Underlying Medical Conditions That Increase Risk of Serious COVID-19 Illnesses for All Ages

Synopsis:

» List of medical conditions and factors that can place a person diagnosed with the novel coronavirus at a higher risk of developing severe symptoms and side effects, of COVID-19.

Key Points:

» Just like with the seasonal flu, seniors, especially those with chronic health conditions, are at higher risk of being affected as COVID-19 spreads.

» Remind everyone in your household of the importance of practicing everyday preventive actions that can help prevent the spread of respiratory illnesses.

Main Digest

Evidence has shown that people with underlying health conditions, including lung disease, seem to be at greater risk of serious illness from COVID-19.

The CDC has issued guidelines for people who are at higher risk.

Begin to practice everyday preventive actions NOW.

Remind everyone in your household of the importance of practicing everyday preventive actions that can help prevent the spread of respiratory illnesses.

The CDC recommends getting ready for COVID-19 NOW, and to help protect yourself by doing the following:

» Avoid crowds.
» Stay at home as much as possible.

» Cover your coughs and sneezes with a tissue.

» Avoid cruise travel and non-essential air travel.

» If you really need to go out in public, keep away from others who are sick, limit close contact and wash your hands often.

» The CDC recommends you have access to several weeks of medicines and supplies in case you need to stay home for prolonged periods of time.

» Wash your hands often with soap and water for at least 20 seconds, especially after going to the bathroom; before eating; and after blowing your nose, coughing, or sneezing.

Medical Conditions that Increase Risk of Serious COVID-19 for All Ages

Just like with the seasonal flu, seniors, especially those with chronic health conditions, are at higher risk of being affected as COVID-19 spreads. Other conditions that could cause serious side effects of Coronavirus COVID-19 include:

» Blood Disorders - For example: Sickle cell disease or on blood thinners.

» Chronic Kidney Disease - For example: Patient has been told to avoid or reduce the dose of medications because kidney disease, or is under treatment for kidney disease, including receiving dialysis.

» Chronic Liver Disease - As defined by your doctor. (e.g., cirrhosis, chronic hepatitis) For example: Patient told to avoid or reduce dose of medications due to liver disease or under treatment for liver disease.

» Endocrine Disorders - For example: diabetes mellitus

» Immunosuppression (Compromised Immune System) - For example: Seeing a doctor for cancer, treatment such as chemotherapy or radiation, received an organ or bone marrow transplant, taking high doses of corticosteroids or other immunosuppressant medications, HIV or AIDS.

» Lung Disease - Asthma or chronic obstructive pulmonary disease, chronic bronchitis, emphysema or other chronic conditions associated with impaired lung function or respiratory disorders that require oxygen.
» Metabolic Disorders - For example: inherited metabolic disorders and mitochondrial disorders.

» Neurological, Neurologic, Neurodevelopment Conditions - For example: disorders of the brain, spinal cord, peripheral nerve, and muscle such as cerebral palsy, epilepsy, seizure disorders, stroke, intellectual disability, moderate to severe developmental delay, muscular dystrophy, or spinal cord injury (SCI).

» Recent Pregnancy - Current or recent pregnancy in the last two weeks.

If you are among those listed above for being at a higher risk of severe symptoms of COVID-19, you should begin to act NOW by:

» Stocking up on supplies.

» Avoid crowds as much as possible.

» Avoid cruise travel and non-essential air travel.

» Taking extra precautions to keep space between yourself and others.

» If you do need to go out in public, keep away from others who are sick, limit close contact and wash your hands often.

» During a COVID-19 outbreak in your community, stay home as much as possible to further reduce your risk of being exposed.

**N95 Masks**

*The 8210V Disposable Respirator from 3M is rated N95 and blocks 95% of all non-oil particle matter down to .03 microns from getting into the lungs.*

A disposable N95 mask, or respirator, is a safety device that covers the nose and mouth and helps protect the wearer from breathing in some hazardous substances. The 'N95' designation means that when subjected to careful testing, the respirator blocks at least 95 percent of very small (0.3 micron) test particles. An N95 mask protects you from breathing in small particles in the air. The best mask for bacteria and virus protection is an N95 or N100.

The OSHA directive indicates that a respirator can be reused as long as it "maintains its structural and functional integrity and the filter material is not physically damaged or soiled." Properly fitted N95 masks could help prevent transmission of the COVID-19 virus and the CDC is currently recommending N95 masks for health workers.
The 8210V Disposable Respirator from 3M - (as pictured above) - is rated N95 and blocks 95% of all non-oil particle matter down to .03 microns from getting into the lungs.

**Watch for COVID-19 Symptoms and Warning Signs**

1 - Pay attention for potential COVID-19 symptoms including, fever, cough, and shortness of breath. If you feel like you are developing symptoms, call your doctor.

2 - If you develop emergency warning signs for COVID-19 get medical attention immediately. In adults, emergency warning signs*:

» Bluish lips or face

» New confusion or inability to arouse

» Persistent pain or pressure in the chest

» Difficulty breathing or shortness of breath

*This list is not all inclusive. Please consult your medical provider for any other symptoms that are severe or concerning.

**Related Documents**

1 - **Underlying Medical Conditions That Increase Risk of Serious COVID-19 Illness for All Ages** : Disabled World (2020/03/13)

2 - **Preparing for Natural Disaster for People with Disabilities and Other Special Needs** : Excerpted by Brittney Bettonville - Lighthouse for the Blind - Saint Louis (2018/12/22)

3 - **Overseas Emergency Services Phone Numbers** : Disabled World (2018/12/19)

4 - **211 Assistance Services in Canada and U.S.** : Disabled World (2012/06/08)

5 - **Wildfires: Before, During and After the Crisis** : Wendy Taormina-Weiss (2012/07/02)

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Courting Catastrophe:
How ICE is Gambling with Immigrant Lives Amid a Global Pandemic
Acknowledgements

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Design by: Carly Pérez Fernández
Translation by: Gabriela Viera and Gabriela Marquez-Benitez

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About Detention Watch Network

Detention Watch Network (DWN) is a national coalition of organizations and individuals building power through collective advocacy, grassroots organizing, and strategic communications to abolish immigration detention in the United States. Founded in 1997 by immigrant rights groups, DWN brings together advocates to unify strategy and build partnerships on a local and national level.

Visit www.detentionwatchnetwork.org
Summary

Under ordinary circumstances, Immigration and Customs Enforcement (ICE) custody has proven to be deadly for the people detained at the agency’s network of over 200 jails and detention centers across the country. Now facing a global health crisis, ICE’s shameful record of medical negligence, limited and rotten food provisions, poor sanitation, and demonstrated inability to properly respond to past infectious disease outbreaks means that there is a serious risk of COVID-19 outbreaks at immigration detention centers. These facilities threaten the lives of the people deprived of their liberty inside and the surrounding communities outside.

