December 14th, 2020

The Honorable Eric Holcomb
Governor of Indiana
Indiana Statehouse, 200 W. Washington St.
Indianapolis, Indiana 46204-2797

Dear Governor Holcomb,

As you are likely aware, the COVID-19 pandemic has disproportionately affected certain vulnerable communities. In particular, we have seen significantly higher rates of infection, serious illness, and death among people living in congregate care settings (such as nursing homes, psychiatric hospitals, developmental disability centers, intermediate care facilities, and large group homes), those incarcerated in prisons, jails, and immigration detention, and—at a broader level—people in communities of color. These groups are in dire need of protection from COVID-19, and we urge you to prioritize them, alongside healthcare workers, when planning for the allocation and distribution of vaccines.

We recognize that vaccine allocation and distribution will present a tremendous challenge to state officials, who must balance a number of different public-health, practical, and political considerations with the fact that the immediate supply of available vaccines will be severely limited. But a vaccine-distribution plan cannot be considered fair or equitable if it does not take into account, and attempt to redress, the disproportionate impact the pandemic has had on these at-risk communities. Moreover, decisions regarding which populations are prioritized must be made via a transparent, evidence-based, and impartial process that includes input from these impacted communities.

Congregate care facilities

People who live or work in congregate, long-term, and institutional care settings should be among the populations who receive priority access to COVID-19 vaccines. While COVID-19 infections and deaths in nursing homes have rightfully garnered publicity and intervention, vaccines should be prioritized for staff and residents at a variety of facilities, including nursing homes, psychiatric hospitals, developmental disability centers, intermediate care facilities, and large group homes. The individuals who live in these facilities are overwhelmingly people with disabilities and are thus at high risk of COVID-19 complications or death. In addition, the people who work in these facilities are disproportionately low-income, women of color, and immigrants—all populations disproportionately affected, infected, and killed by the virus.[1]

[1] Wyatt Koma et al., *Low-Income and Communities of Color at Higher Risk of Serious Illness if Infected with Coronavirus*, Kaiser Family Foundation (May 7, 2020), https://www.kff.org/coronavirus-covid-19/issue-brief/low-income-and-communities-of-color-at-higher-risk-of-serious-illness-if-infected-with-coronavirus/; Lucy Erickson, PhD, *The Disproportionate Impact of COVID-19 on Women of Color*, Society for Women's Health Research (April 30, 2020), https://swhr.org/the-disproportionate-impact-of-covid-19-on-women-of-color/; Jorge Loweree, *The Impact*

Long-term care facilities are home to less than 1% of the nation's population, but residents and staff account for 40% of those who have died from COVID-19 nationwide.[2] People with disabilities and older adults who live in these facilities are more likely to have conditions that preclude them from receiving a vaccine, leaving them to rely on the immunity of those around them for protection. They are also more likely to die or suffer serious complications if infected by COVID-19 and are typically less able to limit their exposure because of the congregate settings in which they live. For example, people with disabilities who were living in group homes in New York state had far higher rates of COVID-19 infections, compared with other state residents, and their risk of dying was markedly higher as well.[3] Indeed, in Indiana, 49.5% of the state's COVID-19 deaths have occurred in long-term care facilities.[4] Across the country, these infections and deaths have been marked by troubling racial disparities.[5]

Prisons, jails, and immigration detention

Similarly troubling is the disproportionate impact that COVID-19 has had in another congregate setting: prisons, jails, and immigration detention. People held in these facilities, who are also disproportionately people of color and people with disabilities, should likewise be prioritized for vaccine access, as should staff who are in close contact with—and pose enormous risk to—incarcerated people.

Individuals living in carceral settings have higher rates of disability and chronic health issues due, in part, to the physical stress and strain imposed by imprisonment. They also often lack adequate nutrition, health care, access to fresh air, and proper hygiene measures. They have very little to no control over their exposure to COVID-19 and, as a result, are in greater danger of contracting and dying from the disease. For example, recent studies have found that the rate of COVID-19 cases in federal and state prisons is more than four times the national rate and that the mortality rate in federal prisons is twice that of the general population.[6] Meanwhile, earlier this year, the COVID-19 case rate in immigration detention—including state and local prisons and jails that rent space to ICE—was calculated to be about thirteen times higher than the rate of the U.S. population.[7] This

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of COVID-19 on Noncitizens and Across the U.S. Immigration System, American Immigration Council (Sept. 30, 2020), https://www.americanimmigrationcouncil.org/research/impact-covid-19-us-immigration-system.

[2] Priya Chidambaram et al., *COVID-19 Has Claimed the Lives of 100,000 Long-Term Care Residents and Staff*, Kaiser Family Foundation (Nov. 25, 2020), https://www.kff.org/policy-watch/covid-19-has-claimed-the-lives-of-100000-long-term-care-residents-and-staff/.

