DOC correctional facilities currently provide MAT to incarcerated individuals. Other services in prisons and jails, like counterpart services in the community, are facing reductions based on the COVID-19 pandemic: there has been a substantial reduction in contract staff and caseworker staff, who traditionally provide

these services to the incarcerated population. That resources are strained all-around is simply a reality of the current crisis. In light of this, and in light of the known dangers of COVID-19 exposure in carceral environments, general concerns about access to treatment should not serve as the reason for keeping individuals incarcerated and at greater risk of potentially lethal exposure.

4. Third, services are available to assist released individuals to find safe and available shelter.

    a. Available shelters:

        i. Although some shelters are at strained capacity and are no longer accepting new guests, other shelters are maintaining operations and accommodating new guests when they are able to.

        ii. The following is a non-exhaustive list of shelters that are maintaining operations and accommodating new guests as they have space available: Pine St. Inn, Southampton St. Shelter, Woods Mullen Shelter (all in Boston), Father Bill's and Mainspring (Brockton), LifeBridge Salem, Lowell Transitional Living Center, Net of Compassion (Worcester), Sister Rose Shelter (New Bedford), Springfield Rescue Mission Shelter, and the Wellspring Warming Center (Springfield). These shelters are also implementing various protocols to limit spread of the virus, including increased cleaning in high touch areas, set staff rotations, bagged meals, and handwashing and sanitizer stations. Net of Compassion in Worcester, for example, is observing social distancing within three new shelter spaces with daily medical checks on site; it also plans to open a fourth shelter to offer more specialized care to guests who are symptomatic and positive for COVID-19 and will have a doctor present 24 hours a day.

        iii. Spaces are also being considered and repurposed to provide additional shelter and appropriate resources. The state-owned Newton Pavilion is being specifically repurposed to provide up to 250 beds for individuals lacking permanent residences

who are in need of COVID-19 related quarantine, and the City of Springfield is considering utilizing its Armory Building as a potential day center.

iv. Although currently unspecified publicly, MEMA (Massachusetts Emergency Management Administration) is in the process of identifying additional shelter and quarantine locations for individuals experiencing homelessness across the state.

b. Homelessness support services:

i. Additional organizations who serve this population have taken substantial steps to address virus-related needs. For example, Boston's Health Care for the Homeless Program has significantly ramped up operations in response to the pandemic. Currently, the organization is screening individuals at shelter entrances to identify people with potential positive diagnoses, operating three testing tents at large-volume sites, operating a newly-converted wing of its respite program as an isolation unit, operating two, 24/7 medical tents, operating a 24/7 hotline and mobile field service, and preparing for a shortage in personal protective equipment by creating a homemade prototype based on hospital models. The City of Worcester is also offering a 24-7 COVID-19 hotline, and Net of Compassion is offering 24-hour health screening at shelter sites.

c. Comparative housing in custody:

i. As evidenced at the Rikers Island facility in New York, where in less than one week, infections exploded from 1 prisoner to 52 (with an additional 96 waiting for testing as of March 25th) jails and houses of corrections are potentially disastrous settings for the spread of coronavirus.

ii. Preventing spread of coronavirus within a carceral setting depends on the individual sheriff's department's or correctional organization's ability to provide testing, social distancing, cleaning, hygiene products, and quarantine to

individuals who by design do not have the ability to exercise personal choice in movement or hygiene practices. Reports gathered from inmates in Massachusetts to date suggest that safety measures put in place inside correctional facilities are inconsistent at best.

iii. While not a perfect alternative to a carceral setting, shelters may be able to offer more flexibility for individuals in spacing in living quarters, more access to cleaning and hygiene, and access to medical services and testing; more importantly, the people staying in shelter can choose to relocate or enter into shelter quarantine if conditions become hazardous.

Signed under the pains and penalties of perjury this 30th day of March, 2020.

_____ _____

Carrie Burke, LICSW

COMMONWEALTH OF MASSACHUSETTS
SUPREME JUDICIAL COURT

Suffolk, ss. No. SJ-2020-0115

COMMITTEE FOR PUBLIC COUNSEL SERVICES and
MASSACHUSETTS ASSOCIATION OF
CRIMINAL DEFENSE LAWYERS,
Petitioners,

v.

CHIEF JUSTICE OF THE TRIAL COURT,
Respondent.

AFFIDAVIT OF OLIVIA DUBOIS

I, Olivia Dubois, state the following to be true to the best of my knowledge, information and belief:

1. I am a Social Service Advocate with the Roxbury Defenders unit of the Committee for Public Counsel Services. I work as part of legal defense teams to represent adults charged with misdemeanor and felony offenses in the Roxbury, Dorchester, and West Roxbury divisions of the BMC and Suffolk Superior Court.

2. On March 25, 2020, I attempted to meet with three of my clients at the Suffolk County Jail. Two of the clients are housed in general population and one client is housed in the medically assisted treatment unit.

4. Each client I met with reported very poor opportunities for hygiene and sanitation at the jail. For example, none of my clients had access to hand sanitizer or cleaning products, and their requests to obtain soap by filling out indigency forms to waive otherwise required fees were ignored. Only one of the three individuals had occasional access to paper towels; there was no access to paper towels by the other two individuals.

4. My clients who are housed in general population also noted that there is insufficient room in their unit, which houses roughly sixty people, to maintain safe social distance from one another. They noted that they congregate as per usual for recreational time, meals, and to stand in a line to obtain prescription medication. Two clients told me that they are forced to sit directly next to one another during meal-times because there are insufficient seats to space themselves out further.

5. My client on the medically assisted treatment unit told me that he is required to sit directly next to other inmates, in a group of approximately ten people, to receive Suboxone from a nurse. Neither medical nor correctional staff on the medically assisted treatment unit are wearing gloves or masks.

6. I was told by one of my clients that a correctional officer on his unit has not been at work since March 13, when he was observed by my client to be coughing up blood.

7. Based on my interviews with clients, I believe that groups of more than ten people are routinely being forced to congregate in confined spaces at jail. From my own observation, correctional officers at the facility are not consistently wearing masks and gloves when interfacing with the public or the inmates.

8. I have also corresponded via email with a family member of a client who is housed in the medical unit. Because of his diagnosis, my client is immuno-compromised and extremely vulnerable. His relative indicated to me in an email dated March 25, 2020, that neither he nor the other individuals on the unit are given access to hand sanitizer or hand sanitizer wipes and they are all forced to touch the same soap dispenser and shower. Like my other clients, he reported to his relative, who relayed to me, that large groups of people are regularly congregating in close quarters, making it impossible to maintain the recommended social distance. He worries that new inmates coming into the unit appear not to be initially quarantined.

Signed under the pains and penalties of perjury this 25th day of March, 2020:

/s/ *Olivia Dubois*

Olivia Dubois
Committee for Public Counsel Services
7 Palmer Street, Suite 302
Roxbury, MA 02119

COMMONWEALTH OF MASSACHUSETTS
SUPREME JUDICIAL COURT

Suffolk, ss. SJC-12926

COMMITTEE FOR PUBLIC COUNSEL SERVICES and
MASSACHUSETTS ASSOCIATION OF
CRIMINAL DEFENSE LAWYERS,
Petitioners,

v.

CHIEF JUSTICE OF THE TRIAL COURT and others,
Respondents.

AFFIDAVIT OF DR. JONATHAN GIFTOS

I, Dr. Jonathan Giftos, state that the following is a true and accurate statement to the best of my knowledge and belief:

1. I am a doctor duly licensed to practice medicine in the State of New York. I am board certified in internal medicine and addiction medicine. I received my Bachelor of Science degree from Boston College, and my Medical Degree from Mount Sinai School of Medicine

2. I am currently the Medical Director of Addiction Medicine & Drug User Health at Project Renewal and a Clinical Assistant Professor in the Department of Medicine at Albert Einstein College of Medicine.

3. Between August 2016 and January 2020, I was an Attending Physician and the Clinical Director of Substance Use Treatment for NYC Health & Hospitals, Division of Correctional Health Services at Rikers Island. During this time, I provided primary medical care to detainees and sentenced patients, and supervised the nation's oldest and largest jail-based opioid treatment program. I successfully led an effort to remove non-clinical barriers to opioid treatment program enrollment in 2017, which dramatically expanded treatment access from 25% to over 80%, while also reducing post-release mortality for people with opioid use disorder.

4. Based on four years of providing medical care at Rikers Island, I know that correctional settings increase the risk of contracting an infectious disease like COVID-19. This is because there are high numbers of people with chronic, often untreated, illnesses housed in a setting with minimal levels of sanitation, limited access to personal hygiene, limited access to medical care, and no possibility of staying at a distance from others. Correctional facilities house large groups of

inmates together, and move inmates in groups to eat and recreate. They frequently have insufficient medical care for the population, and, in times of crisis, even those medical staff cease coming to the facility. As a result, there are more people susceptible to getting infected congregated together in a context in which fighting the spread of an infection is nearly impossible.

5. Indeed, outbreaks of the flu regularly occur in jails, and during the H1N1 epidemic in 2009, many jails and prisons dealt with high numbers of cases.[1]

6. My time at Rikers Island also exposed me to the limitations of correctional health care. Similar to an outpatient primary care clinic, correctional health care is designed to provide urgent care for ailments that are non-life threatening. It is not capable of providing the type of care one receives in a hospital, let alone in an intensive care unit. As a result, when an incarcerated person requires hospitalization or intensive care, they are transferred to a hospital in the community. During my time at Rikers Island, we routinely transferred incarcerated people to community hospitals to receive care that we could not provide at the facility.

7. During the COVID-19 pandemic, these limitations in correctional health care have important public health implications not just for incarcerated populations, but for the general population as well.

8. According to the most recent estimates, at least 15% of people who contract COVID-19 will require hospitalization, and %5 will require intensive care. Based on the vulnerability of the incarcerated population, it is likely that these numbers would be at least as high, if not higher, within a correctional setting.

9. A person who contracts COVID-19 in jail or prison and requires hospitalization will need to be transferred to a community hospital. As a result, the problem of a prison outbreak of COVID-19 infections cannot and will not be contained within the institution itself. Instead, it will explode into the community, increasing the pressure on our already taxed community hospitals.

10. Even at baseline, ICU beds and ventilators in our community hospitals are a scarce commodity. A recent analysis by the Harvard Global Health Institute indicates that under most scenarios, "vast communities in America are not prepared to take care of the COVID-19 patients" that require hospital care.[2] An outbreak of COVID-19 at a jail or prison, which would likely require numerous transfers to a community hospital, could push a hospital even further past its breaking point. Specifically, a surge in COVID-19 infections in a correctional setting could mean that ICU beds in the community hospital would no longer be available to everyone who needed them.

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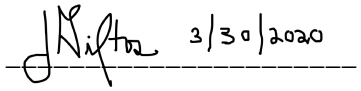
[1] See *Prisons and Jails are Vulnerable to COVID-19 Outbreaks*, The Verge (Mar. 7, 2020), https://bit.ly/2TNcNZY.

[2] https://projects.propublica.org/graphics/covid-hospitals

11. Correctional settings are not equipped to keep people safe during this pandemic. There are too many structural limitations, and correctional health care can only do so much. Decreasing the incarcerated population so that there is more ability to physically distance within the facility and fewer people who can contract the virus inside the facility is the only way to prevent the complications from surging. Otherwise, the unchecked transmission of COVID-19 in jail or prison will have serious, and fatal, implications for the broader community.

12. Decreasing the incarcerated population will also decrease the necessary staffing for the facility. Reducing the number of needed correctional officers and healthcare workers will, in turn, reduce the number of people entering and exiting the facility on a daily basis. This too will reduce the spread of COVID-19 to the broader community.

Signed under the pains and penalties of perjury on March 30, 2020.



Jonathan Giftos, MD

CURRICULUM VITAE

Jonathan M. Giftos, MD, AAHIVS

Medical Director, Addiction Medicine & Drug User Health
Project Renewal, Inc.