Recommendations

It is imperative that ICE take the following actions immediately to protect our collective health:

- Immediately release all detained immigrants to mitigate the spread of COVID-19
- Cease all enforcement operations to prevent new people from being detained and ensure that immigrants are not afraid to seek medical attention
- Eliminate all check-ins and mandatory court appearances to comply with social distancing recommendations
- Ensure all facilities where people are detained in ICE custody, be it county jails or dedicated facilities, are prioritizing the health and wellbeing of people detained, including a waiver of all costs associated with soap, sanitizer, and other hygiene products and a commitment to making these supplies widely available.
Introduction

Amid an ongoing global pandemic caused by the novel coronavirus, COVID-19, ICE can and should immediately release all people from its custody. Public health experts agree that the best way to prevent the spread of COVID-19 is to promote good hygiene with proper and frequent hand washing, and to practice social distancing. People locked up in immigration detention are extremely vulnerable to the spread of infectious disease because they are unable to take these necessary and basic precautions to protect themselves. This fact is compounded by ICE’s horrific record of medical negligence and inability to provide basic necessities imperative to maintaining healthy immune function and sanitation.

Lack of Sanitation and Basic Necessities

People in immigration detention face an egregious lack of basic necessities to maintain their physical and mental health under normal circumstances. According to countless reports from advocates as well as the Department of Homeland Security’s Office of Inspector General (OIG), ICE fails to provide adequate hygienic products critical to halting the spread of illness. OIG inspectors have reported that bathrooms at the Stewart Detention Center in Georgia lacked hot water, and individuals at both Stewart and the Hudson County Jail in New Jersey were not provided with adequate supplies of toilet paper, soap, shampoo, and toothpaste.

Despite guidance from the Centers for Disease Control and Prevention (CDC) and a broad range of medical professionals recommending that people practice extra care in washing their hands, using hand sanitizer and disinfecting surfaces, there have been numerous reports of ICE failing to take these basic precautions inside detention centers. Hand sanitizer is not available and access to soap continues to be limited. One of the primary recommendations to slow the spread of COVID-19 is the practice of social distancing, keeping at least six to ten feet away from others. This is impossible to comply with in ICE facilities where immigrants are housed together in shared living quarters. Denying immigrants the ability to take even the most basic precautions to protect themselves is of grave concern.

In addition to the lack of access to basic hygiene, conditions inside ICE detention centers put immigrants at heightened risk to contract illnesses. ICE serves food that is often moldy or expired, creating conditions for deteriorating health and immune function. At the Essex County Correctional Facility in New Jersey, inspectors found slimy and foul-smelling lunch meat and moldy bread in kitchen refrigerators. Similarly, at the Adelanto ICE Processing Center in California, inspectors found spoiled chicken and other expired food. Further, the well-documented verbal and physical abuse, extensive use of isolation, and lack of access to the outdoors in facilities contribute to mental and physical stress that lowers immune function. Coupled with a callous disregard for the health of detained immigrants when they seek medical attention, these conditions exacerbate the potential for the rapid spread of COVID-19 in ICE facilities.
Troubling Record of Medical Negligence and Deaths

ICE has repeatedly shown to be incapable of adequately responding to outbreaks of contagious diseases and providing the proper care for people in custody.10 Outbreaks of mumps,11 scabies,12 and other highly contagious diseases have been documented to spread aggressively in detention facilities.13 In October 2018, the Texas Department of State Health Services reported five confirmed cases of mumps among immigrants transferred between two ICE detention centers. By August 2019, there were 898 reports of mumps cases in 57 facilities. According to the CDC report, 84 percent of patients were exposed while in custody. This rapid spread of mumps foretells what could happen when people inside ICE custody are exposed to COVID-19.

“This rapid spread of mumps foretells what could happen when people inside ICE custody are exposed to COVID-19.”

ICE has proven time and again that it is unable and unwilling to adequately care for people in need of medical attention. Recent investigations into deaths in immigration detention, Code Red: The Fatal Consequences of Dangerously Substandard Medical Care in Immigration Detention,14 Fatal Neglect: How ICE Ignores Deaths in Detention15 and Systemic Indifference: Dangerous and Substandard Medical Care in US Immigration Detention,16 have found that inadequate medical care has contributed to nearly half of all deaths in ICE custody and that the agency lacks urgency and transparency when reporting deaths. Since 2003 there have been 207 deaths in ICE detention. In the last few months we have seen a troubling spike in the number of reported deaths of immigrants in ICE custody. As of March 23, 2020, 10 people have died in ICE custody in fiscal year 2020, more than the number of lives lost the entire previous fiscal year. In April 2019, a 54-year-old man died in his ICE cell in Arizona due to complications from the flu.17 Another man died from symptoms of liver cirrhosis after repeatedly informing ICE of his conditions and pleading for medical care.18
Public Health Risk

Grouping people inside jails, prisons and detention centers puts our collective health at risk. Facility staff and people newly detained or recently transferred can spark outbreaks by bringing the virus into facilities, while staff can also take it back into their communities when they go home. Over 3,000 medical professionals have warned that it is only a matter of time before the virus spreads throughout jails, detention centers and surrounding communities. As long as ICE keeps people locked up and continues to engage in enforcement operations that bring new people into detention centers, the risk of spreading the virus grows exponentially.

Relying on ICE to manage a COVID-19 outbreak would not only risk the lives of the people in custody, but also increase the threat of spread to the general public. Despite extremely high levels of funding, the agency has proven incapable of providing proper medical care for people in its custody. ICE insists that it is instituting and following appropriate procedures to address the pandemic and is seeking supplemental funding for continued operations and additional quarantine facilities. But ICE is not a medical provider, nor should it serve as one under any circumstances. ICE has long perfected a pattern of deceptively requesting funding increases to improve conditions in its facilities. As a result, the agency’s budget has grown by the billions and ICE’s network of jails has rapidly expanded along with it, while OIG reports continue to condemn their conditions. An agency whose explicit mission is to terrorize immigrant communities will not prioritize nor understand how to address a public health crisis. Healthcare is best provided by medical professionals in appropriate clinical settings.

"Over 3,000 medical professionals have warned that it is only a matter of time before the virus spreads throughout jails, detention centers and surrounding communities."
Recommendations

It is imperative that ICE take the following actions immediately to protect our collective health:

- Immediately release all detained immigrants to mitigate the spread of COVID-19
- Cease all enforcement operations to prevent new people from being detained and ensure that immigrants are not afraid to seek medical attention
- Eliminate all check-ins and mandatory court appearances to comply with social distancing recommendations
- Ensure all facilities where people are detained in ICE custody, be it county jails or dedicated facilities, are prioritizing the health and wellbeing of people detained, including a waiver of all costs associated with soap, sanitizer, and other hygiene products and a commitment to making these supplies widely available.

Conclusion

Communities across the country have already witnessed the devastating impacts of immigration detention. We’ve seen the deterioration of the mental and physical health of those held in ICE facilities. Now, facing a global pandemic, the lives of everyone in its custody are in even more jeopardy. It’s clear that more resources for or dependence on ICE, an agency that is not intended to provide medical care or respond to health needs, is not the solution. Doctors, advocates, government officials, and even a former ICE Director’ve been sounding the alarm. ICE should immediately use its authority to release all people in detention – for their sake and for ours.
Endnotes


Endnotes


18 Id.


Letter from Dr. Allen and Dr. Rich to Congress

Dear Committee Chairpersons and Ranking Members:

We are physicians—an internist and an infectious disease specialist—with unique expertise in medical care in detention settings.1 We currently serve as medical subject matter experts for the

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1 I, Dr. Scott Allen, MD, FACP, am a Professor Emeritus of Medicine, a former Associate Dean of Academic Affairs and former Chair of the Department of Internal Medicine at the University of California Riverside School of Medicine. From 1997 to 2004, I was a full-time correctional physician for the Rhode Island Department of Corrections; for the final three years, I served as the State Medical Program. I have published over 25 peer-reviewed papers in academic journals related to prison health care and am a former Associate Editor of the International Journal of Prisoner Health Care. I am the court appointed monitor for the consent decree in litigation involving...
Department of Homeland Security’s Office of Civil Rights and Civil Liberties (CRCL). One of us (Dr. Allen) has conducted numerous investigations of immigration detention facilities on CRCL’s behalf over the past five years. We both are clinicians and continue to see patients, with one of us (Dr. Rich) currently providing care to coronavirus infected patients in an ICU setting.