[3] Roni Caryn Rabin, *Developmental Disabilities Heighten Risk of Covid Death*, N.Y. Times (Nov. 11, 2020), https://www.nytimes.com/2020/11/10/health/covid-developmental-disabilities.html.

[4] *Indiana COVID-19 Data Report,* ISDH (Dec. 12, 2020)*, https://www.coronavirus.in.gov/2393.htm*

[5] Priya Chidambaram et al., *Racial and Ethnic Disparities in COVID-19 Cases and Deaths in Nursing Homes*, Kaiser Family Foundation (Oct. 27, 2020), https://www.kff.org/coronavirus-covid-19/issue-brief/racial-and-ethnic-disparities-in-covid-19-cases-and-deaths-in-nursing-homes/?utm_campaign=KFF-2020-Coronavirus&utm_medium=email&_hsmi=2&_hsenc=p2ANqtz--w7cH71_TA9szizWXkzhF3Op6PWdeh9dAk3_T1ywabR0Zc8nh2.

[6] Cid Standifer & Frances Stead Sellers, *Prisons and Jails Have Become a "Public Health Threat" During the Pandemic, Advocates Say*, Washington Post, Nov. 11, 2020, https://www.washingtonpost.com/national/coronavirus-outbreaks-prisons/2020/11/11/b8c3a90c-d8d6-11ea-930e-d88518c57dcc_story.html.

[7] Parsa Erfani et al., *COVID-19 Testing and Cases in Immigration Detention Centers, April-August 2020*, JAMA Network (Oct. 29, 2020), https://jamanetwork.com/journals/jama/fullarticle/2772627#:~:text=From%20April%20to%20August%202020%2C%20the%20mean%20monthly%20case%20rate,2.0%20to%206.9%20per%20month; Adrianna Rodriguez, *'A stain on our country': ICE efforts to stop COVID-19 spread fail to protect*

is a staggering statistic that is only likely to worsen given ICE's continued civil immigration enforcement operations,[8] its neglect in testing detained immigrants, and its refusal to release medically vulnerable people from detention, among other failures.[9]

In Indiana alone, incarcerated individuals have an infection rate that is 82% higher than the state's infection rate as a whole, and the death rate from COVID-19 for this population is 71% higher.[10] Though state officials might be tempted to disregard or discount these individuals' rights to receive early vaccine treatment because they are in a carceral setting, Indiana has a legal obligation to take care of the people it chooses to incarcerate, including those in immigration detention in state and local facilities. That is especially true here because our state's prison population, 36.6% of which is Black and Latinx, reflects historic racism at all levels of our criminal legal system.[11]

Indiana also has a moral and ethical obligation to provide robust care for incarcerated and detained people. Doctors work under a professional ethical obligation to treat every human being as possessing equal dignity, worth, and value, and the American Medical Association has emphasized medical professionals' ethical obligation to treat patients without discriminating based on any "personal or social characteristics that are not clinically relevant,"[12] including whether they are rich or poor, friend or foe, incarcerated or free, disable or non-disabled, or citizen or non-citizen. Although you may not be a doctor or other medical professional, as Indiana's top decisionmaker regarding vaccine allocation and distribution, you have a similar ethical duty: You must ensure

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immigrant detainees from virus, USA Today (Nov. 11, 2020), https://www.usatoday.com/story/news/health/2020/11/11/covid-ice-detainee-case-rate-higher-than-general-us-study/6220333002/.

[8] *See* Abdullah Shihipar, William Goedel and Sophia Gurule, *ICE is putting people who were released due to COVID-10 back in jails*, Business Insider, Nov. 15, 2020, https://www.businessinsider.com/ice-arrests-covid-19-pandemic-decarceration-prison-third-wave-2020-11.

[9] *See, e.g.* DHS Office of Inspector General, *Early Experiences with COVID-19 at ICE Detention Facilities*, U.S. Department of Homeland Security (June 18, 2020), https://www.oig.dhs.gov/sites/default/files/assets/2020-06/OIG-20-42-Jun20.pdf; Letter from Dr. Scott Allen and Dr. Josiah Rich to House Committees on Homeland Security and Oversight and Reform (Mar. 19, 2020), https://www.documentcloud.org/documents/6816336-032020-Letter-From-Drs-Allen-Rich-to-Congress-Re.html#document/p4/a557238; Andrea Castillo, *ICE deliberately limited testing at Bakersfield immigration facility with COVID-19 outbreak*, LA Times (Aug. 6, 2020), https://www.latimes.com/california/story/2020-08-06/amid-coronavirus-outbreak-at-bakersfield-immigration-facility-emails-show-ice-deliberately-limited-testing; Antonio Olivo et al., *ICE flew detainees to Virginia so the planes could transport agents to D.C. protests. A huge coronavirus outbreak followed,* Washington Post (Sept. 11, 2020), https://www.washingtonpost.com/coronavirus/ice-air-farmville-protests-covid/2020/09/11/f70ebe1e-e861-11ea-bc79-834454439a44_story.html.