BIOGRAPHICAL INFORMATION

Name:	Jonathan Matthew Giftos	Birth Date:	January 5th, 1981
Home Address:	415 9th Street, Apt 33, Brooklyn, NY 11215	Phone:	603-682-4543

EDUCATION AND TRAINING

EDUCATION

Mount Sinai School of Medicine — New York, NY — 2008 - 2012
Medical Degree, *Alpha Omega Alpha*

Boston College — Chestnut Hill, MA — 1999 - 2003
Bachelor of Science: Chemistry, *Cum laude*
Minor in Hispanic Studies

POSTGRADUATE

Montefiore Medical Center, Department of Internal Medicine — Bronx, NY — 2015 - 2016
Chief Resident, Primary Care & Social Internal Medicine

Montefiore Medical Center, Department of Internal Medicine — Bronx, NY — 2012 - 2015
Intern & Resident, Primary Care & Social Internal Medicine

CERTIFICATION & LICENSURE

Board Certified, Addiction Medicine (ABPM)	2020-2030
Credentialed as HIV Specialist, American Academy of HIV Medicine (AAHIVM)	2016 - Present
Board Certified, American Board of Internal Medicine (ABIM)	2015 - 2025
New York State Medical License # 276899	2018 - 2020
DEA Number + Buprenorphine waiver (X-number)	2017 - 2020

ACADEMIC APPOINTMENT

Clinical Assistant Professor of Medicine, Albert Einstein College of Medicine	2019 - Present
Instructor of Clinical Medicine, Albert Einstein College of Medicine	2016 - 2019

CLINICAL EXPERIENCE

MEDICAL DIRECTOR, Addiction Medicine & Drug User Health (January 2020 - Present)
Project Renewal, Inc. (3rd Street Clinic; OASAS Licensed Programs; Support & Connection Center)

- Clinical and administrative supervision of Project Renewal's OASAS-licensed programs (Part 816, 822)
- Primary Care & Addiction Medicine Physician at Project Renewal's FQHC at 3rd Street
- Addiction medicine physician at Project Renewal's Support & Connection Center in East Harlem

MEDICAL DIRECTOR, KEY EXTENDED ENTRY PROGRAM (OTP) (July 2017-January 2020)
NYC Health + Hospitals, Division of Correctional Health Services (Rikers Island)

- Clinical and administrative supervision of the nation's oldest, largest jail-based opioid treatment program
- Managed ongoing partnership with NYC MOCJ, DOHMH, DOCCS, DAs to optimize enrollment
- Managed ongoing QI initiatives related to various components of treatment program
- Piloted buprenorphine expansion project in the NYC jail-system

ATTENDING PHYSICIAN, CORRECTIONAL HEALTH SERVICE (August 2016-January 2020)
NYC Health + Hospitals, Division of Correctional Health Services (Rikers Island)

- Provided primary medical care to detainees and sentenced patients in NYC Jail System
- Managed acute opioid withdrawal; initiated & maintained patients on methadone & buprenorphine
- Manage patients with HIV and provide treatment for patients with chronic hepatitis C

ATTENDING PHYSICIAN, BRONX TRANSITIONS CLINIC (July 2015-July 2017)
Comprehensive Health Care Center, Montefiore Medical Center (Bronx, NY)

- Served as a Voluntary Preceptor supervising residents caring for formerly incarcerated patients

ATTENDING PHYSICIAN, ADULT MEDICINE PRACTICE (July 2015-June 2016)
Comprehensive Health Care Center, Montefiore Medical Center (Bronx, NY)

- Served as primary provider for > 350 patients at a Federally Qualified Community Health Center
- Worked as part of an interdisciplinary team caring for medically complex, underserved patients
- Served as chief-resident, which involved clinical oversight of resident physician practice

ATTENDING PHYSICIAN, INTERNAL MEDICINE SERVICE (April 2016)
Moses Division, Montefiore Medical Center (Bronx, NY)

- Served as ward attending on the inpatient teaching service for 2 weeks during chief year
- Led bedside rounds; supervised residents, interns, sub-interns and medical students

SUPERVISING PHYSICIAN, HUMAN RIGHTS CLINIC/HEALTHRIGHT INTERNATIONAL (July 2015-June 2016)
Comprehensive Health Care Center, Montefiore Medical Center (Bronx, NY)

- Supervised full spectrum of medical resident participation in Human Rights Clinic
- Authorized final medical affidavit submitted to courts on behalf of applicants for asylum

PHYSICIAN, HUMAN RIGHTS CLINIC/HEALTHRIGHT INTERNATIONAL (July 2012-June 2015)
Comprehensive Health Care Center, Montefiore Medical Center (Bronx, NY)

- Provided comprehensive clinical examinations for survivors of torture
- Wrote medical affidavits and testified on behalf of applicants for asylum

PHYSICIAN, INPATIENT MEDICAL SERVICE (October 2014)
Kisoro District Hospital, Doctors for Global Health (Kisoro, Uganda).

- Provided inpatient medical care for the emergency ward and male ward at rural hospital
- Provided outpatient medical care and supervised medical students at continuity clinic
- Received extensive training in Tropical Medicine through Montefiore's Global Health course

HONORS AND AWARDS

Compassionate Care Aware, NY Harm Reduction Educators (NYHRE) Annual Gala	2018
Honoree, Voices of Community Activists & Leaders (VOCAL) Annual Gala	2017
Arnold P. Gold Foundation, Presidential Level Grant ($3,500) to fund Harvard Macy Institute Proposal	2013
Bechtel Geriatrics Scholarship Award Summit, University of California San Francisco (UCSF)	2013
Ellen Parker Memorial Award for Outstanding Community Service in Geriatrics	2012
Alpha Omega Alpha (AOA) Honor Society, Lambda Chapter, Mount Sinai School of Medicine	2012
Gold Humanism Honor Society, Mount Sinai School of Medicine	2012
The “Art of Medicine” Award, Mount Sinai School of Medicine	2011
Rocco D. LaPenta Medical Scholar (2009-2012), Mount Sinai School of Medicine	2009
James Freed Alumni Merit Scholar, Mount Sinai School of Medicine	2008
Joseph R. Stanton, M.D. Boston College Commencement Award	2003
Romance Language Book Award for Most Improved Student in Spanish, Boston College	2002

PROFESSIONAL ASSOCIATIONS

Association for Medical Education and Research in Substance Abuse (AMERSA)	2017 - Present
American Academy of HIV Medicine (AAHIVM)	2016 - Present
Society of General Internal Medicine (SGIM)	2011 - Present

PUBLICATIONS & PRESENTATIONS

BOOKS / BOOK CHAPTERS

1. Fox, AD, Jakubowski, A, **Giftos, JM.** ‘Enhancing Treatment Access and Effectiveness: Toward Patient-Centered Models of Care’, in Wakeman, SE, Kelly, JF (editors) *Treating Opioid Addiction*, In Press.

PEER REVIEWED PUBLICATIONS

1. Velasquez M, Flannery, M, Badolato, R, Vittitow, A, McDonald, RD, Tofighi, B, Garment, AR, **Giftos, JM**, Lee, JD. Perceptions of extended-release naltrexone, methadone, and buprenorphine treatments following release from jail. *Addiction Science & Clinical Practice,* Volume 14, Article number: 37 (2019)

2. **Giftos JM,** Mitchell A, MacDonald, RF. *Medicine & Mass Incarceration: Education and Advocacy in the NYC Jail System.* American Medical Association, Journal of Ethics. September 2017.

3. Bloom-Feshbach K., Casey D, Schulson L, Gliatto P, **Giftos JM** and Karani R. *Health Literacy in Transitions of Care: An Innovative Objective Structured Clinical Examination for Fourth-Year Medical Students in an Internship Preparation Course*. Journal of General Internal Medicine. Oct 2015. pp 1-5.

4. McKee MD, Fletcher J, Schechter C, **Giftos JM**, Sigal I, Walker E. *A Collaborative Approach to Control Hypertension in Diabetes: Outcomes of a Pilot Intervention.* Journal of Primary Care & Community Health.

NON-PEER REVIEWED PUBLICATIONS

1. **Giftos JM,** Tesema, L**.** *When Less is More: Reforming the Criminal Justice Response to the Opioid Epidemic.* ABA Judges Journal. 2018.

2. **Giftos JM**. *Community Health Workers: Key to Reducing Disparities in End-of-Life Care.* GeriPal.org, Sept 2013

ABSTRACTS (oral and poster)

1. **Giftos JM,** Kaba F, Johnson CJ, MacDonald RF. *Jail-Based Initiation of Buprenorphine/Naloxone Treatment for Patients with Opioid Use Disorders.* Oral Abstract, AMERSA Annual National Conference. November 2017.’

2. **Giftos JM,** Macdonald, RF, Stein, MR, Fox AD. *Caring for Formerly Incarcerated Patients: A Longitudinal Curriculum with OSCE.* Poster presented at the Innovations in Medical Education poster session. Society of General Internal Medicine Annual Conference 2016.

3. **Giftos JM,** Safo, SA. *The Cortisol Conundrum: Iatrogenic Cushing Syndrome in an HIV-positive Patient.* Clinical vignette presented as poster at Society of General Internal Medicine Annual Conference 2015. Toronto, Canada.

4. **Giftos JM.** MacDonald RF, Venters HD. *Beyond Compassionate Release: Health-based Advocacy in the Jail System.* Presented oral abstract at American Public Health Association Conference 2014. New Orleans, LA.

PROFESSIONAL ACTIVITIES: INVITED LECTURES, WORKSHOPS, AND SEMINARS

1. NYU Center for Opioid Epidemiology &Policy Launch Event. Invited Panelist. (June 2019)

2. Opioid Overdose Prevention Summit. Bronx DA's Office. Invited Panelist (May 2019)

3. "Reducing Harms of Reentry for Patients with Opioid Use DIsorder", presented as grand rounds at the Department of Family Medicine, Icahn School of Medicine at Mount Sinai (October 2018).

4. "Substance Use & Incarceration", presented as grand rounds at the Project for Psychiatric Outreach to the Homeless (PPOH), Janian Healthcare, Center for Urban & Community Solutions (October 2018).

5. "Reducing Harms of Reentry for Patients with Opioid Use DIsorder", presented at Primary Care & the Opioid Crisis Conference, Icahn School of Medicine at Mount Sinai (September 2018).

6. "Reducing Harms of Reentry for Patients with Opioid Use DIsorder", presented at NYC Health + Hospitals, Office-Based Addiction Treatment ECHO (June 2018).

7. "Reducing Harms of Reentry for Patients with Opioid Use DIsorder", presented at Massachusetts Office-Based Addiction Treatment ECHO (March 2018).

8. "Evidence Based Treatment for Opioid Use Disorder", NYC Rx Stat Collaborative (January 2018)

9. "Why Incarceration Matters for Medical Carer", presented as grand rounds at the Division of General Internal Medicine, Icahn School of Medicine at Mount Sinai (June 2017).

10. "Everywhere But Safe", Film Screening and Panelist, CUNY School of Public Health (May 2017)

11. "Dual Loyalty Workshop: Solitary Confinement", Workshop Facilitation, In-Focus Course, Icahn School of Medicine at Mount Sinai (October 2016)

12. "Optimizing End-of-Life Care for Vulnerable Populations", Bechtel Geriatrics Scholarship Award Summit. University of California San Francisco (June 2013)

13. Medical Education Scholarship Dinner. Keynote Speaker. Icahn School of Medicine at Mount Sinai (May 2012)

PROFESSIONAL ACTIVITIES: INSTITUTIONAL LEADERSHIP

Board of Directors, St. Ann's Corner of Harm Reduction	2016 to 2019
NY Health Professionals for Safe Consumption Spaces, Founder	2016 to Present
Chief Resident, Primary Care & Social Medicine, Montefiore Medical Center	2015 - 2016
President, Alpha Omega Alpha Lambda Chapter, Mount Sinai School of Medicine	2011 - 2012
Promotions Committee, Elected Student Representative, Mount Sinai School of Medicine	2011 - 2012
Admissions Committee, Student Representative, Mount Sinai School of Medicine	2011 - 2012
Students as Patient and Community Educators (SPACE), Co-leader	2011 - 2012
Primary Care Interest Group, Founder and President	2009 - 2010

PROFESSIONAL ACTIVITIES: TEACHING & EDUCATIONAL SCHOLARSHIP

1. **Director of Clinical Education**, Correctional Health Services; NYC Health + Hospitals (2016-2017)
- I developed curriculum to support educational goals of medical students, residents and attendings caring for patients affected by the criminal justice system.
- Support addiction service by training providers and addiction counselors in harm reduction and medication for addiction treatment, specifically buprenorphine and methadone maintenance.

2. **Chief Resident**, Primary Care & Social Internal Medicine Residency Program (2015-2016)
- Served as chief resident for the Primary Care & Social Internal Medicine track of IM residency program
- Scheduled and coordinated ambulatory clinic experience for 30 primary care residents
- Facilitated delivery of a complex curriculum that included didactics, journal clubs, seminars, observed clinical encounters, specialty clinics and community based experiences.

3. **Participant**, Harvard Macy Institute Program for Postgraduate Trainees (2014)
- Participated in 3 day long intensive course to build skills as a clinician educator
- Workshop Project: Improving Resident Communication w/ Seriously Ill Patients and their Families.

4. **Co-Director**, Students as Patient & Community Educators (SPACE); Mount Sinai School of Medicine (2011-2012)
- Spearheaded institutional effort to expand health literacy education at Mount Sinai School of Medicine.

PROFESSIONAL ACTIVITIES: Consulting & Expert Testimony

Bronx Defenders
Brooklyn Defenders
Legal Aid Society of New York
Civil Rights Clinic, Benjamin N. Cardozo School of Law
Drug Policy Alliance
Just Leadership
New York State Department of Health
Pelican Bay Class Action Lawsuit
Physicians for Human Rights
Seth Freed Wessler (investigative journalist)
VERA Institute of Justice
Voices of Community Activists & Leaders (VOCAL)

LANGUAGES

English (fluent, native)
Spanish (fluent, non-native)

COMMONWEALTH OF MASSACHUSETTS
SUPREME JUDICIAL COURT

Suffolk, ss. No. SJC-12926

COMMITTEE FOR PUBLIC COUNSEL SERVICES and
MASSACHUSETTS ASSOCIATION OF
CRIMINAL DEFENSE LAWYERS,
Petitioners,

v.

CHIEF JUSTICE OF THE TRIAL COURT, and others,
Respondents.

AFFIDAVIT OF REBECCA KILEY

I, Rebecca Kiley, state the following to be true to the best of my knowledge, information and belief:

(1) I am the attorney-in-charge of the Appeals Unit of the Public Defender Division of the Committee for Public Counsel Services. In that role, I have communicated with many trial public defenders and bar advocates who have filed emergency motions for release of their clients since the inception of the COVID-19 pandemic.