As experts in the field of detention health, infectious disease, and public health, we are gravely concerned about the need to implement immediate and effective mitigation strategies to slow the spread of the coronavirus and resulting infections of COVID-19. In recent weeks, attention has rightly turned to the public health response in congregate settings such as nursing homes, college campuses, jails, prisons and immigration detention facilities (clusters have already been identified in Chinese and Iranian prisons according to news reports and an inmate and an officer have reportedly just tested positive at New York’s Rikers Island). Reporting in recent days reveals that immigrant detainees at ICE’s Aurora facility are in isolation for possible exposure to coronavirus. And a member of ICE’s medical staff at a private detention center in New Jersey has now been reported to have tested positive for coronavirus.

We have shared our concerns about the serious medical risks from specific public health and safety threats associated with immigration detention with CRCL’s Officer Cameron Quinn in an initial letter dated February 25, 2020, and a subsequent letter of March 13, 2020. We offered to medical care at Riverside County Jails. I have consulted on detention health issues both domestically and internationally for the Open Society Institute and the International Committee of the Red Cross, among others. I have worked with the Institute of Medicine on several workshops related to detainee healthcare and serve as a medical advisor to Physicians for Human Rights. I am the co-founder and co-director of the Center for Prisoner Health and Human Rights at Brown University (www.prisonerhealth.org), and a former Co-Investigator of the University of California Criminal Justice and Health Consortium. I am also the founder and medical director of the Access Clinic, a primary care medical home to adults with developmental disabilities.

I, Dr. Josiah (Jody) Rich, MD, MPH, am a Professor of Medicine and Epidemiology at The Warren Alpert Medical School of Brown University, and a practicing Infectious Disease Specialist since 1994 at The Miriam Hospital Immunology Center providing clinical care for over 22 years, and at the Rhode Island Department of Corrections caring for prisoners with HIV infection and working in the correctional setting doing research. I have published close to 190 peer-reviewed publications, predominantly in the overlap between infectious diseases, addictions and incarceration. I am the Director and Co-founder of The Center for Prisoner Health and Human Rights at The Miriam Hospital (www.prisonerhealth.org), and a Co-Founder of the nationwide Centers for AIDS Research (CFAR) collaboration in HIV in corrections (CFAR/CHIC) initiative. I am Principal Investigator of three R01 grants and a K24 grant all focused on incarcerated populations. My primary field and area of specialization and expertise is in the overlap between infectious diseases and illicit substance use, the treatment and prevention of HIV infection, and the care and prevention of disease in addicted and incarcerated individuals. I have served as an expert for the National Academy of Sciences, the Institute of Medicine and others.

work with DHS in light of our shared obligation to protect the health, safety, and civil rights of detainees under DHS’s care. Additionally, on March 17, 2020 we published an opinion piece in the Washington Post warning of the need to act immediately to stem the spread of the coronavirus in jails and prisons in order to protect not only the health of prisoners and corrections workers, but the public at large.6

In the piece we noted the parallel risks in immigration detention. We are writing now to formally share our concerns about the imminent risk to the health and safety of immigrant detainees, as well as to the public at large, that is a direct consequence of detaining populations in congregate settings. We also offer to Congress, as we have to CRCL, our support and assistance in addressing the public health challenges that must be confronted as proactively as possible to mitigate the spread of the coronavirus both in, and through, immigration detention and congregate settings.

Nature of the Risk in Immigration Detention and Congregate Settings

One of the risks of detention of immigrants in congregate settings is the rapid spread of infectious diseases. Although much is still unknown, the case-fatality rate (number of infected patients who will die from the disease) and rate of spread for COVID-19 appears to be as high or higher than that for influenza or varicella (chicken pox).

In addition to spread within detention facilities, the extensive transfer of individuals (who are often without symptoms) throughout the detention system, which occurs with great frequency in the immigration context, could rapidly disseminate the virus throughout the entire system with devastating consequences to public health.7

Anyone can get a coronavirus infection. While healthy children appear to suffer mildly if they contract COVID-19, they still pose risk as carriers of infection, particularly so because they may not display symptoms of illness.8 Family detention continues to struggle with managing outbreaks of influenza and varicella.9 Notably, seven children who have died in and around

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7 See Hamed Aleaziz, “A Local Sheriff Said No To More Immigrant Detainees Because of Coronavirus Fears. So ICE Transferred Them All To New Facilities,” BuzzFeed News, March 18, 2020 (ICE recently transferred 170 immigrant detainees from Wisconsin to facilities in Texas and Illinois. “‘In order to accommodate various operational demands, ICE routinely transfers detainees within its detention network based on available resources and the needs of the agency…’ an ICE official said in a statement.”), available at https://www.buzzfeednews.com/article/hamedaleaziz/wisconsin-sheriff-ice-detainees-coronavirus.


9 Indeed, I (Dr. Allen) raised concerns to CRCL, the DHS Office of Inspector General, and to Congress in July 2018, along with my colleague Dr. Pamela McPherson, about the risks if harm to immigrant children in family detention centers because of specific systemic weaknesses at those facilities in their ability to provide for the medical and mental health needs of children in detention. See, e.g., July 17, 2018 Letter to Senate Whistleblower Caucus Chairs from Drs. Scott Allen and Pamela McPherson, available at https://www.wyden.senate.gov/imo/media/doc/Doctors%20Congressional%20Disclosure%20SWC.pdf. Those concerns, including but not limited to inadequate medical staffing, a lack of translation services, and the risk of
immigration detention, according to press reports, six died of infectious disease, including three deaths from influenza.10 Containing the spread of an infection in a congregate facility housing families creates the conditions where many of those infected children who do not manifest symptoms will unavoidably spread the virus to older family members who may be a higher risk of serious illness.

Finally, as you well know, social distancing is essential to slow the spread of the coronavirus to minimize the risk of infection and to try to reduce the number of those needing medical treatment from the already-overwhelmed and inadequately prepared health care providers and facilities. However, social distancing is an oxymoron in congregate settings, which because of the concentration of people in a close area with limited options for creating distance between detainees, are at very high risk for an outbreak of infectious disease. This then creates an enormous public health risk, not only because disease can spread so quickly, but because those who contract COVID-19 with symptoms that require medical intervention will need to be treated at local hospitals, thus increasing the risk of infection to the public at large and overwhelming treatment facilities.

