



Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Elsevier hereby grants permission to make all its COVID-19-related research that is available on the COVID-19 resource centre - including this research content - immediately available in PubMed Central and other publicly funded repositories, such as the WHO COVID database with rights for unrestricted research re-use and analyses in any form or by any means with acknowledgement of the original source. These permissions are granted for free by Elsevier for as long as the COVID-19 resource centre remains active.

Letter to the Editor in Response to “COVID-19 and the Correctional Environment: The American Prison as a Focal Point for Public Health”



In “COVID-19 and the correctional environment: the American prison as a focal point for public health,” Montoya-Barthelemy et al.¹ acknowledged that during the coronavirus disease (COVID)-19, response correctional workers are essential personnel because of their daily contact with a high-risk population. In their opinion, careful preparation and planning are essential for containment. In a comparable paper by Irvine et al.,² modelers postulated that COVID-19 outbreaks in Immigration and Customs Enforcement Facilities would overwhelm available intensive care unit beds. We describe how similar tools as those described by Montoya-Barthelemy et al.¹ and Irvine et al.² helped reduce severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) introduction into the largest juvenile detention center in the nation, which employs 600 staff members, of whom, 561 (94%) are considered essential. In March 2020, after the WHO declared COVID-19 a pandemic,³ the organization’s medical and executive teams began joint planning to develop a response to COVID-19. There were 2 objectives: (1) preventing visitors and staff from introducing SARS-CoV-2 to the facility and (2) early education of employees regarding hand hygiene,

respiratory etiquette, social distancing, symptom identification, and appropriate use of personal protective equipment. Residents were separated into 2 cohorts: (1) newly arrived intakes (NAIs) and (2) the facility’s general population (GP). After admission, each member of the NAI cohort was housed in 2-tiered 7-day phases and tested for SARS-CoV-2 using swabs to collect nasal specimens for polymerase chain reaction testing. Asymptomatic members of the NAI cohort were integrated into the GP after 14 days if the results were negative. The medical team participated in >100 meetings and training sessions and helped develop approximately 75 written policies. The county’s courts reduced the GP by reviewing cases and releasing residents who met certain criteria (Figure 1). During the first 60 days, 14 members of the staff tested positive, a 2.8% attack rate. When someone tested positive, video surveillance technology helped identify staff members with significant close contact with ill employees. In addition, residents identified as contacts were quarantined according to the established quarantine guidelines.⁴ On April 21, 2020, because the prevalence of COVID-19 in the GP was unknown as were community transmission rates and rates of asymptomatic carriage, we conducted a point survey of the facility’s residents. Of the 144 current and incoming residents tested, none of the 88 GP residents (0%) tested positive for SARS-CoV-2, whereas of 56 members (8%) of the NAI cohort tested positive. All the 5 positive NAI residents were medically isolated on the COVID unit following standard isolation guidelines.⁴

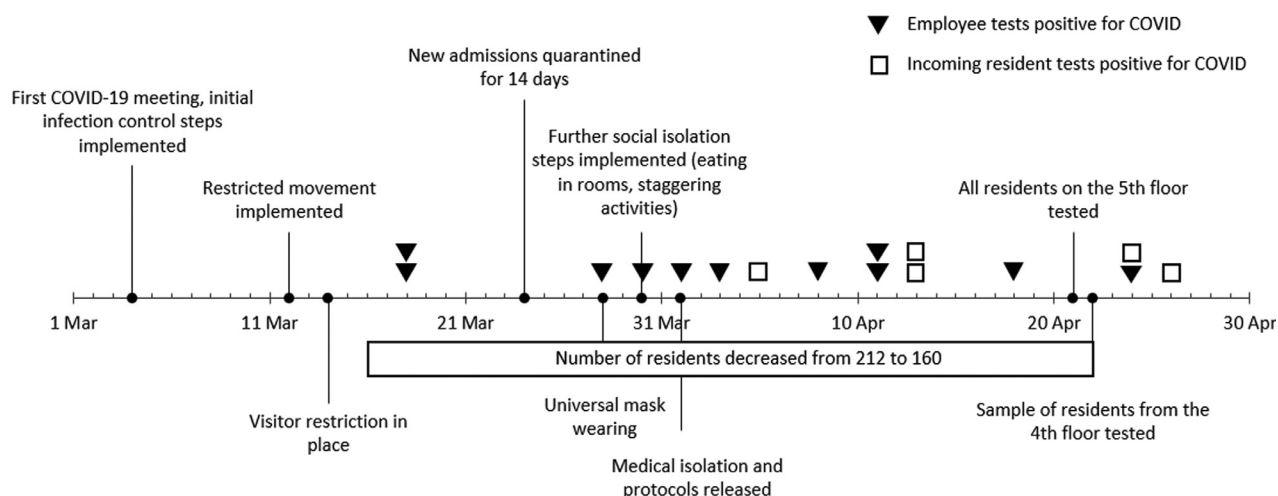


Figure 1. Timeline of infection control measures and COVID-19 positive results. Apr, April; COVID, coronavirus disease; Mar, March.

The absolute risk difference between the NAI and GP cohorts was 7.4% (95% CI =0.80%, 13.9%); this result represents the excess risk of SARS-CoV-2 infection among the NAI cohort. As expected, the risk for SARS-CoV-2 in the NAI cohort was higher than that in the GP cohort (RR=13.7, 95% CI=0.8, 243). By focusing on early active administrative engagement and combining technology with enhanced infection control surveillance, the medical team was able to safely integrate the NAI cohort into the facility's general population.

ACKNOWLEDGMENTS

No financial disclosures were reported by the authors of this paper.

Larissa H. Unruh, MD, MPH

Department of Emergency Medicine, John H Stroger Jr. Hospital of Cook County Health, Chicago, Illinois

Sadhana Dharmapuri, MD

Department of Pediatrics, John H. Stroger Jr. Hospital of Cook County, Chicago, Illinois
Cermak Health Services, Cook County Juvenile Temporary Detention Center, Chicago, Illinois

Kenneth L. Soyemi, MD, MPH, MBA

Department of Pediatrics, John H. Stroger Jr. Hospital of Cook County, Chicago, Illinois
Cermak Health Services, Cook County Juvenile Temporary Detention Center, Chicago, Illinois

<https://doi.org/10.1016/j.amepre.2020.05.003>

REFERENCES

1. Montoya-Barthelemy AG, Lee CD, Cundiff DR, Smith EB. COVID-19 and the correctional environment: the American prison as a focal point for public health. *Am J Prev Med.* 2020;58(6):888–891. <https://doi.org/10.1016/j.amepre.2020.04.001>.
2. Irvine M, Coombs D, Skarha J, et al. Modeling COVID-19 and its impacts on U.S. Immigration and Enforcement (ICE) Detention Facilities, 2020. *J Urban Health.* May 2020:1–9. <https://doi.org/10.1007/s11524-020-00441-x>.
3. Cucinotta D, Vanelli M. WHO declares COVID-19 a pandemic. *Acta Biomed.* 2020;91(1):157–160. <https://doi.org/10.23750/abm.v91i1.9397>.
4. Interim guidance on management of coronavirus disease 2019 (COVID-19) in correctional and detention facilities. Centers for Disease Control and Prevention; 2020. <http://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html>.