(2) I have heard, anecdotally, that several such requests have been granted, including several by agreement with the prosecutor.

(3) However, I have also heard from many attorneys regarding cases in which motions for release were denied. Based on their accounts, it appears that some trial court judges do not believe they have authority to order release, that others do not regard the pandemic as the kind of emergency that warrants release, and that some even regard the pandemic as a reason to detain defendants, not a reason to release them. Moreover, some judges have refused to allow even agreed-upon motions for release.

(4) In a case currently pending before the single justice, *Tompkins v. Commonw*ealth, SJ-2020-0123, the defendant seeks relief from the denial of a motion for release under R. Crim. P. 30(a). The Superior Court judge who heard the motion (Agostini, J.) noted that he did not believe he had authority to allow the motion, as the sentence was constitutional at the time it was imposed. The judge wrote that he "believe[d] that this is first an issue for the SJC to resolve in its supervision of the judicial system."

(5) In a case that has been joined with this case by reservation and report of the single justice, *Christie v. Commonwealth*, SJC-12387, the defendant seeks relief from the denial of a motion for release. In the Superior Court, Mr. Christie sought emergency release but asked in the alternative that his sentence be stayed until the effects of the pandemic have been ameliorated. The Superior Court judge who heard the motion (Tochka, J.) indicated that he did not believe he had the authority to allow it.

(6) I was informed by an attorney that his motion to rescind his client's bail revocation was denied in the Quincy District Court by a judge who stated that he was without authority to allow the motion.

(7) Attorneys have informed me that three different judges of the Chelsea District Court have denied *agreed-upon* motions for release for pretrial detainees.

(8) I have also been informed that, on March 23, a judge sitting in Waltham District Court denied a COVID-19 based motion to release a medically compromised individual who was being held on a probation violation warrant even though the probation department was asking that the defendant be released. The defendant in that case is on probation for stealing $260 worth of goods from Home Depot (which was recovered), is alleged to have committed technical violations of probation for which he faces at most the imposition of a suspended nine-month sentence, and has been given a May date to be brought back to court. An emergency petition pursuant to G. L. c. 211, § 3 was filed in that case on March 24, and is pending before the single justice. *Jonas Moses-Gilson v. Commonwealth*, SJ-2020-0116.

(9) In denying a motion for expedited telephonic argument on an appeal from the denial of a motion to stay, in light of the pandemic, a single justice of the Appeals Court wrote, "The COVID-19 pandemic is an unfortunate development that has impacted all walks of life. In my judgment, it is not a reason to treat this case differently than the hundreds of criminal cases now pending before the Appeals Court." See Order Denying Motion for Expedited Ruling and Telephonic Argument, Appeals Court No. 2020-P-0029 (March 25, 2020).

(10) On March 26, I was advised by an attorney practicing in Norfolk County, the county from which that appeal arose that an assistant district attorney had informed the judge hearing an emergency motion for release on COVID-19 grounds that the Appeals Court has held that the pandemic does not represent a changed circumstance justifying release. Presumably, the ADA referred to the order of the single justice cited in the foregoing paragraph.

(11) Attorneys have informed me that judges in at least four superior courts (Salem, Worcester, Hampden, Norfolk) and one district court (New Bedford) have indicated that they regard an actual diagnosis of COVID-19 at the facility in question to be necessary before the pandemic can be regarded as a factor weighing in favor of release. In one such case, the judge indicated that he regarded the defendant's claims of heightened risk of COVID-19 as speculative, and the attorney's concerns as overblown. That defendant, who is over the age of sixty, unsuccessfully filed a motion for

emergency relief *last year* on the basis of the jail's failure to appropriately treat his life-threatening respiratory issues. Finally, I am told that one Worcester Superior Court judge indicated that if COVID-19 enters the facility, "it will be contained."

(12) I have been advised by more than one attorney that, in rejecting motions for release, the same Worcester Superior Court judge has invoked his view that certain defendants will not comply with COVID-19 "best practices" if released.

(13) An attorney reports that in his district court case, a motion to reduce bail for a defendant held on $5000 was denied, despite the fact that the defendant faces a severe risk of morbidity if infected with COVID-19 because of his age (69) and because he has emphysema and HIV.

(14) Another attorney informed me that a Dedham District Court judge imposed a six-month suspended sentence on her client, following a finding of technical violations of probation. When the attorney noted that her client's heart condition put him at increased risk of morbidity due to COVID-19, the judge responded, "I am not the Department of Health."

(15) Another attorney reports that, on Friday, March 27, he spoke to two clerks in the Boston Municipal Court regarding an agreed upon COVID-19 based motion to release an individual which had been previously submitted in order to confirm that the motion had been received. The first clerk reported that he had not seen the motion. The second stated that all motions to reduce bails or revoke bail revocations are being "put in the basket" and were not being docketed because "only emergency matters" were being heard, that it was up to the judge hearing the case on the date of the defendant's next scheduled appearance whether the motion would be heard, and that the attorney should bring a copy of the motion with him to the BMC on that date.

Signed this 29th day of March, 2020.

/s/ Rebecca Kiley
Rebecca Kiley
Attorney-in-Charge
Committee for Public Counsel Services
Public Defender Division – Appeals Unit

COMMITTEE FOR PUBLIC COUNSEL SERVICES and
MASSACHUSETTS ASSOCIATION OF
CRIMINAL DEFENSE LAWYERS,
Petitioners,

v.

CHIEF JUSTICE OF THE TRIAL COURT,
Respondent.

AFFIDAVIT OF VICTOR LEWIS, M.D.

I, Victor Lewis, state the following to be true to the best of my knowledge, information and belief:

1. I received my doctorate in medicine in 1987 and I was practicing physician at Massachusetts General Hospital (MGH) from 1990 through October 2019. During that same time period, I was a member of faculty at Harvard Medical School.

2. During part of that time, 1991-1998, I was a general internist for HIV infected patients at the immunodeficiency clinic at Boston City Hospital/Boston Medical Center. Since 2001, I have also been an independent contractor with the Commonwealth of Massachusetts Department of Mental Health.

3. I retired from my practice at MGH in Chelsea at the end of October 2019. Since the beginning of March of this year I have been working two shifts per week at the MGH Walk-In Clinic which has now become the Acute Respiratory Care Clinic for patients referred for respiratory complaints who do not meet criteria for Covid-19 testing.

4. In addition to my clinical responsibilities in Chelsea, I had been and still am part of a multidisciplinary team monitoring the medical and mental health care of inmates who are in segregation in both medium and maximum Massachusetts Department of Correction (DOC) facilities. This activity has involved visits to all DOC facilities which have a segregation unit once or twice a year, meeting with prison officials and interviewing inmates and then subsequently reviewing their medical records. Following these visits, a report with recommendations is submitted to the Commissioner of the Department of Correction.

5. The DOC has two infirmaries, one for men at Souza-Baranowski Correctional Center (SBCC) and one for women at MCI-Framingham.

6. The men's infirmary has a maximum capacity of 36 beds, although practically speaking there are only 18 beds, accepts patients from all of DOC's men's facilities and is almost always full.

7. On March 6, 2020, I conducted an audit at MCI-Shirley. MCI-Shirley has the DOC's only Skilled Nursing Facility, which provides a nursing home level of care for people who cannot function on their own. The SNF has 31 total beds, 28 of which are medical beds and 3 beds that are reserved for mental-health watch cells. MCI-Shirley is the only facility with capability for dialysis. The SNF is almost always at capacity. As a result there is a backlog to get into the Skilled Nursing Facility (SNF) at MCI-Shirley so patients have to wait at the infirmary for a bed to become available.

8. There is also an Assisted Daily Living (ADL) unit at MCI-Shirley that has fifteen beds. The ADL is for elderly patients who have trouble getting around. The ADL is also almost always full and there is a wait list to get in.

9. Each prison has a Health Services Unit (HSU). The HSUs have limited beds and are not set up for very acute care. The HSU is like an urgent care doctor's office, though they do have beds to treat people for a day or two.

10. Patients that cannot be treated within the DOC may be sent to a locked ward at the Shattuck Hospital.

11. On January 3, 2020, I conducted an audit at MCI-Framingham. The infirmary has 30 beds (this statistic was from June of 2018) and the majority of the patients admitted to the infirmary are for opiate or alcohol detoxification. In the past, the infirmary had ten to fifteen new admissions daily but that is now down to only two to three admissions daily as a result of the reduced population. (MCI Framingham transferred approximately 180 prisoners to county facilities when some county facilities started accepting female inmates who were awaiting trial or had received relatively short sentences).

12. On June 22, 2018, I conducted an audit of SBCC and reported as follows:

"The HSU infirmary has 18 cells, some of the cells have a capacity for 2 inmates but are generally kept as single inmates cells. In addition to the 18 cells used as infirmary beds there are generally 2 other rooms available for mental-health watches or for occasional other needs. The infirmary cannot

provide intensive care unit (ICU) level of care and anyone who needs ICU case would have to be transferred to an outside hospital. There remains a problem at the facility where inmates who do not have the need of acute infirmary inpatient care and are awaiting transfer to either a SNF or an ADL unit must remain in the infirmary until beds are available. At the time of our visit there were 2 such inmates within the HSU. One of these inmates had been in the infirmary waiting for transfer for approximately 4 weeks and the other for approximately 2-3 weeks. Inmates in the infirmary are confined to their cells, they do not have any programming and they did not get any recreation time. Inmates in the infirmary are not necessarily originally from SBCC but can come from anywhere in the DOC system as this is now the only inpatient infirmary for male inmates within the DOC."

13. On March 3, 2019, I conducted an audit at MCI-Norfolk. MCI-Norfolk has the other men's ADL unit which, as of May 2017, had thirteen beds. At our visit in 2019, I was told that many of these inmates ideally require daily medical evaluations by a provider but often times this is not possible.

14. There is generally an older population serving prolonged sentences at this facility. From my May 2017 report: "The facility had 736 inmates who are followed for chronic diseases."

15. Based on my knowledge from conducting these and other audits over the past 20 years, it is my opinion that it will not take much to overwhelm DOC's health care system once the COVID-19 pandemic spreads. The older prisoners are often in poor health and are at high risk of complications and death. As the number of inmates with the infection increases there will be an increase risk to correctional staff who will then increase the risk to their families and communities.

Signer under the pains and penalties of perjury this 27th day of March, 2020.

/s/ Victor Lewis

_____

Victor Lewis, MD

Harvard Medical School Curriculum Vitae

Date Prepared: **March 2020**

Name: **Victor Lewis, M.D.**

Office Address: **151 Everett Ave., Chelsea, MA 02150**

Home Address: **33 Clark Rd., Brookline, MA 02445**

Work Phone: **Cell 617-515-3370**

Work Email: **vlewis1@partners.org**

Place of Birth: Brooklyn, New York

Education

8/1983-5/1987	MD		Albert Einstein College of Medicine
9/1980-6/1983	BA		CUNY; Hunter College
1/1980-6/1980		Paramedic Program; Institute of Emergency Medicine	Albert Einstein College of Medicine
9/1969-1/1971			San Francisco State College
1/1967-6/1969			City College of New York

Postdoctoral Training

7/1987-6/1990	Residency Program in Social Medicine	Internal Medicine Tract	Montefiore Hospital & Medical Center

Faculty Academic Appointments

9/1990-	Clinical Assistant		Harvard School of Medicine

Appointments at Hospitals/Affiliated Institutions

5/2017-10/2019	Associate Physician	Medicine	Massachusetts General Hospital
5/2013-2017	Assistant Physician	Medicine	Massachusetts General Hospital
10/1990-	Assistant in Medicine	Medicine	Massachusetts General

5/2013			Hospital
1/1991-8/1998	General Internist	For HIV Infected Patients; Immunodeficiency Clinic	Boston City Hospital/Boston Medical Center
9/1990-9/1990	Graduate Assistant	Adult Medicine Practice	Chelsea Memorial Health Center/MGH Chelsea
7/1990-8/1990	Part-time Physician		Montefiore Medical Center; Rikers Island Health Service
12/1983-3/1986	Part-time Paramedic	Emergency Ambulance	Roosevelt St. Lukes Hospital
2/1980-8/1983	Paramedic	Serving Harlem Hospital Area	Health and Hospitals Corporation; EMS

Other Professional Positions

11/1992-	Clinical Supervisor	Nurse Medical Manager HIV MGH/Chelsea HIV Program
1/2010-2/2010	Volunteer Physician	McCord Hospital, Durban, South Africa
1/2001-	Independent Contractor	Commonwealth of Massachusetts; Department of Mental Health

Committee Service

Local

06/21/12-2014	Steering Committee Global Primary Care Scholars Program

Professional Societies

Member	American Academy of HIV Medicine Massachusetts Medical Society

Honors and Prizes

06/03/2011	Outstanding Physician of the year	Massachusetts League of Community Health Centers

Report of Local Teaching and Training

Teaching of Students in Courses

Preceptor	Longitudinal Primary Care course 1994-2005

International

06/07/2012	Non-infectious complications of long term HIV Infection Mbarara University of Science and Technology Mbarara, Uganda
12/07/2012	Global Primary Care Scholars Update-report on June 2012 visit to Uganda.
	General Medicine Unit Grand Rounds -MGH Boston

Report of Clinical Activities and Innovations

Current Licensure and Certification

1980	Paramedic License
1991	Board Certified Internal Medicine
2001-2021	Recertified- Board Certified Internal Medicine
2002-2021	HIV Specialist; Certified by the American Academy of HIV Medicine
2004	Revised Massachusetts Medical License- including certification to prescribe buprenorphine for out patient treatment of narcotics addiction

Practice Activities

3/2020	Ambulatory Care	MGH Medical Walk in Unit	8 hours/week
1990 –	Ambulatory Care	MGH/Chelsea	5.5 sessions/week
10/2019	HIV ambulatory care	ID clinic Boston city Hospital/Boston Medical Center	1 session/week
1/1991-8/1998			5 days/week
7/1990-8/1990	Ambulatory care	Rikers Island Health Service/Montefiore Medical Center	

Report of Scholarship

Publications

Peer reviewed publications in print or other media

Peter A Selwyn, Diana Hartel, Victor A. Lewis, Et. Al. "A Prospective Study of the Risk of Tuberculosis among Intravenous Drug Users with Human Immunodeficiency Virus Infection." New England Journal

of Medicine 320:545-50, March 2, 1989.