As local hospital systems become overwhelmed by the patient flow from detention center outbreaks, precious health resources will be less available for people in the community. To be more explicit, a detention center with a rapid outbreak could result in multiple detainees—five, ten or more—being sent to the local community hospital where there may only be six or eight ventilators over a very short period. As they fill up and overwhelm the ventilator resources, those ventilators are unavailable when the infection inevitably is carried by staff to the community and are also unavailable for all the usual critical illnesses (heart attacks, trauma, etc). In the alternate scenario where detainees are released from high risk congregate settings, the tinderbox scenario of a large cohort of people getting sick all at once is less likely to occur, and the peak volume of patients hitting the community hospital would level out. In the first scenario, many people from the detention center and the community die unnecessarily for want of a ventilator. In the latter, survival is maximized as the local mass outbreak scenario is averted.

It is additionally concerning that dozens of immigration detention centers are in remote areas with limited access to health care facilities. Many facilities, because of the rural locations, have only one on-site medical provider. If that provider gets sick and requires being quarantined for at least fourteen days, the entire facility could be without any medical providers at all during a foreseeable outbreak of a rapidly infectious disease. We simply can’t afford a drain on resources/medical personnel from any preventable cases.

Proactive Approaches Required

Before coronavirus spreads through immigration detention, proactivity is required in three primary areas: 1) Processes for screening, testing, isolation and quarantine; 2) Limiting transport and transfer of immigrant detainees; and 3) Implementing alternatives to detention to facilitate as much social distancing as possible.

Protocols for early screening, testing, isolation and quarantine exist in detention settings to address infectious diseases such as influenza, chicken pox and measles. However, the track record of ICE facilities implementing these protocols historically has been inconsistent. In the current scenario, with widespread reporting about the lack of available tests for COVID-19 and challenges for screening given the late-onset display of symptoms for what is now a community-spread illness, detention facilities, like the rest of country, are already behind the curve for this stage of mitigation.

Detention facilities will need to rapidly identify cases and develop plans to isolate exposed cohorts to limit the spread, as well as transfer ill patients to appropriate facilities. Screening should occur as early as possible after apprehension (including at border holding facilities) to prevent introduction of the virus into detention centers. We strongly recommend ongoing consultation with CDC and public health officials to forge optimal infection prevention and control strategies to mitigate the health risks to detained patient populations and correctional workers. Any outbreak in a facility could rapidly overwhelm the capacity of healthcare programs. Partnerships with local public health agencies, hospitals and clinics, including joint planning exercises and preparedness drills, will be necessary.

Transferring detainees between facilities should be kept to an absolute minimum. The transfer process puts the immigrants being transferred, populations in the new facilities, and personnel all at increased risk of exposure. The nationwide network of detention centers, where frequent and routine inter-facility transfers occur, represents a frighteningly efficient mechanism for rapid spread of the virus to otherwise remote areas of the country where many detention centers are housed.

Finally, regarding the need to implement immediate social distancing to reduce the likelihood of exposure to detainees, facility personnel, and the general public, it is essential to consider releasing all detainees who do not pose an immediate risk to public safety.

chronic diseases. COVID-19 infection among these groups will require many to be transferred to local hospitals for intensive medical and ventilator care—highly expensive interventions that may soon be in short supply.

Given the already established risks of adverse health consequences associated with the detention of children and their families, the policy of detention of children and their families in should be reconsidered in light of these new infectious disease threats so that children would only be placed in congregate detention settings when lower risk community settings are not available and then for as brief a time as possible.

In addition, given the low risk of releasing detainees who do not pose a threat to public safety—i.e., those only charged with immigration violations—releasing all immigration detainees who do not pose a security risk should be seriously considered in the national effort to stop the spread of the coronavirus.

Similarly, the practice of forcing asylum seekers to remain in Mexico has created a de facto congregate setting for immigrants, since large groups of people are concentrated on the US southern border as a result of the MPP program in the worst of hygienic conditions without any basic public health infrastructure or access to medical facilities or the ability to engage in social distancing as they await asylum hearings, which are currently on hold as a consequence of the government’s response to stop the spread of the coronavirus. This is a tinderbox that cannot be ignored in the national strategy to slow the spread of infection.

ICE recently announced that in response to the coronavirus pandemic, it will delay arresting immigrants who do not pose public safety threats, and will also stop detaining immigrants who fall outside of mandatory detention guidelines. But with reporting that immigrant detainees at ICE facilities are already being isolated for possible exposure to coronavirus, it is not enough to simply stop adding to the existing population of immigrant detainees. Social distancing through release is necessary to slow transmission of infection.

Reassessing the security and public health risks, and acting immediately, will save lives of not only those detained, but also detention staff and their families, and the community-at-large.

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15 Release of immigrants from detention to control the coronavirus outbreak has been recommended by John Sandweg, former acting head of ICE during the Obama administration, who further noted, "'The overwhelming majority of people in ICE detention don't pose a threat to public safety and are not an unmanageable flight risk.'... 'Unlike the Federal Bureau of Prisons, ICE has complete control over the release of individuals. ICE is not carrying out the sentence imposed by a federal judge....It has 100% discretion.'" See Camilo Montoya-Galvez, ‘'Powder kegs': Calls grow for ICE to release immigrants to avoid coronavirus outbreak, CBS News, March 19, 2020, available at https://www.cbsnews.com/news/coronavirus-ice-release-immigrants-detention-outbreak/.
Our legal counsel, Dana Gold of the Government Accountability Project, is supporting and coordinating our efforts to share our concerns with Congress and other oversight entities about the substantial and specific threats to public health and safety the coronavirus poses by congregate settings for immigrants. As we similarly offered to DHS, we stand ready to aid you in any way to mitigate this crisis and prevent its escalation in light of our unique expertise in detention health and experience with ICE detention specifically. Please contact our attorney, Dana Gold, at danag@whistleblower.org, or her colleague, Irvin McCullough, at irvinm@whistleblower.org, with any questions.

Sincerely,

/s/
Scott A. Allen, MD, FACP
Professor Emeritus, University of California, School of Medicine
Medical Subject Matter Expert, CRCL, DHS

/s/
Josiah D. Rich, MD, MPH
Professor of Medicine and Epidemiology
The Warren Alpert Medical School of Brown University
Medical Subject Matter Expert, CRCL, DHS

Cc: Dana Gold, Esq. and Irvin McCullough, Government Accountability Project
    Senate Committee on the Judiciary
    House Committee on the Judiciary
    White House Coronavirus Task Force
Open Letter to ICE from Medical Professionals Regarding COVID-19

Acting Director Matthew T. Albence
U.S. Immigration and Customs Enforcement
500 12 St. SW
Washington, D.C. 20536

March 18, 2020

Re: Letter from Medical Professionals Regarding COVID-19

Dear Acting Director Albence,

As concerned clinicians, we are writing this letter to urge U.S. Immigration and Customs Enforcement (ICE) officials to release individuals and families from immigration detention while their legal cases are being processed to prevent the spread of COVID-19 and mitigate the harm of an outbreak.

In light of the rapid global outbreak of the coronavirus disease 2019 (COVID-19), we want to bring attention to the serious harms facing individuals in immigration detention facilities under the custody of ICE. Health and Human Services Secretary Azar declared a public health emergency on January 31, 2020. As of March 13, 2020, there have been over 132,000 confirmed cases worldwide with nearly 5,000 deaths.

