In the US, correctional facilities have been the site of rising cases and outbreaks of coronavirus disease 2019 (COVID-19). Multiple issues fuel the introduction and spread of COVID-19 in correctional facilities, while other factors, such as the high rate of chronic health issues among incarcerated populations, may result in an increased concentration of severe disease. Indeed, the COVID-19 death rate in prisons is higher than in the general population. Because Black American individuals and other people of color are overrepresented in correctional facility populations, COVID-19 outbreaks in this setting are likely to magnify existing structural racism and health inequities that have resulted in members of racial minority groups being disproportionately affected by the pandemic. In part because of the potential for outbreaks in correctional facilities to overwhelm local healthcare systems, Kinner et al have written, "Prison health is public health." Hospitals, correctional facilities, and policy makers thus must work together to prepare for the care of persons who are incarcerated and hospitalized with COVID-19 by anticipating several key issues.

First, routine capacity-associated challenges will be amplified in hospitals with geographic proximity to correctional facilities; some critical access hospitals—which have fewer resources—may be devastated. State-level hospital planning should account for the fact that 1 hospital can be overrun by a COVID-19 outbreak in a nearby correctional facility. This is especially important, considering that higher COVID-19 death rates have been associated with hospitalization in facilities with decreased intensive care unit capacity. Furthermore, these correctional officers may serve as possible vectors of COVID-19 between correctional facilities and hospitals. Correctional facilities should reconsider 2-guard policies, especially for persons who are hospitalized and incarcerated with lower security concerns or critically ill or intubated. In the setting of an outbreak within a correctional facility, persons who are incarcerated and hospitalized could be cohorted and guards consolidated, especially within dedicated COVID-19 care units.

Third, while the additional protections persons who are incarcerated have when participating in clinical research provide important safeguards, these can also create a barrier to receiving investigational therapies. Many health systems have rushed to complete institutional review board (IRB) applications to secure coveted study-site slots for trials of candidate COVID-19 therapies, and this will likely be the case for the foreseeable future. The inclusion of persons who are incarcerated requires additional planning, documentation, and IRB review. Thus, including persons who are incarcerated in these studies involves either taking additional time to assemble the initial IRB application or amending it at a later date. Waiting can mean that persons who are incarcerated do not receive interventions with the potential to benefit them, especially when they are at risk of presenting with more severe disease. Trials of unproven therapies should not be misconstrued as treatment, but access to these studies is important in cases where no accepted treatment exists or is available. In the current pandemic, correctional facilities, hospitals, IRBs, and pharmaceutical companies should prepare in advance for enrollment of persons who are incarcerated into clinical trials.
Similarly, pharmaceutical companies and hospital-based scarce-allocation committees must ensure persons who are incarcerated are not unfairly excluded from the limited supply of investigational drugs made available for compassionate use, especially given that many of these individuals have comorbidities that might otherwise render them ineligible for trial enrollment. Professional societies have advocated for “equitable access” to such therapies for persons who are incarcerated. Thoughtfully but expeditiously formulating policies and procedures can help ensure that the health disparities already faced by persons who are incarcerated are not amplified during the pandemic.

Persons who are incarcerated are at risk of being disproportionately affected by COVID-19, magnifying existing and identifying new issues with their care in the hospital setting. Key stakeholders should engage in coordinated planning to ensure there are sound policies in place to guide the care of persons who are incarcerated and hospitalized with COVID-19, protecting patients, hospital and correctional facility personnel, and local healthcare systems. Such efforts will help mitigate the outcomes of a sudden influx of patients who are incarcerated on healthcare systems, especially given the concern that persons who are incarcerated and have COVID-19 may present later in their disease course and thus with more severe disease than other patients.6

ARTICLE INFORMATION
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