Narrative Report (limit to 500 words)

I was a primary care internist with an interest in the care of the HIV infected patients and in treatment of patients with substance abuse problems. After completing my training at Montefiore Medical Center in the Bronx in 1990 I had been a staff physician at MGH Chelsea providing primary care to a diverse patient population and have also been active in setting up a comprehensive HIV program at our health center. Although my primary work was as a primary care physician I have had a long-standing interest in HIV care. I had been involved in setting up a Chelsea based program for comprehensive HIV care which now receives funding through the Massachusetts Department of Public Health. I had been the principal HIV provider for patients at our health center for many years. In recent years I had provided care for a panel of approximately 60 HIV patients. I had also acted as a clinical supervisor for our HIV nurse medical manager. I had also been involved in the treatment of patients with opiate addiction and had been involved in a team providing outpatient treatment with buprenorphine.

In addition to my clinical responsibilities in Chelsea I had been and still am part of a multidisciplinary team monitoring the medical and mental health care of inmates who are in segregation in both medium and maximum Massachusetts Department of Corrections facilities. This activity has involved visits to all DOC facilities which have a segregation unit once or twice a year, meeting with prison officials and interviewing inmates and then subsequently reviewing their medical records. Following these visits a report with recommendations is submitted to the Commissioner of the Department of Corrections.

I also have an interest in medical care in resource poor settings. In 2010 I worked as a volunteer physician in an HIV clinic in Durban, South Africa for 4 weeks. In June of 2012 I was part of the initial Global Primary Care Scholars Program's trip to Uganda. This involved visiting a medical school/hospital complex and a rural Health Center and was part of a new exchange program with colleagues in Uganda.

I retired from my practice at MGH Chelsea practice at the end of October 2019. Since the beginning of March of this year I have been working 2 shifts per week at the MGH Walk In Clinic which has now become the Acute Respiratory Care Clinic for patients referred for respiratory complaints who do not meet criteria for Covid19 testing.

Throughout my career I have worked to provide care to a diverse group of patients many of whom are patients often overlooked by society. I have worked to establish programs which can ensure high-quality care for this challenging population of patients. I have worked to maintain the knowledge and expertise which allows me to provide a high-quality care to all of my patients.

COMMONWEALTH OF MASSACHUSETTS
SUPREME JUDICIAL COURT

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COMMITTEE FOR PUBLIC COUNSEL SERVICES and
MASSACHUSETTS ASSOCIATION OF
CRIMINAL DEFENSE LAWYERS,
Petitioners,

v.

CHIEF JUSTICE OF THE TRIAL COURT, and others,
Respondents.

AFFIDAVIT OF DAVID RANGAVIZ

I, David Rangaviz, state the following to be true to the best of my knowledge, information and belief:

(1) I work as a staff attorney in the Appeals Unit of the Public Defender Division of the Committee for Public Counsel Services.

(2) In that capacity, I represent Mr. Glenn Christie, who is currently incarcerated in the Massachusetts Treatment Center serving a 1-2 year sentence for three technical violations of his probation (i.e., no allegation of a new criminal offense). He started his sentence on April 29, 2019.

(3) Mr. Christie suffers from hypothyroidism, spinal stenosis, and kidney disease. He presently relies upon a wheelchair, and is awaiting a body scan to confirm whether his past episode of thyroid cancer has recurred. Given his various medical conditions, if he contracts COVID-19, he is at very serious risk of complications or death.

(4) In a phone call on March 25, 2020, Mr. Christie gave me permission to share our confidential communications with this Court to explain the experience of those at the Massachusetts Treatment Center during this outbreak.

(5) On Thursday, March 12, 2020, I began working remotely from home due to the coronavirus pandemic. As a result of that, I was unable to answer calls from Mr. Christie to my office. To communicate, he began leaving me voicemails and I would respond to him via the unsecured Corrlinks email system. This would cause a time lag in our communications, usually around 24 hours for emails to deliver.

(6) On Monday, March 16, 2020, at 1:28PM, Mr. Christie left me a voicemail stating that he "can't get any information, they won't tell us anything except that visits are done, no outside volunteers coming in. The latest one is 'no non-essential medical or court trips.'" Because Mr. Christie is pending a body scan for the potential return of his cancer, he was scared about whether he could get that treatment. "Just the mental anguish that it's causing is really starting to get to me," he said in the message. The next day, Tuesday, March 17, 2020, Mr. Christie sent me an email over the Corrlinks system, stating that "we are being totally left in the dark as it pertains to all things Corona."

(7) The same day, I filed a petition in the Single Justice session of the Supreme Judicial Court, seeking Mr. Christie's release due to the pandemic. See SJ-2020-107. That petition was denied the next day (Budd, J.).

(8) That day, March 18, 2020, Mr. Christie sent me an email over the Corrlinks system, stating that "fellow inmates are being presumptively quarantined; that the facility was on lock down 'to all outside non-staff and visitors'; that we will not get tested for the virus if symptomatic (per correctional officers' statements); we are being left in the dark as it pertains to Covid-19; and if it is present and spreads in the facility we will be locked in our cells; therefore, unable to make calls." Mr. Christie went on to state in this email that he feared that he was "at a very increased risk of fatality if I should contract Covid 19 in prison."

(9) On Thursday, March 19, 2020, at 9:11AM, Mr. Christie left me a voicemail expressing his fear that "if, god forbid I get this virus with all of my other health issues, yeah it will probably kill me."

(10) On Friday, March 20, 2020, Mr. Christie left me a voicemail message at 9:45AM, in which he stated that there were "definitely more guys getting sick with allegedly not coronavirus, but I don't know if they're even testing. We are left in the dark." He stated that there was one incarcerated person who "the nurse took his temperature, it was 100.7, and he was told to lie down and take some Tylenol."

(11) That same day, Mr. Christie sent me an email over Corrlinks that I received at 6:04PM that there had been a diagnosed case of COVID-19 in his building at the prison. The email subject line reads: "Scared ... urgent update!!!" The email said that they were "100% locked down as of 11am" that day because of the confirmed case. He wrote: "We are not allowed beyond our six man dorm rooms, except to use the 'communal' bathroom --- a cesspool of germs as we are running out of soap. We are being fed room-by-room and the same for medications. We are currently unable to use the phones and the officer does not know what is planned about when that will (or if) change!" He reported that "it is on the verge of panic in here."

(12) The next day, this single diagnosis was reported publicly.[1] The day after that, three more cases were reported—two incarcerated people and a guard.[2] As of the filing of this affidavit, there are now ten cases in his facility.[3]

(13) I did not hear from Mr. Christie again—either over the phone or by email—until an email that I received on March 23, 2020, at 3:38PM (given the time lag, it had likely been sent the day before). Unlike Mr. Christie's prior emails, this email was riddled with spelling errors of particular words, which he wrote at the top had been done "on pupose [sic]" to avoid censorship of his non-confidential communications. Correcting those intentional misspellings, he wrote that "things are bad" and they are being "denied all calls including LEGAL calls," as he had specifically asked to call his attorney and been denied. He stated that "the 'one' confirmed [case] was a dining hall food server who had contact with more than half the population a few times per day for several days!" He also reported that the facility was severely under-staffed because approximately 30 correctional officers had been sent home, so the inmates were locked in their dormitory areas. He said that "no special sanitizing or segregating has been done." And, when the inmates need medications they are forced to line up in a "small dorm hallway with 50-60 other mates (some showing symptoms)." He wrote that the Treatment Center does "NOT have enough medical staff here – less than 5 from what I can gather." The correctional officers had also skipped a dose of his pain medication the prior evening due to the outbreak, so he had been "in agony for hours."

(14) He concluded his email: "I'm actually very frightened right now and the mental environment is declining rapidly."

(15) On March 25, 2020, at approximately 9:30AM, I received a call from Mr. Christie on my personal cell phone. The day before, I had arranged for call forwarding from my office. During that call, Mr. Christie reported that people are just continually being taken out of the unit and "never come back." They cannot receive any numbers of people who are sick from the administration, and they are not told anything new. In his words, "it's just a stalemate." He said that the inmates are spending most of the time in their rooms—he estimated the room was 20' x 10', housing six people on three bunk-beds—and they are forced to share a communal bathroom with inmates in other rooms. For the delivery of food and medicine, the inmates are forced to line up in the hallway, causing between 50-60 people to be lined up, back to front, waiting to receive those supplies. He confirmed the contents of his prior email to me—the first person diagnosed worked in food service at the facility. He said that the correctional officers are not checking people's temperatures, even if they are at high risk for complications. Instead, he said that people have to ask to be checked, and there is no census for symptoms. "They're letting us sit and we're supposed to self-report." He said that "people are on edge."

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[1] See *Coronavirus and prisons: Inmate serving life sentence tests positive for COVID-19 at Massachusetts Treatment Center in Bridgewater*, MassLive (March 21, 2020).

[2] *3 inmates, 1 officer at Mass. prison test positive for coronavirus*, 7 News (March 22, 2020).

[3] *COVID-19 cases at Bridgewater prison facility up to 10*, Commonwealth Magazine (March 24, 2020).

Signed this 27th day of March, 2020.

/s/ David Rangaviz
David Rangaviz
Staff Attorney
Committee for Public Counsel Services
Public Defender Division – Appeals Unit

COMMONWEALTH OF MASSACHUSETTS
SUPREME JUDICIAL COURT

Suffolk, ss. SJC-12926

COMMITTEE FOR PUBLIC COUNSEL SERVICES and
MASSACHUSETTS ASSOCIATION OF
CRIMINAL DEFENSE LAWYERS,
Petitioners,

v.

CHIEF JUSTICE OF THE TRIAL COURT and others,
Respondents.

AFFIDAVIT OF SOPHIE ROSEN

I, Sophie Rosen, state the following to be true to the best of my knowledge, information and belief:

1. I am an attorney in the Public Defender Division (PDD) of the Committee for Public Counsel Services.

2. Within the last week, I have visited the Middlesex House of Correction in Billerica, Massachusetts ("BHOC") to meet with multiple clients incarcerated in that facility.

3. I have also spoken with several clients held at BHOC by telephone. And I have spoken with Attorney Josina Raisler-Cohn, another PDD staff attorney who has four clients held at BHOC with whom she has recently spoken by telephone.

4. The following information is based on my personal experience visiting BHOC and/or was provided to me and Attorney Raisler-Cohn directly by our clients.

5. When I entered the visiting room, a correctional officer provided me with rubber gloves and disinfecting wipes to use on the phone and counter. My clients were not provided with any protective gear.

6. Two clients shared that they are living in a dormitory setting, with somewhere between 35-50 other men. In the dorm, they eat, sleep, and bathe in the same area. They eat at tables with approximately 8 men, at the same time as the rest of the dorm unit. They are constantly around more than 10 people at any given time.

7. Six clients are living in cells. Of those, one shares a cell with another inmate, and their beds are bunked. Four are in single cells. I do not know whether the sixth client has a cellmate.

8. One client shared that the TV in his unit, for which channel selection is controlled by a correctional officer, used to play the news daily, every morning and evening, in English and then Spanish. But since the COVID-19 outbreak, the correctional officers have changed the channel to the Lifetime Network or a daytime game show. This has effectively cut off their access to the news and therefore access to information about the pandemic.

9. Two clients had seen posters and a video with information about how to wash hands and warnings not to touch their face.

10. The clients receive free bars of soap. One client reported that the sink in his cell runs cold water but not hot water. Depending on where they are housed, clients are permitted to clean their cells once or twice a week, and are given cleaning solution for this purpose. They do not have access to other disinfectants or sanitizers, and cannot clean their cells at other times.

11. Visits from family and friends have been suspended. Clients report that they are being permitted several free telephone calls per week; and that the communal phones are being wiped down twice per day, once after lunch and once at night.

12. The clients who are housed in cells eat communally and go to recreation time communally. They eat at a table with 4 or 8 people. Recreational time is communal, with between 40-100 inmates congregating together.

13. Inmates who require medication must congregate together to get their medication. They each receive a paper cup, and use a communal water pitcher to fill their cups. They are in close proximity to the nurse when receiving medications. The nurse does not wear a mask.

14. When asked whether they are "social distancing," those who understood the term said that social distancing was "impossible."

15. All of the clients reported that new inmates are being admitted to the facility every day. One reported that new inmates are first housed in a dorm, then sent to the "hole" or segregation for a few days, and then placed in a housing unit. The other clients were not aware of any precautions or other processes for new inmates.