Conditions of Detention Facilities

Detention facilities, like the jails and prisons in which they are housed, are designed to maximize control of the incarcerated population, not to minimize disease transmission or to efficiently deliver health care. This fact is compounded by often crowded and unsanitary conditions, poor ventilation, lack of adequate access to hygienic materials such as soap and water or hand sanitizers, poor nutrition, and failure to adhere to recognized standards for prevention, screening, and containment. The frequent transfer of individuals from one detention facility to another, and intake of newly detained individuals from the community further complicates the prevention and detection of infectious disease outbreaks. A timely response to reported and observed symptoms is needed to interrupt viral transmission yet delays in testing, diagnosis and access to care are systemic in ICE custody. Further, given the patchwork regulatory system, it is unclear whether ICE or the county and state health departments are responsible for ensuring public health oversight of facilities.

For these reasons, transmission of infectious diseases in jails and prisons is incredibly common, especially those transmitted by respiratory droplets. It is estimated that up to a quarter of the US prison population has been infected with tuberculosis1, with a rate of active TB infection that is 6-10 times higher than the general population.2 Flu outbreaks are regular occurrences in jails and prisons across the United States.3,4 Recent outbreaks of vaccine-preventable illnesses including mumps, influenza, and varicella have similarly spread throughout immigration detention facilities. From September of 2018 to August 2019, 5 cases of mumps ballooned to nearly 900 cases among staff and individuals detained in 57 facilities across 19 states, a number that represents about one third of the total cases in the entire US in that time frame.5 With a mortality rate 10 times greater than the seasonal flu and a higher R0 (the average number of individuals who can contract the disease from a single infected person)6 than Ebola, an outbreak of COVID-
19 in immigration detention facilities would be devastating.

**Risks of a COVID-19 Outbreak in Detention**

Emerging evidence about COVID-19 indicates that spread is mostly via respiratory droplets among close contacts and through contact with contaminated surfaces or objects. Reports that the virus may be viable for hours in the air are particularly concerning. Though people are most contagious when they are symptomatic, transmission has been documented in absence of symptoms. We have reached the point where community spread is occurring in the United States. The number of cases is growing exponentially, and health systems are already starting to be strained. Social distancing measures recommended by the Centers for Disease Control (CDC) are nearly impossible in immigration detention and testing remains largely unavailable. In facilities that are already at maximum capacity large-scale quarantines may not be feasible. Isolation may be misused and place individuals at higher risk of neglect and death. COVID-19 threatens the well-being of detained individuals, as well as the corrections staff who shuttle between the community and detention facilities.

Given these facts, it is only a matter of time before we become aware of COVID-19 cases in an immigration detention system in which detainees live in close quarters, with subpar infection control measures in place, and whose population represents some of the most vulnerable. In this setting, we can expect spread of COVID-19 in a manner similar to that at the Life Care Center of Kirkland, Washington, at which over 50% of residents have tested positive for the virus and over 20% have died in the past month. Such an outbreak would further strain the community’s health care system. Considering the extreme risk presented by these conditions in light of the global COVID-19 epidemic, it is impossible to ensure that detainees will be in a “safe, secure and humane environment,” as ICE’s own National Detention Standards state.

In about 16% of cases of COVID-19 illness is severe including pneumonia with respiratory failure, septic shock, multi organ failure, and even death. Some people are at higher risk of getting severely sick from this illness. This includes older adults over 60 and people who have serious chronic medical conditions like heart disease, liver disease, diabetes, lung disease, and who are immunocompromised. There are currently no antiviral drugs licensed by the U.S. Food and Drug Administration (FDA) to treat COVID-19, or post-exposure prophylaxis to prevent infection once exposed.

As such, we strongly recommend that ICE implement community-based alternatives to detention to alleviate the mass overcrowding in detention facilities. Individuals and families, particularly the most vulnerable—the elderly, pregnant women, people with serious mental illness, and those at higher risk of complications— should be released while their legal cases are being processed to avoid preventable deaths and mitigate the harm from a COVID-19 outbreak.

Sincerely,

Nathaniel Kratz, MD; Internal Medicine, New York, NY
Chanelle Diaz, MD, MPH; Internal Medicine, Bronx, NY
Jonathan Ross, MD, MSc; Internal Medicine, Bronx, NY
Jessica Merlin, MD, PhD, MBA; Internal Medicine & Infectious Disease, Pittsburgh, PA
Leela Davies, MD, PhD; Internal Medicine & Infectious Disease, Boston, MA
6 The R0 is the reproduction number, defined as the expected number of cases directly generated by one case in a population where all individuals are susceptible to infection.
7 Close contact is defined as—
a) being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period of time; close contact can occur while caring for, living with, visiting, or sharing a health care waiting area or room with a COVID-19 case
b) having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on).
8 van Doremalen et al, Aerosol and surface stability of HCoV-19 (SARS-CoV-2) compared to SARS-CoV-1, Mar. 9, 2020, https://www.medrxiv.org/content/10.1101/2020.03.09.20033217v1.full.pdf.
March 19, 2020

To Whom It May Concern:

The Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2), is a newly emerging zoonotic agent initially identified in December 2019 that causes the Coronavirus Disease 2019 (COVID-19), formerly known as the 2019 novel Coronavirus (2019nCoV). Infection with COVID-19 is associated with significant morbidity especially in patients with chronic medical conditions. Based on a recently published systematic review of the literature in which I am a co-author of the study, at least one fifth of infected cases require supportive care in medical intensive care units. Equally concerning is the fact that despite the implementation of optimal supportive interventions, case fatality rate among hospitalized patients is more than 10 percent.

As an infectious disease clinician with a public health degree in the dynamics of infectious diseases epidemics and pandemics, I am concerned about the treatment of immigrants inside detention centers which could make the current COVID-19 epidemic worse in the U.S. by having a high case fatality rate among detainees and potentially spreading the outbreak into the larger community. This epidemic has the potential to become the Coming Prison Plague.

Experience Working with People in DHS Custody

I have experience providing care to individuals in a civil detention center and have performed approximately two medical forensic examinations and fifteen medical second opinion evaluations for patients in the custody of the Department of Homeland Security. Based on my conversations with patients, my own observations, and information that exists regarding the resources available within immigration detention facilities as detailed by the ICE Health Services Corps, it is my professional opinion that the medical care available in DHS custody cannot properly accommodate the needs of patients should there be an outbreak of COVID-19 in an immigration detention facility.

Persons Considered High Risk

People who are considered at high risk of severe illness and death should they be infected with the coronavirus include the following:
• People age 50 or older
• Anyone diagnosed with cancer, autoimmune disease (including lupus, rheumatoid arthritis, psoriasis, Sjogren’s, Crohn’s), chronic lung disease (including asthma, COPD, bronchiectasis, idiopathic pulmonary fibrosis), history of cardiovascular disease (MI), chronic arthritis (rheumatoid, psoriatic), chronic liver or kidney disease, diabetes, hypertension, heart failure, HIV, chronic steroids to treat chronic conditions
• People with a history of smoking

I can also certify that many of the detainees from the Aurora Immigration detention facility that I have cared for as an infectious diseases clinician either at the infectious diseases clinic and inpatient hospital services of the Anschutz Medical Center of the University of Colorado or while performing second opinion evaluations within the Aurora detention facility have chronic medical conditions that place them at high risk of developing severe coronavirus disease and potentially dying from this infection. Some of these medical conditions include HIV/AIDS, uncontrolled diabetes mellitus, chronic obstructive pulmonary disease, and other conditions. Many of them are also malnourished due to poorly nutritional diets.