16. None of the clients were aware of any procedures to be followed if someone in the facility tested positive for the virus or began experiencing symptoms.

17. Two clients said that someone from their dorm unit was removed last week because he had a fever but was returned to the unit approximately two days later.

Signed under the penalty of perjury on this 27th day of March, 2020.

/s/ Sophie Rosen
Staff Attorney
Committee for Public Counsel Services
Public Defender Division

COMMONWEALTH OF MASSACHUSETTS
SUPREME JUDICIAL COURT

Suffolk, ss. SJC-12926

COMMITTEE FOR PUBLIC COUNSEL SERVICES and
MASSACHUSETTS ASSOCIATION OF
CRIMINAL DEFENSE LAWYERS,
Petitioners,

v.

CHIEF JUSTICE OF THE TRIAL COURT and others,
Respondents.

AFFIDAVIT OF DR. KARTHIK SIVASHANKER

I, Dr. Karthik Sivashanker, state that the following is a true and accurate statement to the best of my knowledge and belief:

1. I am currently the Medical Director for Quality, Safety and Equity at Brigham Health and a clinical scholar at the Institute for Healthcare Improvement. I received my undergraduate degree and medical degree from Northwestern University, and my Masters in Public Health from Harvard T.H. Chan School of Public Health. Immediately prior to my current position, I completed a two-year fellowship in Patient Safety and Quality at Harvard Medical School.

2. My fellowship concentrated on several areas, including patient safety theory, quality improvement, effective change management and hospital operations. During this program, I learned principles of health care systems design, and the key interactions between quality and patient safety, medical staff leadership, hospital operations, and senior leadership. I was also an VA Undersecretary for Health Gold Fellow whereby I led the development and national spread of improved processes for assessing, screening, and triaging patients with substance use disorder to improve the timeliness and efficiency of care (i.e., throughput).

3. My current role is focused on advancing excellence in health care access, treatment, and outcomes for all Brigham Health patients through the use of comprehensive strategies that create and sustain an integrated model of quality, safety, experience, and health equity at Brigham and Women's Hospital. Ensuring that our hospital is operating at appropriate capacity is an important component of this work. When a hospital is operating at overcapacity, patients may be unable to receive critical and life-saving services. Disadvantaged patients are disproportionately impacted by problems like overcapacity as it relates to access, which leads to quality of care and safety issues that are filed as safety reports. I review these safety reports with the Quality and Safety team, hospital leadership, and the department involved (including ICU leadership if involving an ICU case).

4. As a matter of best practice, our hospital should operate at 80% capacity to ensure that we have the resources available to manage unexpected surges in volume. Our hospital (like many in the area) often operates at 90-100% capacity on a usual day (i.e., pre-COVID-19 pandemic). In particular, our intensive care unit (ICU) frequently operates at 100% on any given day (pre-COVID-19 pandemic). In my professional capacity, I frequently interact with other area hospitals in Greater Boston that also operate at or above 100% ICU capacity on a regular day (pre-COVID-19 pandemic).

5. If our ICU's go over 100% capacity, we have to convert general medicine rooms into intensive-care rooms which is not ideal, as these rooms are not purposely built for intensive-level care. When we're overcapacity in our ICU's, we will also eventually stop accepting critically-ill patients from other hospitals, and will re-direct ambulances with these patients away from our hospital. On days when every hospital is overcapacity, this could lead to patients not receiving the life-saving care that they need. This is because they will not have critical care beds to which they can be admitted and will instead receive whatever care can be offered to them in the emergency department or general medical floor.

6. Our hospital is already anticipating an overcapacity problem as a result of COVID-19 infections. Based on what we have seen in hospitals in New York and Washington, as well as the results of the Harvard Global Health Institute modeling, our biggest concern is that we will not have sufficient ICU beds, ventilators, and/or personal protective equipment for our staff to safely care for the anticipated volume of critically-ill COVID-19 patients. Based on projected viral spread rates, we may end up in a situation where we will have to start making decisions about who receives a life-saving resource (e.g., ventilator) and who does not. We're also at risk of running out of personal protective equipment to ensure our providers are safe.

7. An influx of individuals infected with COVID-19 from the jails and prisons will exacerbate our already-significant overcapacity problems. New York City is already in a situation where they have to make decisions about who gets a ventilator and who does not. We could quickly arrive at a similar point. Due to these capacity issues, I anticipate that we will see an increase in fatalities not just among COVID-19 patients, but also among individuals who come to the hospital with other medical issues and are unable to get the care that they need. In this way, a significant outbreak in a correctional facility would stress not just the correctional health system, but our community hospital systems as well.

8. As a result of my position, I know that Brigham and Women's Hospital is one of the better prepared hospitals in this area. If we are facing these staggering capacity problems, I anticipate that every hospital is in a similar situation.

9. The COVID-19 pandemic has highlighted how interdependent we are. If individuals in our correctional institutions face a significant health risk like COVID-19, that impacts the general population outside of correctional institutions as well. From a public health perspective, we need to decrease the population in high density areas, including jails and prisons, to help flatten the curve, preserve our hospital capacity and save lives.

Signed under the pains and penalties of perjury on March 29, 2020.

_____

Karthik Sivashanker, MD, MPH, CPPS

KARTHIK SIVASHANKER, MD, MPH, CPPS

ADDRESS: 125 DAY STREET, NORWOOD, MASSACHUSETTS 02062
PHONE: 847.863.5394 **EMAIL:** KSIVASHANKER@BWH.HARVARD.EDU

QUALITY, SAFETY, INNOVATION

Just Culture Leadership ~ Care Redesign ~ Innovation Development ~ Highest Quality and Safe Care ~ Diversity and Inclusion ~ Cross Functional Collaboration ~ Data Sharing and Analysis ~ Decision Analysis and Cost Savings

BACKGROUND

Medical Director for Quality, Safety and Equity, Psychiatrist

SUMMARY OF QUALIFICATIONS

Results-driven, visionary, and empathic professional, offering strong leadership in re-designing medical services to deliver the highest-quality and safest care possible. Excel at formulating initiatives and programs to optimize organizational efficiency, reduce cost, and surpass performance objectives. Effective at building relationships and collaborating with cross-functional healthcare teams and institutions to support key efforts with a unified vision and mission. Promotes a comprehensive strategy that integrates healthcare equity and innovation into quality and safety operations. Proficient in Spanish.

EDUCATION AND TRAINING

Master of Public Health, Candidate 7/2017 – 5/2019
- Harvard T.H. Chan School of Public Health, Boston MA
- Expected completion date May 2019
- Coursework includes financial control and management, epidemiology, biostatistics, decision analysis, big data, quality improvement, implementation research, & social determinants of health

Harvard Medical School Fellowship in Patient Safety & Quality 7/2017 – 7/2019
- Brigham & Women's Hospital, Boston, MA
- CRICO (Harvard Medical Institutions)

Psychosomatic Medicine Fellowship 9/2013 – 9/2014
- Brigham & Women's Hospital, Boston, MA
- Electives included neuropsychiatry, burn/trauma, and psycho-oncology

Internship & Adult Psychiatry Residency 7/2009 – 7/2013
- Weill Cornell-New York Presbyterian Hospital, New York, NY

Doctor of Medicine 9/2004 – 9/2009
- Northwestern University, Feinberg School of Medicine, Chicago, IL
- Fulbright Fellowship from 2007-2008 in Venezuela

Bachelor of Science in Philosophy, Focus in Comparative Literature 9/2000 – 9/2004
- Northwestern University, Evanston, IL
- Undergraduate Pre-Medical Society, *Vice-President*
- Gamma Sigma Alpha Greek Honor Society, *President*

PROFESSIONAL DEVELOPMENT AND LICENSURE

Certifications	Certified Professional in Patient Safety (CPPS) Basic Life Support (BLS) Certified Buprenorphine Provider Subspecialty Certification Eligible in Psychosomatic Medicine
License	Medical License: State of Massachusetts
Training	Institute for Healthcare Improvement Pursuing Equity Initiative (2017-2019) Program Management & Presentation Advantage Essentials (Franklin Covey)

HONORS AND AWARDS

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- Under Secretary for Health (USH) Diffusion of Excellence Gold Fellow
- Brigham Care Redesign Incubator and Startup Program (BCRISP) Shark Tank Finalist ($25,000)
- U.S. Fulbright Award in Venezuela
- AACAP Educational Outreach Program for General Psychiatry Residents Award
- University of Pittsburgh/Dr. Thomas Detre Senior Medical Student Award
- Feinberg School of Medicine Medical Scholarship Recipient
- Awarded Northwestern Department of Public Health Grant ($3000) for Salud Latina/Latino Health Field Experience Research
- Awarded Northwestern Medical Humanities and Bioethics Program Grant ($1000) for Independent Bioethics Research

ACADEMIC APPOINTMENTS

Institute for Healthcare Improvement, *Boston, MA* 7/2019 – Present
- Clinical Scholar

Ariadne Labs, *Boston, MA* 6/2017 – Present
- Affiliate Faculty Member

Boston University School of Medicine, *Boston, MA* 11/2015 – Present
- Assistant Professor

HOSPITAL APPOINTMENTS AND OTHER EMPLOYMENTS

Brigham Health, Department of Quality & Safety and DE&I, *Boston, MA* 7/2019 – Present
- Medical Director for Quality, Safety, and Equity

Institute for Healthcare Improvement, *Boston, MA* 7/2019 – Present
- Clinical Scholar

Justice Resource Institute, Children's Family and Friends, *Lynn, MA* 7/2017 – Present
- Outpatient Psychopharmacologist

Brigham Health, Department of Quality & Safety, *Boston, MA* 7/2017 – 6/2019
- Fellow in Patient Safety and Quality

VA Boston Healthcare, Department of Psychiatry, *West Roxbury, MA* 7/2017 – 6/2019
- Innovation Specialist

VA Boston Healthcare, Department of Psychiatry, *West Roxbury, MA* 9/2014 – 6/2019
- Staff Consultation Liaison Psychiatrist
- Medical/PA Student Site Director

Brigham & Women's Hospital, Department of Psychiatry, *Boston, MA* 9/2011 – 9/2014
- Psychiatry Per-Diem

Lenox Hill Hospital, Department of Psychiatry, *New York, NY* 6/2011 – 6/2013
- Psychiatry Per-Diem

Post-graduate Center for Mental Health, *New York, NY* 6/2011 – 6/2012
- Outpatient Psychopharmacologist

Superior Ambulance 9/2001 – 9/2004
- Emergency Medical Technician

QUALITY IMPROVEMENT AND PATIENT SAFETY

Brigham Health, Boston, MA

Quality, Safety & Equity 7/2019 – Present
Role: Medical Director
- Leading a new approach that systematically integrates equity into quality and safety work, including safety event reporting, collaborative case reviews (i.e., root cause analysis), education, leadership

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engagement, and data (e.g., benchmarks, dashboards, scorecards).

Pharmacy 2.0 7/2017 – Present
Role: Quality and Safety Lead

- Serving as a Quality and Safety representative working with the pharmacy department to reduce costs and improve safety around medications.
- Examples of ongoing initiatives include: Collaborating with the analytics department to obtain accurate reimbursement data for medications, tracking data related to drug shortages, and identifying opportunities for cost savings (e.g., 340B and reducing unnecessary utilization).

Lung Nodule Safety Net 7/2017 – 7/2019
Role: Co-investigator

- Helped develop a new closed-loop system for the communication of follow-up recommendations (Radiology Result Alert and Development of Automated Resolution or RADAR) with a focus on incidental lung nodules.

Operations and Quality & Safety 7/2017 – 7/2018
Role: Quality and Safety Lead

- Working with the chief quality officer and senior vice-presidents in developing and implementing new task forces for hospital-acquired conditions (e.g., CAUTI, CLABSI, hand-washing.

VA Boston Healthcare, West Roxbury, MA

C-TOX Quality Improvement Project 1/2015 – 1/2017
Role: Primary Investigator

- Initiated and led the development and implementation of a new system (C-TOX) for screening and transferring patients who require detoxification.
- C-TOX provides the following features: 1) Evidence-based algorithm supplemented with multidisciplinary consensus 2) Computer-assisted feedback and built-in education on substance screening 3) Key clinical information at the fingertips of providers at the point of care 4) Standardization and redundancy for patient screenings to enhance safety 5) Clear and intuitive design to enhance efficiency.
- C-TOX enhanced the safety and efficiency of the process and led to statistically significant and robust improvements in provider satisfaction.

RESEARCH/INNOVATION

Brigham Health, Boston, MA

DE&I Education Impact Measurement 07/2019 – Present
Role: Researcher

- Partnered with IHI in developing, testing, and spreading the use of validated instruments to measure the impact of DE&I trainings on knowledge, awareness, intentions, and behavior
- Developed a tool focused on measuring implicit bias based on the Stages of Change (Transtheoretical model)
- Developed a multi-stage tool focused on measuring the impact of DE&I education on behavior

Virtual Assistant to Support Safe Chronic Pain Management in Primary Care (BCRISP) 7/2018 – Present
Role: Innovation Lead

- Brigham Care Redesign Incubator and Startup Program Shark Tank Finalist selected out of 78 strong proposals for funding (received $25,000)
- Program will be piloted at BWH Primary Care and Surgery in 2020
- Goal is to utilize a virtual assistant to promote opioid education, alternative treatment options, risk-stratification, pain and functioning assessments and tracking, and treatment adherence

VA Boston Healthcare, West Roxbury, MA

MIT-VA Catalyst 7/2017 – 6/2019
Role: Innovation Lead

- Leading the development and implementation of a new program that brings together MIT and VA

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clinicians, engineers, innovators, and scientists, to conceive and launch collaborative biomedical innovation projects.

- Program will be piloted at VA Boston and goes live in 2019.

USH Diffusion of Excellence Gold Fellow 10/2017 – 10/2018
Role: Primary Investigator

- Primary investigator for a multidisciplinary quality improvement initiative (C-TOX) selected as a Gold Status practice, out of over 400 promising innovations, in a nationwide competition by the Under Secretary for Health to disseminate the best innovative practices across VHA.
- Participated in the second cohort of Under Secretary for Health Gold Status Fellows, spending six months guiding Martinsburg VAMC in adapting and implementing our innovation.
- Practice currently being scaled nationally at VA Healthcare

Fulbright U.S. Student Program, Merida, Venezuela

Fulbright Fellowship 7/2007 – 7/2008
Role: Primary Investigator

- Independent research comprised of qualitative ethnographic interviews and a quantitative behavioral surveillance study of 200+ university dormitory students, exploring attitudes, beliefs and behaviors surrounding HIV/AIDS and other sexually transmitted infections.
- Numerous critical gaps in knowledge were identified and interventions were developed to augment awareness and address social stigmas and misunderstandings.

Feinberg Northwestern University School of Medicine, Chicago, IL

Salud Latino/Latina Public Health Research 2005 (summer)
Role: Primary Investigator

- Worked with Salud Latino/Latina to implement the Popular Opinion Leader (POL) model of the CDC in Latino migrant workers in rural Illinois at high-risk for HIV.
- The project included extensive field research of rural migrant workers, the creation of educational materials and the identification and recruitment of individuals to serve as POLs.

Angiogenesis (Anti-tumor) Research 2003 – 2004
Role: Primary Investigator

- Investigated the utility of anti-angiogenic proteins such as PEDF as a novel treatment for cancer.
- Worked with RNA/DNA (e.g., plasmid purification and digestion), proteins (e.g., total cell extracts, SDS-PAGE and Western blotting, Silver/Coomasie staining, Protein purification using IMAC) and cell cultures (e.g., adherent cells, preparation of conditioned media, cell migration assay).

DEPARTMENTAL, UNIVERSITY, GOVERNMENT COMMITTEES

Massachusetts Public Health Association, Boston, MA

Emergency Task Force on Coronavirus & Equity 3/2020
Role: Invited member

- Asked to participate in a statewide emergency task force on COVID-19 and equity. The goal is to help ensure that vulnerable populations, such as low-income people and immigrants, aren't disproportionately affected by the disease—or by steps taken to combat it.

Brigham Health, Boston, MA

BH COVID 19 Equity, Diversity and Community Health Response Team 3/2020 – Present
Role: Member

- To support the systematic integration of equity into COVID-19 emergency response efforts for patients and employees

Structural Racism and Equity Learning Community 1/2020 – Present
Role: Leader

- Created a cross-institutional learning community for staff and patients across the organization to connect, collaborate, and learn

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Brigham Health Data Committee 12/2019 – Present
Role: Co-leader

- Created a multi-departmental committee to support the use of data to advance equity in quality, safety, research, and other areas.

Pharmacy Cost Optimization Steering Committee 12/2019 – Present
Role: Co-Leader

- Supporting use of high-value low-cost medications

Patient-at-Risk Committee 9/2019 – Present
Role: Member

- Serve on a multi-disciplinary committee that reviews and provides recommendations (e.g., acute care plans and safety flags) for patients considered at high-risk for violence or harm to others.

Department of Medicine Health Equity Committee 7/2019 – Present
Role: Member

- Advancing equity within department of medicine through education, research, and quality improvement

Multi-institutional Healthcare Equity & Data Collaborative 7/2019 – Present
Role: Co-leader

- Developed a consortium consisting of leading academic healthcare institutions to develop, share, and spread best practices in using data to advance equity on a national scale.
- Participating institutions include: University of Chicago, Henry Ford, Massachusetts General Hospital, Rush, Kaiser Permanente, Partners Healthcare, Institute for Healthcare Improvement, and Vizient

Health Equity Summit Planning Committee 7/2018 – Present
Role: Member

- Supporting the design and roll-out of an annual health equity summit at BWH

Social Justice and Equity Task Force 10/2017 – 6/2019
Role: Subcommittee Leader

- Co-leading a subcommittee tasked with developing a system-wide training to address unconscious bias and racism in healthcare.

New England Healthcare System (VISN1), West Roxbury, MA

Heart/VAD & Lung Transplants Committee 9/2015 – 1/2016
Role: Committee Member

- Assisted in the development of a proposal to bring heart and lung transplant services to the New England region.

Regional VA Interfacility Psychiatry Transfer Committee 10/2015 – 12/2015
Role: Committee Member

- Served as the consultation-liaison psychiatry representative on this multidisciplinary committee, developing a regional inter-facility transfer protocol and template.

VA Boston Healthcare, West Roxbury, MA

Ketamine Protocol Committee 5/2016 – 7/2017
Role: Committee Co-Leader

- Led a multidisciplinary initiative to develop the first ketamine treatment program for refractory depression and suicidality at VA Boston, which now serves as the template for other VA hospitals developing ketamine services.

Peer Review Committee 10/2015
Role: Committee Member

- Participated as a peer reviewer in this leadership level committee aimed at enhancing the quality of care at VABHS.

Addictions Task Force Education Sub-Committee 4/2015 – 10/2015
Role: Committee Member

- Involved in developing and implementing addiction-focused education in a long-term residential setting for medical providers (physicians, mid-level practitioners, nurses).

Weill Cornell-New York Presbyterian Hospital, New York, NY

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Disorder of the Quarter 2010 – 2013
Role: Committee Member

- Active contributor to department-wide initiative to enhance the departments' knowledge and use of psychopharmacology.

Residency Council 2010 – 2012
Role: Committee Member

- Responsible for planning weekly academic conferences.

EDUCATIONAL INNOVATIONS AND TEACHING

Brigham Health, Boston, MA

Structural Racism, Equity, and High-Reliability Training 10/2019 – Present
Role: Educator

- Designed, tested, and implemented a 4-hour curriculum to give participants a foundational understanding of the intersection between quality, safety, and equity.
- Training delivered strategically to staff from key groups, including: Quality, Safety, and Risk, Patient Family Relations, Human Resources, Clinical Staff (e.g., PA orientation), and hospital leadership

DE&I Leadership Education (Sperling Accelerator) 09/2019 – Present
Role: Educator

- Helped lead the development and implementation of a 4-hour curriculum on valuing diversity for the top 580+ hospital leaders.

BPOT Registration Staff Training 07/2019 – Present
Role: Educator

- Partnered with Partners Chief Quality Officer to design, test, and implement a multi-stage training with didactic and simulation components
- Target audience is registration staff and trainers (i.e., train-the-trainer model)
- Goal is to enhance the collection and use of demographic data for research, clinical, and quality improvement purposes.

High-Reliability Education (Collaborative Solutions™) 07/2019 – Present
Role: Educator

- Collaborated with lead trainer to integrate equity concepts, cases, and simulations into the hospital-wide high-reliability training
- Goal is to enhance facilitator skills to promote knowledge dissemination, culture change, and operational improvement through the systematic integration of equity with quality and safety.

VA Boston Healthcare, West Roxbury, MA

Schwartz Rounds Program 4/2017 – 7/2017
Role: Moderator

- Program promotes interdisciplinary dialogue by inviting panelists from diverse disciplines to hear a brief presentation on an identified case or topic.
- Caregivers are invited to share their perspectives on the case.

Medical/PA Student Case Reviews 10/2015 – 10/2016
Role: Curriculum Development

- Collaborated with Dr. Fremonta Meyer (Brigham & Womens) to develop novel case-based reviews, covering various major mental illnesses (e.g., bipolar disorder, psychosis, eating disorders).
- Supervised Harvard South Shore residents on this project.
- Case-based reviews implemented in the Harvard Medical School and Boston University medical & physician assistant student curriculums.

Medical and PA Student Site Director 9/2014 – 6/2017
Role: Supervisor

- Provide clinical supervision and education to a diverse array of trainees from multiple institutions, including Boston University and Harvard training programs (psychiatry, neurology, nurse practitioner residents and fellows, medical students, PA students) on the consultation-liaison psychiatry service.

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Boston University, Boston, MA

Mental Health Counseling & Behavioral Medicine Psychopharmacology Course 1/2015 – 9/2018
Role: Lecturer

- Teach a semester-long course on psychopharmacology to mental health counseling students.

Harvard South Shore Psychiatry Residency Program, Brockton, MA

Neuropsychiatry/Emergency Psychiatry 6/2015 – 1/2017
Role: Lecturer

- Provide didactic lectures as part of the PGY-III-IV psychiatry curriculum.

Weill Cornell Medical School, New York, NY

Cyberbullying Curriculum 2012 – 2013
Role: Curriculum Development

- Utilizing state-of-the-art technology, developed a Kahn-Academy style video on cyberbullying introduced into the 2013 psychiatry curriculum.

Feinberg Northwestern University School of Medicine, Chicago, IL

Medical School Ethics Curriculum 6/2005 – 9/2005
Role: Curriculum Development

- Interviewed and videotaped numerous physicians discussing difficult ethical cases for incorporation into the 1st and 3rd-year medical school curriculum. Wrote up ethics cases for small-group discussion.

PROFESSIONAL SOCIETIES: MEMBERSHIP, OFFICES, COMMITTEE ASSIGNMENTS

Institute for Healthcare Improvement (IHI), Boston, MA

Pursuing Equity Initiative 8/2018 – Present
Role: Brigham Health Quality & Safety Representative

- A two-year initiative launched April 2017 to reduce inequities in health, health care access, treatment, and outcomes by implementing comprehensive strategies to create and sustain equitable health systems.
- 8 health care organizations are working with IHI to apply practical improvement methods and tools, spread ideas in peer-to-peer learning, and disseminate results and lessons to support an ongoing national dialogue and action for improving health equity.

American Psychiatric Association, Washington, D.C.

Role: Member 7/2017 – Present

American Academy of Child & Adolescent Psychiatry, Washington, D.C.

Ethics Committee 2011 – 2013
Role: Committee member

- Educated membership about ethical issues, especially in conflict of interest and ethics of influence.
- Explored ethical issues as related to the AACAP policies, referred positions to Council, and provided counsel on complaint and appeals procedures.

News Youth Culture Column 2011 – 2013
Role: Resident Editor

- Identified topics and authors for the column, edited articles, assisted in their publication and wrote articles for the Youth Culture column.

American Psychiatric Association New York County, New York, NY

District Branch 2011 – 2013
Role: Resident Chairman

- Represented residents on the district level of the APA, organizing academic and social events, such as a Residents' movie night screening the documentary "Unlisted: A Story of Schizophrenia."

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- Created a new award for early career psychiatrists, presented at the 2011 NY County District Branch Annual Meeting and Scientific Program.

EDITORIAL BOARDS

Psychosomatics 9/2015
Role: Invited Reviewer

- Invited by and assisted Dr. Grace Chang in reviewing an article, submitted for publication to Psychosomatics, on substance use disorders in pregnancy.

The American Journal of Psychiatry Residents' Journal 6/2011
Role: Guest Section Editor

- Solicited authors, edited articles, and assisted authors in publication.

PUBLICATIONS

Sivashanker, K, Galea, S, Resnick, A. "COVID-19: The Painful Price of Ignoring Inequities" BMJ. 2020 March 18th, 2020; DOI: blogs.bmj.com/bmj/2020/03/18/covid-19-the-painful-price-of-ignoring-health-inequities/

Sivashanker, K, Gandhi, T. "Advancing Safety and Equity Together" N Engl J Med 2020 Jan; 382:301-303. DOI: 10.1056/NEJMp1911700.

Sivashanker, K. Rexrode, K, Nour, N, Kachalia, A. "Healthcare Portraiture and Unconscious Bias." BMJ. 2019 April; DOI: 10.1136/bmj.l1668.

Hammer, M, Kapoor, N, Desai, S, **Sivashanker, K**, Lacson, R, Demers, J, Khorasani, R. "Adoption of a Closed-Loop Communication Tool to Establish and Execute a Collaborative Follow-Up Plan for Incidental Pulmonary Nodules." American Journal of Radiology. 2019 May; DOI:10.2214/AJR.18.20692.

Sivashanker, K., Berkoff, S, Reddy, S, Breu, A, Jones, K, Festin, F. "The Medico-Legal, Ethical, and Clinical Challenges of Psychiatric Advance Directives." Harvard Review of Psychiatry. In press.

Sivashanker K, Fanikos, J, Kachalia, A. "Addressing the Lack of Competition in Generic Drugs to Improve Healthcare Quality and Safety." Journal of General Internal Medicine. 2018 August; DOI: 10.1007/s11606-018-4548-x

Verma, K, Jayadeva, V, Serrano, R, **Sivashanker, K.** "Diagnostic, Treatment, and System Challenges in the Management of Recurrent Neuroleptic Malignant Syndrome on a General Medical Service," Case Reports in Psychiatry, vol. 2018, Article ID 4016087, 5 pages, 2018. https://doi.org/10.1155/2018/4016087.