**Risk Factors Present in Immigration Detention**

Detention of any kind allows for large groups of people to be held together in a confined space and creates the worst type of setting for curbing the spread of a highly contagious infection such as COVID-19. Under the current circumstances, incomplete adherence to infection prevention protocols including the appropriate use of personal protective equipment is insufficient to contain the spread of this disease.

In order to adequately contain any type of outbreak, there must be sufficient resources allocated to determining the risk of infection. Namely, the facility should be testing people who are symptomatic in order to determine whether they have COVID-19. Based on news reports, it is my understanding that DHS is not testing people in its custody. The effective institution of interventions to mitigate an outbreak will fail without having the ability to test those infected inside detention centers.

Should an outbreak occur, the number of isolation rooms in a given detention facility is insufficient to comply with the recommended airborne/droplet isolation guidelines. Another important consideration that complicates disinfection and decontamination practices in detention facilities is the ability of this coronavirus to survive in aerosol and metal surfaces which are highly prevalent security materials. The current outbreak requires multiple routine disinfection and decontamination of all surfaces of the facility. With a large population of detainees and staff coming in and out of any given facility, it is highly unlikely to maintaining optimal infection prevention practices.
Responding to this outbreak calls for highly-trained staff to correctly institute and enforce isolation and quarantine procedures, and to have the training to wear personal protective equipment. It is required that during the outbreak, sufficient nursing and medical staff need to be trained in infection control prevention practices, in implementing triage protocols, and adequate training in the medical management of suspect, probable and confirmed cases of coronavirus infection. This same personnel would have to initiate the management of those with severe disease. Since these are closed facilities, the number of exposed, infected, and ill detainees may prove to rapidly overwhelm staff and resources within a detention center. As a result, many patients would need transfer to hospitals near detention centers potentially overwhelming surrounding healthcare systems which are already functioning at full-capacity caring for the general community.

**Likely Outcome if COVID-19 Spreads in Immigration Detention**

Given the large population density of immigration detention centers, and the ease of transmission of this viral pathogen, the attack rate may take exponential proportions. Behind the walls of a detention center, the basic reproductive rate of the infection ($R_0=2$) may be responsible for infecting between 30-50% of detainees and staff within a facility. Of these one-fifth will require hospital admission, and about 10% will develop severe disease requiring intensive care unit. For an immigration detention center that holds 1500 detainees, we can estimate that 500-650 may acquire the infection. Of these, 100 to 150 individuals may develop severe disease potentially requiring admission to an intensive care unit. Of these, 10-15 individuals may die from respiratory failure. The cost of care of in the intensive care unit is in the order of $5000 to $8,000 dollars per day for those requiring mechanical ventilation.

**Risk Minimization Through Release from Detention**

In contrast, releasing those in the high risk age groups and those with underlying medical conditions with lessen the impact of an outbreak of COVID-19. The main reason is that those in these groups at risk carry the highest concentration of virus in their respiratory secretions and act as human incubators of the virus. Additionally, by having a reduced number of people and held together in a confined space, there is a reduced number of networks of transmission of the infection. This intervention is the public interest since the release people from detention will minimize the number of people infected with COVID-19 that may potentially spread to the surrounding communities around detention centers.

**Conclusion**

Besides the humanitarian premise and the moral justification for the release of detainees in the midst of the ongoing epidemic in the U.S., the potential medical impact that COVID-19 may produce among detainees may become devastating and require major financial
investment by ICE. Therefore, anticipating the impact of this epidemic inside immigration detention facilities justifies exploring alternative strategies to reduce its impact in U.S. soil. The prompt release on parole of detainees with medical conditions at risk of severe disease and death due to coronavirus infection may reduce the impact of this outbreak among detention facilities. This intervention may also effectively reduce the potential spillover of the outbreak from a detention center into the community.

Sincerely,

Carlos Franco-Paredes, MD, MPH, DTMH (Gorgas)
Associate Professor of Medicine
Division of Infectious Diseases
Department of Medicine
Division of infectious Diseases
Program Director Infectious Disease Fellowship
Training Program, University of Colorado
PERSONAL INFORMATION
Carlos Franco-Paredes, M.D., M.P.H.
731 Dexter Street
Denver, CO 80220
(229)344-1748
Carlos.franco-paredes@cuanschutz.edu
carlos.franco.paredes@gmail.com
U.S. Citizen and Mexican Citizen
Languages: English and Spanish

CURRENT PROFESSIONAL POSITION AND ACTIVITIES:
• Associate Professor of Medicine, Division of Infectious Diseases, University of Colorado Denver School of Medicine, Anschutz Medical Campus and Infectious Diseases (July 2018 - ongoing).
• Fellowship Program Director, Division of Infectious Diseases, University of Colorado Denver School of Medicine, Anschutz Medical Campus (March 2019- ongoing).

EDUCATION
1989 -1995     M.D. - La Salle University School of Medicine, Mexico City, Mexico
1996-1999      Internship and Residency in Internal Medicine, Emory University School of Medicine Affiliated Hospitals, Atlanta, GA
1999-2002      Fellowship in Infectious Diseases, Emory University School of Medicine Affiliated Hospitals, Atlanta, GA
1999-2002      Fellow in AIDS International Training and Research Program, NIH Fogarty Institute, Rollins School of Public Health, Emory University, Atlanta, GA
1999 - 2002    Masters Degree in Public Health (M.P.H.) Rollins School of Public Health, Emory University, Atlanta, GA, Global Health Track
2001-2002      Chief Medical Resident, Grady Memorial Hospital, Emory University School of Medicine, Atlanta, GA
2006          Diploma Course in Tropical Medicine, Gorgas. University of Alabama, Birmingham and Universidad Cayetano Heredia, Lima Peru

CERTIFICATIONS
1999-Present   Diplomat in Internal Medicine American Board of Internal Medicine (Recertification 11/2010-11/2020)
2001-present   Diplomat in Infectious Diseases, American Board of Internal Medicine, Infectious Diseases Subspecialty (Recertification 04/2011-04/2021)
2005-present   Travel Medicine Certification by the International Society of Travel Medicine
2007-present   Tropical Medicine Certification by the American Society of Tropical Medicine – Diploma in Tropical Medicine and Hygiene (DTMH - Gorgas)

EMPLOYMENT HISTORY:

Carlos Franco-Paredes, MD, MPH
Revised: 03/16/2020
Carlos Franco-Paredes, MD, MPH