Field, T, **Sivashanker, K**, Ghoston, M, Golubovic, N. "Ketamine and the Glutamate Hypothesis of Depression." Counseling Today. 2018, May.

Hinrichs, K, Sharma, S, Thurston, J, **Sivashanker, K,** Chang, G. "Management of opioid use disorders among veterans in sub-acute rehab: Use of an interdisciplinary task force to address an emerging concern." [Letter to the Editor]. *Substance Abuse.* 2015 Dec; 16:0

Sivashanker, K., Mufson, M., Mittal, L., Ross, E., Suzuki, J. "Challenges in the management of acute on chronic pain in a pregnant woman at high-risk for opioid dependence in the general hospital setting." Harvard Review of Psychiatry. 2015 March; 23(2):157-66.

Sivashanker, K. "Cyberbulling and the Digital" Journal of the American Academy of Child and Adolescent Psychiatry. 2013 Feb;52(2):113-5. doi: 10.1016/j.jaac.2012.11.008.

Sivashanker, K. (September/October, 2012). Not just "gay" or "straight" – youth culture, identity and sexuality: interview with Peter Daniolos. *AACAP News*, 43(6), 288-299.

Sivashanker, K. (May/June, 2012). Online Social Networks and Suicide. *AACAP News*, *43*(3), 118-119.

Sivashanker, K. July 2011. Test Your Knowledge Questions. *The American Journal of Psychiatry Residents' Journal.* http://ajp.psychiatryonline.org/misc/Residents_Journal.dtl

Sivashanker, K. May 2011. Early Intervention for Schizophrenia Part 2: A Review. *The American Journal of Psychiatry Residents' Journal*, 5(6), 2-5. http://ajp.psychiatryonline.org/cgi/data/168/5/A34/DC2/1

Sivashanker, K. April 2011. Early Intervention for Schizophrenia Part 1: A Review. *The American Journal of Psychiatry Residents' Journal.* 6(4), 2-5. http://ajp.psychiatryonline.org/cgi/data/168/4/A38/DC2/1

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AUDIO/VISUAL PUBLICATIONS

Sivashanker, K. Interview. "Advancing Safety and Equity Together." NEJM Podcast. January 23rd, 2020
Sivashanker, K. Audio Interview. "Pursing Equity: Moving from Information to Action." Institute for Healthcare Improvement. Release Date Pending.

INVITED TALKS AND CASE PRESENTATIONS

Sivashanker, K. *Advancing Safety and Equity Together*. Brigham Health 5th Annual Partners Quality & Safety Symposium, September 16th, 2020 (Boston, MA)

Billings, F, **Sivashanker, K,** Pimental, M, Urman, R, Fields, K, Cotugno, M, Sarin, P, Eappen, S. *Reducing Medication Waste While Improving Access to Sugammadex: A Quality Improvement Project in Medication Stewardship*. Academy Health Poster Session, June 13th, 2020 (Boston, MA)

Sivashanker, K, Duong, T. *Safe Care is Equitable Care*. Institute for Healthcare Improvement Patient Safety Congress, May 14th-15th, 2020 (Orlando, FL)*

Sivashanker, K, Burks, D, Frederico, F. *An Integrated Approach to Quality, Safety, and Equity*. BMJ/IHI International Forum Quality and Safety in Healthcare, April 28th-30th, 2020 (Copenhagen, Denmark)*

Sivashanker, K, Burks, D. *Advancing Equity*. Institute for Healthcare Improvement Chief Quality Officer Professional Development Program, March 24th, 2020 (Boston, MA)

Sivashanker, K. *Advancing Equity and Safety Together*. Institute for Healthcare Improvement Executive Development Program, March 16th, 2020 (Boston, MA)

Sivashanker, K. *Advancing Safety and Equity Together*. Brigham Health Quality Grand Rounds, February 13th, 2020 (Boston, MA)

Sivashanker, K, Duong, T. *Pursuing Equity: Moving from Information to Action*. IHI National Forum, December 10th, 2019 (Orlando, FL)

Sivashanker, K. *Integrating Health Equity into Quality and Patient Safety*. Healthcare Quality and Safety Conference 2019, November 6th, 2019 (Boston, MA)

Sivashanker, K. *Racism, Equity, and High-Reliability*. Institute for Healthcare Improvement Fellowship Program, September 30th, 2019 (Boston, MA)

Sivashanker, K, Schiff, G, Barnett, M, De Zengotita, Jaime. *Equity vs Equality: Barriers in Preventative Medicine and Cancer Screening*. Brigham Health Primary Care M&M, August 6th, 2019 (Boston, MA)

Sivashanker, K, Burks, D. *Advancing Equity*. Institute for Healthcare Improvement Chief Quality Officer Professional Development Program, June 13th, 2019 (Boston, MA)

Sivashanker, K, Tierney, D, Nickerson, C, Raymond, N. *Health Inequity is a Patient Safety Emergency*. Brigham's Commitment to Health Equity Spring Event, May 29th, 2019 (Boston, MA)

Sivashanker, K, Reid, A. *Advancing Health Equity*. Institute for Healthcare Improvement Patient Safety Executive Development Program, March 11th, 2019 (Boston, MA)

Sivashanker, K, Ewing, T. *Integrating Health Equity into Patient Safety and Quality*. Brigham Health 4th Annual Partners Quality & Safety Symposium, March 8th, 2019 (Boston, MA)

Sivashanker, K, Haile-Mariam, A, Demirci, S. *C TOX: A Substance Detox E Consultation*. IHI National Forum Storyboard Session, December 13th, 2017 (Orlando, FL)

Sivashanker, K, Charness, M. *Diffuse Post Hypoxic Leukoencephalopathy: She who has Borne the Battle*. VA Boston Healthcare Medical Forum, April 4th, 2017 (West Roxbury, MA)

Sivashanker, K., *E Consult Implementation: Impact of a Novel Screening & Transfer Process for Patients Seeking Substance Detoxification*. VISN 8 Process Improvement Program Showcase, March 31st, 2017 (Tampa, FL *via teleconference*)

Sivashanker, K., Norian, E. *Dueling Diagnoses: Depression in Primary Care*. VA Boston Healthcare Medical Forum, March 28th, 2017 (West Roxbury, MA)

Sivashanker, K, Reddy, S. *Navigating Diagnostic and Treatment Challenges in Catatonia*. Harvard Medical School Mental Health Grand Rounds, February 22nd 2017 (Brockton, MA)

Sivashanker, K, Baughman, A. *Alcohol Use Disorder and Withdrawal Management*. VA Boston Healthcare Medicine Department Noon Conference, December 23rd, 2016 (West Roxbury, MA)

Sivashanker, K. *Changing Practice: Impact on Provider Satisfaction with a Novel E Consult Screening and Transfer Process for Patients Seeking Substance Detoxification*. Academy of Psychosomatic Medicine, November 11th 2016 (Austin, Texas)

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Sivashanker, K, Hsu, D, Thurston, J, Tuttle, M. *Rum Fits: Innovations in the Management of Complicated Alcohol Withdrawal in the Acute Medical Setting.* VA Boston Healthcare Medical Forum, April 12th, 2016 (West Roxbury, MA)

Sivashanker, K. *Neurobiology of Addiction and Medication-Assisted Therapy for Alcohol Use Disorder.* VA Boston Healthcare Medicine Department Noon Conference, April 11th 2016 (West Roxbury, MA)

Sivashanker, K, Moye, J. *Can Psychiatric Illness be Terminal?* Dana Farber Harvard Palliative Care Faculty Seminar, February 12th 2016 (Boston, MA)

Sivashanker, K, Klein, J. *My Wit Begnis to Turn: Frontotemporal Dementia.* VA Boston Healthcare Medical Forum, December 1st 2015 (West Roxbury, MA)

Sivashanker, K, Hess, M, Serrao, R, Hoffmester, P. *A Conspicuous Conondrum.* VA Boston Healthcare Medical Forum, October 27th 2015 (West Roxbury, MA)

Tsai, G., **Sivashanker, K**. *Voices: A Documentary.* 166th American Psychiatric Association Annual Meeting, May 18-22nd 2013, (San Francisco, CA)

Sivashanker, K. *Behavioral Surveillance of HIV/AIDS and other Sexually Transmitted Infections Among Youth in Venezuela.* Fulbright Enhancement Conference, March 30-April 5 2008 (Quito, Ecuador).

Sivashanker, K. *HIV/AIDS in Latino Migrant Workers in Rural Illinois: The Popular Opinion Model.* MPH Field Experience Meeting, Sept 15, 2005 (Chicago, IL).

Sivashanker, K. *Alternative Ending to Crime and Punishment: Christianity vs. Psychological Realism.* Undergraduate Research Symposium, May 21, 2003 (Chicago, IL).

*Invited speaker, slides/content/syllabi prepared, but prohibited from speaking due to institutional coronavirus travel ban.

EXTRACURRICULAR ACTIVITIES

Voices Documentary Soundtrack
Role: Composer

- Composed original music for this award-winning documentary on the homeless mentally-ill, presented at the 2014 APA conAference. http://www.voicesdocumentary.com

Appendix: Court Actions Across the Country to Reduce Incarceration in Light of Covid-19[1]

State	Judicial Body	Forum	Nature of Relief
Alabama	Circuit Court for the 19th Judicial Circuit of Alabama	Administrative order	• Judge Fuller ordered "all inmates currently held on appearance bonds of $5,000.00 or less be immediately released on recognizance with instructions to personally appear at their next schedule court appearance."[2]
Arizona	Coconino County court system and jail, Judge Dan Slayton, along with other county judges	Court order	• As of March 20, 2020, Judge Dan Slayton and other county judges have released around 50 people who were held in the county jail on non-violent charges.[3]
California	Supreme Court of California, Chief Justice Tani Cantil-Sakauye	Advisory	• The Chief Justice issued guidance encouraging the state's superior courts to, among other things: o "Lower bail amounts significantly for the duration of the coronavirus emergency, including lowering the bail amount to $0 for many lower level offenses." o "Consider a defendant's existing health conditions, and conditions existing at the anticipated place of confinement, in setting conditions of custody for adult or juvenile defendants." o "Identify detainees with less than 60 days in custody to permit early release, with or without supervision or community-based treatment."[4]
	Sacramento Superior Court, Judge Hom	Order	• The Court entered a standing order authorizing their sheriff to release those within 30 days of release, regardless of crime.[5]
Kentucky	Kentucky, Chief Justice John Minton Jr.	Letter to state judges and court clerks	• Kentucky, Chief Justice John Minton Jr. told state's judges and court clerks to release jail inmates "as quickly as we can" noting, "jails are susceptible to worse-case scenarios due to the close proximity of people and the number of pre-existing conditions," and that courts have the responsibility "to work with jailers and other county officials to safely release as many defendants as we can as quickly as we can."[6]

Maine	State of Maine Superior Court, Chief Justice Mullen and District Court Chief Judge Sparaco and Deputy Chief Judge French	Emergency Order	• The Superior Court and District Court ordered all trial courts to immediately vacate all outstanding warrants for unpaid fines, restitution, fees, and failures to appear.[7]
Michigan	Chief Justice Bridget M. McCormack, Michigan Supreme Court	Joint Statement	• In a Joint statement, Chief Justice McCormack urged judges to "use the statutory authority they have to reduce and suspend jail sentences for people who do not pose a public safety risk[,]... release far more people on their own recognizance while they await their day in court...[a]nd judges should use probation and treatment programs as jail alternatives.[8]
Montana	Supreme Court of Montana, Chief Justice McGrath	Letter to Judges	• Chief Justice of the Montana Supreme Court urged judges to "review your jail rosters and release, without bond, as many prisoners as you are able, especially those being held for non-violent offenses."[9]
New Jersey	New Jersey Supreme Court, Chief Justice Rabner	Consent Order	• In New Jersey, after the Supreme Court ordered briefing and argument on why it should not order the immediate release of individuals serving county jail sentences, the Attorney General and County Prosecutors agreed to create an immediate presumption of release for every person serving a county jail sentence in New Jersey.[10]
New York	New York State Supreme Court, Bronx County, Justice Doris M. Gonzales	Judicial ruling based on writ of habeas corpus	• In a habeas petition brought by the Legal Aid Society, a Justice Doris M. Gonzales ordered the release of 106 individuals currently held at Rikers Island on a non-criminal technical parole violation. These individuals were selected in the petition by virtue of their age and/or underlying medical condition.[11]
	New York Supreme Court Justice Mark Dwyer	Judicial ruling based on writ of habeas corpus	• In a habeas petition brought by the Legal Aid Society, a Justice Mark Dwyer ordered the release of 16 individuals currently held at Rikers Island on pretrial detention or parole violation. These individuals were selected in the petition by virtue of their age and/or underlying medical condition.[12]

Ohio	Ohio Supreme Court, Chief Justice Maureen O'Connor	News Conference	• Chief Justice O'Connor urged "judges to use their discretion and release people held in jail and incarcerated individuals who are in a high-risk category for being infected with the virus."[13]
South Carolina	Supreme Court of South Carolina, Chief Justice Beatty	Memorandum	• The Chief Justice instructed that "any person charged with a non-capital crime shall be ordered released pending trial on his own recognizance without surety, unless an unreasonable danger to the community will result or the accused is an extreme flight risk."[14]
Texas	Travis County, Texas, Judges	Individual Court Orders	• Travis County has begun releasing some defendants in custody with underlying health conditions, to reduce the potential spread of COVID-19 in the county's jails. After Austin saw its first positive cases of COVID-19, judges in the county nearly doubled its release of people from local jails on personal bonds, with one judge alone reversing four bond decisions after "balancing this pandemic and public health safety of inmates against what they're charged with."[15]
Utah	Utah Supreme Court and Utah Judicial Council, Chief Justice Durrant	Administrative Order	• The Chief Justice of the Utah Supreme Court ordered that for defendants in-custody on certain misdemeanor offenses, "the assigned judge must reconsider the defendant's custody status and is encouraged to release the defendant subject to appropriate conditions."[16]
Washington	Washington Supreme Court, Chief Justice Stephens	Order	• Chief Justice Stephens ordered judges not to issue bench warrants for failure to appear, "unless necessary for the immediate preservation of public or individual safety" and "to hear motions for pretrial release on an expediated basis without requiring a motion to shorten time." Additionally, for populations designated as at-risk or vulnerable by the Centers for Disease Control, the COVID-19 crisis is presumed to be a material change in circumstances to permit amendment of a previous bail order or to modify conditions of pre-trial release.[17]
Wyoming	Wyoming Supreme Court, Chief Justice Davis	Order	• The Chief Justice instructed judges to issue summonses instead of bench warrants, unless public safety compels otherwise.[18]

Federal Criminal Detention	C.D. Cal, Judge James V. Selna	Minute Order	• The Court granted temporary release for 90 days, pursuant to 18 U.S.C. § 3142 (i), which authorizes discretionary temporary release when necessary for a person's defense or another compelling reason. Judge Selna held the defendant's age and medical conditions, which place him in the population most susceptible to COVID-19, and in light of the pandemic, to constitute "another compelling reason" and granted his temporary release.[19]
	D. Ct., Judge Jeffrey A. Meyer	Order	• Judge Meyer ordered the release of defendant stating that "the conditions of confinement at Wyatt are not compatible" with current COVID-19 public health guidance concerning social distancing and avoiding congregating in large groups. Judge Meyer is one of four federal judges in Connecticut who has released inmates in connection with the COVID-19 pandemic.[20]
	D.D.C., Judge Randolph D. Moss	Minute Order	• Judge Moss released defendant, despite acknowledging offense charged--marijuana distribution and felon in possession—"is serious" because among other factors mitigating public safety concerns "incarcerating the defendant while the current COVID-19 crisis continues to expand poses a greater risk to community safety than posed by Defendant's release to home confinement."[21]
	D.D.C., Judge Randolph D. Moss	Memorandum Opinion	• Judge Moss released defendant while awaiting trial after weighing the risk to the public of releasing defendant [charged with distribution of child pornography] directly against risk to community safety if defendant remained incarcerated in light of the COVID-19 pandemic.[22]

	D. Nev., Judge Jones	Opinion and Order	• Judge Jones delayed defendant's date to surrender to begin his intermittent confinement by a minimum of 30 days because "[i]n considering the total harm and benefits to prisoner and society . . . temporarily suspending [defendant's] intermittent confinement would appear to satisfy the interests of everyone during this rapidly encroaching pandemic." In coming to this conclusion, the court placed weight on the fact that "incarcerated individuals are at special risk of infection, given their living situations, and may also be less able to participate in proactive measures to keep themselves safe; because infection control is challenging in these settings.[23]
	D. S.C., Judge David C. Norton	Order	• Judge Norton granted compassionate release for 73-year-old with severe health conditions under the First Step Act, "[g]iven defendant's tenuous health condition and age, remaining incarcerated during the current global pandemic puts him at even higher risk for severe illness and possible death, and Congress has expressed its desire for courts to [release federal inmates who are vulnerable to COVID-19]."[24]
	N.D. Cal., Judge Vince Chhabria	Sua Sponte Order	• Judge Chhabria issued a sua sponte decision extending defendant's surrender date from June 12, 2020 to September 1, 2020 stating: "By now it almost goes without saying that we should not be adding to the prison population during the COVID-19 pandemic if it can be avoided . . . To avoid adding to the chaos and creating unnecessary health risks, offenders who are on release and scheduled to surrender to the Bureau of Prisons in the coming months should, absent truly extraordinary circumstances, have their surrender dates extended until this public health crisis has passed."[25]
	N.D. Cal., Judge Hixson	Order	• Judge Hixon released a 74-year old in light of COVID-19 holding "[t]he risk that this vulnerable person will contract COVID-19 while in jail is a special circumstance that warrants bail. Release under the current circumstances also serves the United States' treaty obligation to Peru, which – if there is probable cause to believe Toledo committed the alleged crimes – is to deliver him to Peru alive."[26]

	S.D.N.Y., Judge Paul A. Engelmayer	Amended Order	• Judge Englemayer granted defendant temporary release from custody, pursuant to 18 U.S.C. § 3142(i), "based on the unique confluence of serious health issues and other risk factors facing this defendant, including but not limited to the defendant's serious progressive lung disease and other significant health issues, which place him at a substantially heightened risk of dangerous complications should be contract COVID-19 as compared to most other individuals."[27]
	S.D.N.Y., Judge Alison J. Nathan	Opinion & Order	• Judge Nathan ordered the Defendant released subject to the additional conditions of 24-hour home incarceration and electronic location monitoring as directed by the Probation Department based in part on "the unprecedented and extraordinarily dangerous nature of the COVID-19 pandemic" which may place "at a heightened risk of contracting COVID-19 should an outbreak develop [in a prison]."[28]
Federal Immigration Detention	9th Cir., Judges Wardlaw, M. Smith, and Judge Siler, 6th Cir., sitting by designation.	Sua Sponte Order	• The panel held "[i]n light of the rapidly escalating public health crisis, which public health authorities predict will especially impact immigration detention centers, the court *sua sponte* orders that Petitioner be immediately released from detention and that removal of Petitioner be stayed pending final disposition by this court."[29]
	C.D. Cal, Judge Terry J. Halter, Jr.	TRO and order to show cause based on writ of habeas corpus	• Judge Halter ordered the release of two ICE detainees. The court found that in detention "[p]etitioners have not been protected [against risks associated with COVID-19]. They are not kept at least 6 feet apart from others at all times. They have been put into a situation where they are forced to touch surfaces touched by other detainees, such as with common sinks, toilets and showers. Moreover, the Government cannot deny the fact that the risk of infection in immigration detention facilities – and jails – is particularly high if an asymptomatic guard, or other employee, enters a facility. While social visits have been discontinued at Adelanto, the rotation of guards and other staff continues."[30]
	D. Mass, Judge Mark L.Wolf	Oral Order	• Judge Wolf ordered the release, with conditions, from ICE custody a member of the class in *Calderon v. Nielsen* based, in part, on the "extraordinary circumstances" posed by COVID-19.[31]

	S.D.N.Y., Judge George B. Daniels	Memorandum Decision and Order	• Judge Daniels ordered the release, under *Mapp v. Reno*, 241 F.3d 221 (2d Cir. 2001), of an individual as there was likelihood of success on the merits and COVID-19 risks and individual's own medical issues constituted "extraordinary circumstances warranting release."[32]
	S.D.N.Y., Judge Alison J. Nathan	Opinion and Order	• Judge Nathan ordered the immediate release of four detainees finding "no evidence that the government took any specific action to prevent the spread of COVID-19 to high-risk individuals . . . held in civil detention."[33]
	S.D.N.Y., Judge Analisa Torres	Memorandum Decision and Order.	• Judge Torres granted immediate release on recognizance for ten individuals in immigration detention who have a variety of chronic health conditions that put them at high risk for COVID-19. These conditions include obesity, asthma, diabetes, pulmonary disease, history of congestive heart failure, respiratory problems, gastrointestinal problems, and colorectal bleeding. The court held detainees face serious risks to their health in confinement and "if they remain in immigration detention constitutes irreparable harm warranting a TRO."[34]

[1] This chart provides only a sample of the judicial action taken throughout the country as judges continue to respond to the COVID-19 pandemic.

[2] Administrative Order, No. 2020-00010, Ala. Ct. App. (Mar. 18, 2020), https://drive.google.com/file/d/1I4QLwsytSVkdOuo5p6qb1JcuFWcAV4oA/view?usp=sharing. Note: the original order has been revised to provide discretion to the Sheriffs. See Mike Carson, *Alabama Judge Orders Jail Inmates Released, then Leaves it Up to Sheriffs,* AL.Com (Mar. 19, 2020), https://www.al.com/news/2020/03/alabama-judge-orders-jail-inmates-released-then-leaves-it-up-to-sheriffs.html.

[3] Scott Buffon, *Coconino County Jail Releases Nonviolent Inmates in Light of Coronavirus Concerns*, Arizona Daily Sun (updated Mar. 25, 2020), https://azdailysun.com/news/local/coconino-county-jail-releases-nonviolent-inmates-in-light-of-coronavirus/article_a6046904-18ff-532a-9dba-54a58862c50b.html.

[4] Advisory from California Chief Justice Tani Cantil-Sakauye to Presiding Judges and Court Executive Officers of the California Courts (Mar. 20, 2020), https://newsroom.courts.ca.gov/news/california-chief-justice-issues-second-advisory-

on-emergency-relief-measures.

[5] *Standing Order of the Sacramento Superior Court*, No. SSC-20-PA5 (Mar. 17, 2020), https://www.saccourt.ca.gov/general/standing-orders/docs/ssc-20-5.pdf.

[6] Kyle C. Barry, *Some Supreme Courts Are Helping Shrink Jails to Stop Outbreaks. Others Are Lagging Behind.*, The Appeal (Mar. 25, 2020), https://theappeal.org/politicalreport/some-supreme-courts-are-helping-shrink-jails-coronavirus; John Cheves, *Chief Justice Pleads for Kentucky Inmate Release Ahead of COVID-19 but Progress Slow*, Lexington Herald Leader (Mar. 23, 2020), https://www.kentucky.com/news/coronavirus/article241428266.html.

[7] Emergency Order Vacating Warrants for Unpaid Fines, Unpaid Restitution, Unpaid Court-Appointed Counsel Fees, and Other Criminal Fees (Mar. 17, 2020), https://www.courts.maine.gov/covid19/emergency-order-vacating-warrants-fines-fees.pdf.

[8] Joint Statement of Chief Justice Bridget M. McCormack, Mich. Sup. Ct. and Sheriff Matt Saxton, Exec. Dir., Mich. Sheriff Ass'n (Mar. 26, 2020), https://courts.michigan.gov/News-Events/press_releases/Documents/CJ%20and%20MSA%20Joint%20Statement%20draft%202%20(003).pdf.

[9] Letter from Chief Justice Mike McGrath, Mont. Sup. Ct, to Mont. Ct. of Ltd. Jurisdiction Judges (Mar. 20, 2020), https://courts.mt.gov/Portals/189/virus/Ltr%20to%20COLJ%20Judges%20re%20COVID-19%20032020.pdf?ver=2020-03-20-115517-333.

[10] Consent Order, *In the Matter of the Request to Commute or Suspend County Jail Sentences*, No. 084230 (N.J. March 22, 2020), https://www.aclu-nj.org/files/5415/8496/4744/2020.03.22_-_Consent_Order_Filed_Stamped_Copy-1.pdf.

[11] *People of the State of New York, ex rel., v. Cynthia Brann*, No. 260154/2020 (Sup. Ct. NY Mar. 25, 2020), https://linkprotect.cudasvc.com/url?a=https%3a%2f%2flegalaidnyc.org%2fwp-content%2fuploads%2f2020%2f03%2fLAS-Mass-Parole-Holds-Writ.pdf&c=E,1,pDbcoVtCJ0c6j6E8cI3m276yaRsx-nzttikQuvDWwS91mRHj6RhL8o5pEJmJl-lk86sC7-f1rq9dTIh2Pe3ZmAUcoZCiC9er2g4Z4mL_ToQ,&typo=1; see also Frank G. Runyeon, *NY Judges Release 122 Inmates as Virus Cases Spike in Jails*, Law360 (March 27, 2020), https://www.law360.com/newyork/articles/1257871/ny-judges-release-122-inmates-as-virus-cases-spike-in-jails.

[12] *Jeffrey v. Bran,* (Sup. Ct. NY Mar. 26, 2020). See Press Release, Redmon Haskins, *Legal Aid Wins Release of 16 Incarcerated New Yorkers at a High Risk of COVID-19 from City Jails* (Mar. 26, 2020),

https://legalaidnyc.org/wp-content/uploads/2020/03/03-26-20-Legal-Aid-Wins-Release-of-16-Incarcerated-New-Yorkers-at-a-high-risk-of-COVID-19-from-City-Jails.pdf;
see also Runyeon, *NY Judges Release 122 Inmates, supra* note 11.

[13] Press Conference, Ohio Chief Justice Maureen O'Connor and Gov. Mike DeWine (Mar. 19, 2020); *see also* WLWT5, *Release Ohio Jail Inmates Vulnerable to Coronavirus, Chief Justice Urges* (Mar. 19, 2020), https://www.wlwt.com/article/release-ohio-jail-inmates-vulnerable-to-coronavirus-chief-justice-urges/31788560#.

[14] Memorandum from Chief Justice Beatty, Sup. Ct of S.C to Magistrates, Mun. Judges, and Summary Ct. Staff (March 16, 2020), https://www.sccourts.org/whatsnew/displayWhatsNew.cfm?indexId=2461.

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