- 2002 - 2004 - Advisor to the Director of the National Center for Child and Adolescent Health and of the National Immunization Council (NIP), Ministry of Health Mexico; my activities included critical review of current national health plans on vaccination, infectious diseases, soil-transmitted helminthic control programs; meningococcal disease outbreaks in the jail system, an outbreak of imported measles in 2003-2004 and bioterrorism and influenza pandemic preparedness. I represented the NIP at meetings of the Global Health Security Action Group preparation of National preparedness and response plans for Mexico
- 2005 – 2011- Co-Director Travel Well Clinic, Emory University Emory Midtown Hospital
- 2004- 8/2009 -Assistant Professor of Medicine Department of Medicine, Division of Infectious Diseases Emory University School of Medicine, Atlanta GA
- 9/2009- 3/2011 Associate Professor of Medicine Department of Medicine, Division of Infectious Diseases Emory University School of Medicine, Atlanta GA
- 1/2007 – 3/2011 Assistant Professor of Public Health Hubert Department of Global Health Rollins School of Public Health, Emory University, Atlanta GA
- 4/2011 –5/2013 - Associate Professor of Public Health in Global Health Hubert Department of Global Health Rollins School of Public Health, Emory University, Atlanta GA
- 3/2011- 5/2017 - Phoebe Physician Group –Infectious Diseases Clinician Phoebe Putney Memorial Hospital, Albany, GA.
- June 19, 2017-June 31, 2018–Visiting Associate Professor of Medicine, Division of Infectious Diseases, University of Colorado Denver, Anschutz Medical Campus
- June 2004- present - Adjunct Professor of Pediatrics, Division of Clinical Research, Hospital Infantil de México, Federico Gómez, México City, México. Investigador Nacional Nivel II, Sistema Nacional de Investigadores (12/2019); SNI III Sistema Nacional de Investigadores (1/2020-); Investigador Clínico Nivel E, Sistema Nacional de Hospitales

HONORS AND AWARDS
Carlos Franco-Paredes, MD, MPH

1995  Top Graduating Student, La Salle School of Medicine
1997  Award for Academic Excellence in Internal Medicine, EUSM
1999  Alpha Omega Alpha (AOA) House staff Officer, EUSM
2002  Pillar of Excellence Award. Fulton County Department of Health and Wellness
      Communicable Disease Prevention Branch, Atlanta GA
2002  Emory University Humanitarian Award for extraordinary service in Leadership
      Betterment of the Human Condition the Emory University Rollins School of Public
      Health
2002  Winner of the Essay Contest on the Health of Developing Countries:
      Causes and Effects in Relation to Economics or Law, sponsored by the Center for
      International Development at Harvard University and the World Health
      Organization Commission on Macroeconomics Health with the essay “Infectious
      Diseases, Non-zero Sum Thinking and the Developing World”
2002  “James W. Alley” Award for Outstanding Service to Disadvantaged Populations,
      Rollins School of Public Health of Emory University May 2002. Received during
      Commencement Ceremony Graduation to obtain the Degree of Masters in Public
      Health
2006  Golden Apple Award for Excellence in Teaching, Emory University, School of Med
2006  Best Conference Award Conference, “Juha Kokko” Best Conference
      Department of Medicine, EUSM
2007  “Jack Shulman” Award Infectious Disease fellowship, Excellence in Teaching
      Award, Division of Infectious Diseases, EUSM
2007  Emerging Threats in Public Health: Pandemic Influenza CD-ROM, APHA’s Public
      Health Education and Health Promotion Section, Annual Public Health Materials
      Contest award
2009  National Center for Preparedness, Detection, and Control of Infectious Diseases.
      Honor Award Certificate for an exemplary partnership in clinical and
      epidemiologic monitoring of illness related to international travel. NCPDCID
      Recognition Awards Ceremony, April 2009. CDC, Atlanta, GA
2012  The ISTM Awards Committee, directed by Prof. Herbert
      DuPont, selected the article “Rethinking typhoid fever
      vaccines” in the Journal of Travel Medicine (Best Review Article)
2012  Best Clinical Teacher. Albany Family Medicine Residency Program
2018  Outstanding Educator Award – Infectious Diseases Fellowship, Division of
      Infectious Diseases, University of Colorado, Anschutz Medical Center, Aurora
      Colorado

EDITORSHIP AND EDITORIAL BOARDS
2007-Present  Deputy/Associate Editor PLoS Neglected Tropical Disease
               Public Library of Science
2017-2018       Deputy Editor, Annals of Clinical Microbiology and Antimicrobials
               BMC
2007-2019       Core Faculty International AIDS Society-USA -Travel and Tropical Medicine/HIV/AIDS

INTERNATIONAL COMMITTEES
2018- Member of the Examination Committee of the International Society of Travel Medicine.
Carlos Franco-Paredes, MD, MPH

Developing Examination Questions and Proctoring the Certificate in Traveler’s Health Examination
Proctor Certificate of Traveler’s Health Examination (CTH) as part of the International Society of
Travel Medicine—12th Asia-Pacific Travel Health Conference, Thailand 21-24 March 2019
Proctor Certificate of Traveler’s Health Examination (CTH), Atlanta, GA, September, 2019

PRESENTATIONS AT NATIONAL/INTERNATIONAL MEETINGS
2017- Meeting of the Colombian Society of Infectious Diseases, August 2017:
Discussion of Clinical Cases Session, Influenza, MERS-Coronavirus, Leprosy, Enteric Fever
2018 – Cutaneous Mycobacterial Diseases, Universidad Cayetano Heredia,
Lima, Peru, Mayo 2018
2018 – Scientific Writing Seminar, ACIN, Pereira, Colombia, August 2-4, 2018
2019 – First International Congress of Tropical Diseases ACINTROP 2019. March 21, 2019, Monteria,
Colombia, Topic: Leishmaniasis
2019 – One Health Symposium of Zoonoses, Pereira Colombia, August 16-17, 2019, Topic: Zoonotic
Leprosy
2019 – Congress Colombian Association of Infectious Diseases (ACIN), Topic: Leprosy in Latin America,
Cartagena, Colombia, August 21-24, 2019
2019 – World Society Pediatric Infectious Diseases, Manila Philippines, November 7-9, 2019 - Tropical
Medicine Symposium: Diagnosis, Treatment, and Prevention of Leprosy.
2019 – FLAP. Federacion Latino Americana de Parasitologia, Panama, Panama, November 26, 2019, Oral
Transmission of Leprosy Symposium
2019 – FLAP. Federacion Latino Americana de Parasitologia, Panama, Panama, November 27, 2019,
Leprosy Situation in the Americas.

PUBLICATIONS
BOOKS
Franco-Paredes C, Santos-Preciado JI. Neglected Tropical Diseases in Latin America and the Caribbean,
ISBN: 978-0-12-804423-0

RESEARCH ORIGINAL ARTICLES (clinical, basic science, other) in refereed journals:
351:1262-1263.
A, Rubio N, Franco-Paredes C. Lepidopterism Due to the Exposure of the Moth Hylesia metabus in

SOUTHEAST IMMIGRANT FREEDOM INITIATIVE // COVID-19 PAROLE INFORMATIONAL GUIDE FOR SPONSORS
Carlos Franco-Paredes, MD, MPH

Carlos Franco-Paredes, MD, MPH


Carlos Franco-Paredes, MD, MPH


41. Chastain DB, Henao-Martinez AF, Franco-Paredes C. A clinical pharmacist survey of prophylactic strategies used to prevent adverse events of lipid-associated formulations of amphotericin B. Infect Dis 2019;


RESEARCH ORIGINAL ARTICLES AS COLLABORATOR (clinical, basic science, other) in refereed journals:


Carlos Franco-Paredes, MD, MPH


REVIEW, EDITORIALS, CASE SERIES, CASE REPORT ARTICLES:


Carlos Franco-Paredes, MD, MPH


Carlos Franco-Paredes, MD, MPH


Carlos Franco-Paredes, MD, MPH


Carlos Franco-Paredes, MD, MPH


Carlos Franco-Paredes, MD, MPH


152. Franco-Paredes C. Health Equity is not only Healthcare Delivery. Lancet 2011; 377: 1238.


Carlos Franco-Paredes, MD, MPH


Carlos Franco-Paredes, MD, MPH


Carlos Franco-Paredes, MD, MPH


FORMAL TEACHING

Medical Student Teaching
2001 - 2002  Clinical Methods, Emory University School of Medicine
2001 - 2002  Clinical Instructor Harvey Cardiology Course, Emory University School of Medicine
2001 - 2002  Problem-Based Learning for Second year Medical Students, EUSM
2005-2011 Clinical Methods Preceptor, ECLH
2006-2008  Medical Spanish - Instructor for M2, EUSM
2006-2007  Directed Study on Social Determinants of Infectious Diseases for M2 students (Lindsay Margolis and Jean Bendik), EUSM
2007-2011  Instructor - Global Health for M2 Students, EUSM
2007-2008 Presentation-Case Discussion – Social Determinants of Diseases – Coordinated by Dr. Bill Eley – Emory School of Medicine New Curriculum.
2018-  Small Group: Parasitic Diseases, Microbiology Course for First Year Medical Students, University of Colorado, Anschutz Medical Center.
2019-  MS-2 Small group discussion Microbiology, University of Colorado, Anschutz Medical Center: Parasitic Diseases, CNS Infections, Septic Arthritis-Cat Bite
2020-  MS-2 Small group discussion Microbiology, University of Colorado, Anschutz Medical Center: Parasitic Diseases, CNS Infections, Septic Arthritis-Cat Bite

Graduate Program

Training programs
2006-2011  Professor - GH511 (Global Health 511) International Infectious Diseases Prevention and Control, Rollins School of Public Health
2009-2011  Professor – GH500 D – Key Issues in Global Health, Career MPH Program
2006-2011  Thesis Advisor to students Global Health Track – Hubert Department of Global Health, Rollins School of Public Health of Emory University
2008-2011 Coordinator International Exchange between Rollins School of Public Health and National Institute of Public Health, Cuernavaca, Mexico – Supported by the Global Health Institute
Carlos Franco-Paredes, MD, MPH

of Emory University

Residency and Fellowship Program:

2004-2011 Resident Report – Noon Conferences Emory Crawford Long Hospital and Grady Memorial Hospital

2004-2011 Didactic Lectures on Parasitic Diseases and Non-tuberculous mycobacterial diseases for Internal Medicine Residents and Infectious Disease Fellows

2005-2008 Coordinator Journal Club Infectious Disease Division

2005-2011 Travel Medicine Elective, Internal Medicine Residents (2 internal residents per month)

2005 Grand Rounds – EUH - Department of Medicine: “Travel Medicine”

2006 Grand Rounds – ECLH – Department of Medicine: “Malaria”

2008 Grand Rounds - ECLH – Department of Medicine: “Leprosy”

2008-2011 Journal Club Coordinator, Internal Medicine Residency Program – ECLH

2009 Grand Rounds - EUH – Department of Medicine: “Leprosy a Modern Perspective of an Ancient Disease”

2009 Grand Rounds – Pulmonary and Critical Care Division – Neglected Tropical Diseases of the Respiratory Tract, June 16, 2009

2017 Grand Rounds – Leprosy, University of Colorado, Anschutz Medical Center, Division of Infectious Diseases, December 2017

2017 Grand Rounds – Infections associated with Secondary Antiphospholid Syndrome, University of Colorado, Anschutz Medical Center, Division of Rheumatology

2018 Didactic Session – Travel Medicine (Pretravel and Postravel) Infectious Diseases Fellowship Anschutz Medical Center, Division of Infectious Diseases

2017- Infectious Diseases Fellows Clinic, University of Colorado, Anschutz Medical Center, IDPG.

2019 Invited Speaker: Travel Medicine, Pretravel/Postravel Care, Physician Assistant Program, September 12, 2019, University of Colorado, Anschutz Medical Center

Other categories:

2000-2002 Physician Assistant Supervision during Fellowship/Junior Faculty, Emory University

2004-2007 Mentoring of four College Students to enter into Medical School (Emory, Southern University, and Dartmouth):
Lindsay Margolis 2004-Emory University
Michael Woodworth 2005 – Emory University
Peter Manyang 2007 – Southern University
Padraic Chisholm 2007 – Southern University/Emory University

2009-2011 Project Leader. Partnership – Emory Global Health Institute – University-wide - Emory Travel Well Clinic and is titled Hansen's disease in the state of Georgia: A Modern Reassessment of an Ancient Disease”.
http://www.globalhealth.emory.edu/fundingOpportunities/projectideas.php. Students: 5 MPH students (RN/MPH, MD/MPH)

2017- Infectious Diseases Fellowship Program, University of Colorado, Anschutz Medical Center. Teaching activities Inpatient and outpatient (ID Fellows Weekly Clinic)

2019- Infectious Diseases Fellowship Program Director University of Colorado, Aurora Colorado

Supervisory Teaching:
Ph.D. students directly supervised:
Carlos Franco-Paredes, MD, MPH

Global Health, Rollins School of Public Health - PhD Task Force Member – 2007-2009

Residency Program:
Emory University: Internal Medicine Residents and Infectious Disease Fellows Supervision – Inpatient
Months – 3-4 months per year on Grady Wards. I participated in the presentation and discussion of
clinical cases, and discussion of peer-reviewed journal with medical students, residents, and fellows.
Overall evaluations: Outstanding Teacher. (Anna Von 2005-2006; Seth Cohen 2008, Susana Castrejon
2007; Lindsay Margoles 2007-2008; Jean Bendik 2006-2008; Meredith Holtz 2007-2008)

University of Colorado, Anschutz Medical Center (since June 2017- present). Case discussion in infectious
diseases during clinical rounds inpatient services (ID Gold, ID Blue, ID Orthopedics).

2004-2009 Thesis advisor – MPH Students – Hubert Department of Global Health – Concentration
Infectious Diseases: Brenda Thompson 2004; Katrina Hancy 2004; Trina Smith 2006; Melissa Furtado
2007-2008; Oidda Museru 2008-2009; Hema Datwani 2010; Ruth Moro 2010; Talia Quandelacy 2010
2015 – Class GH511, Topic: “Leprosy” as part of the International Infectious Diseases, Global Health
Track, Rollins Schooef of Public Health, Emory University, Atlanta GA

2017 – Class GH511, Topic: “Leprosy” as part of the International Infectious Diseases, Global Health
Track, Rollins School of Public Health, Emory University, Atlanta GA

2019 - Project Mentorship – Diffuse lepromatous leprosy. Undergraduate Student,
University of Colorado, Boulder. Mikali Ogbasselassie. Project was carried out in
Collaboration with the Dermatology Center of the Hospital General de Mexico.
Poster presentation by Mikali Ogbasselassie September 22, 2019, UMBC, Baltimore, Maryland.