[10] *A State-by-State Look at Coronavirus in Prisons*, *The Marshall Project, (Dec. 11, 2020),* https://www.themarshallproject.org/2020/05/01/a-state-by-state-look-at-coronavirus-in-prisons

[11] *Indiana Department of Correction Fact Card,* (July 1, 2020), https://www.in.gov/idoc/files/FACTCARD_07_2020.pdf

[12] *AMA Code of Medical Ethics*, American Medical Association, https://www.ama-assn.org/system/files/2019-01/code-of-medical-ethics-chapter-1_0.pdf ("Physicians must also uphold ethical responsibilities not to discriminate against a prospective patient on the basis of race, gender, sexual orientation or gender identity, or other personal or social characteristics that are not clinically relevant to the individual's care."). *See also* Edmund F. Howe, *When, If Ever, Should Military Physicians Violate a Military Order to Give Medical Obligations Higher Priority?*, The Society of Federal Health Professionals (Nov. 1, 2015), https://academic.oup.com/milmed/article/180/11/1118/4160612 (reporting a consensus among doctors that an American battlefield surgeon had a professional ethical obligation to disobey orders and treat a wounded Iraqi solider even though it could have delayed the care given to a similarly injured American soldier); *see also The Physician's Pledge*, World Medical Association Declaration of Geneva (July 9, 2018), https://www.wma.net/policies-post/wma-declaration-of-geneva/.

that Indiana does not discriminate against incarcerated people and that officials base vaccine priorities on the clear public-health evidence that—like people in congregate and long-term care settings—people held in prisons, jails, and immigration detention are in grave danger and have a heightened need for vaccine access.

Communities of color

People of color are already disproportionately affected by COVID-19 within the congregate care and carceral settings, as discussed above. But the virus has disproportionately harmed communities of color on a much broader scale even beyond those contexts, and vaccine distribution plans must address the disparate harm suffered by these communities.

Nationally, Black, Latinx, and Indigenous people are approximately four times more likely than the general population to be hospitalized due to COVID-19 and approximately three times more likely to die.[13] And in Indiana, Latinx Hoosiers make up 12% of COVID-19 cases in the state while only making up 7% of the state's population.[14] These alarming disparities are rooted in generations of discrimination and racism against people of color, which has manifested in reduced access to quality and timely health care (thus compounding health inequities that make COVID-19 more deadly), the concentration of Black and Brown people in "essential" jobs, poverty flowing from discrimination in employment, and redlining that has concentrated marginalized communities into areas characterized by food deserts, pollution, and overcrowding.

This history—and our present reality—must be taken into account as vaccine distribution decisions are made. It is imperative that communities of color do not get short shrift when it comes to vaccine access. For example, any costs associated with obtaining a vaccine will disproportionately affect these vulnerable communities and hinder access; thus, it is vital that vaccines are available to all—regardless of immigration status—at no cost.[15]

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Decisions regarding the allocation and distribution of COVID-19 vaccines will no doubt be difficult and complex. Indiana must, however, heed its moral and legal obligations to make these decisions based on the public-health evidence, prioritizing access for those communities that have been disproportionately affected by the disease.

Further, decisions about vaccine allocation and distribution must occur through a transparent process in which Indiana officials communicate with the public openly, clearly, accurately, and straightforwardly about the vaccine allocation criteria and framework. We urge you to hold all

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[13] *COVID-19 Hospitalization and Death by Race/Ethnicity*, Centers for Disease Control and Prevention (Nov. 30, 2020), https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html.

[14] *Kaiser Family Foundation's "State Data and Policy Actions to Address Coronavirus",* (Dec. 7, 2020), https://www.kff.org/statedata/custom-state-report/?i=455997~464095~464104&g=in&view=3

[15] Katie Conner, *Vaccine for COVID-19 may be free, but you could still see a bill. Here's what we know*, CNET (Dec. 2, 2020), https://www.cnet.com/personal-finance/vaccine-for-covid-19-may-be-free-but-you-could-still-see-a-bill-heres-what-we-know/ (describing how some providers may charge administrative or other fees for administering a vaccine even though the federal government is shouldering the cost of the vaccines themselves).

meetings publicly online, and we urge you to solicit input from impacted communities, including incarcerated people and people living in congregate care settings, who may not have access to standard online meetings, and who may need accessible meetings and support to participate. We also urge you to partner with entities, such as the signatories of this letter, which are committed to addressing systemic inequities; groups with expertise in the difficulties faced by people who work and reside in congregate care settings, and people held in jails, prisons, and immigration detention; and other rights and community-based groups, who can help ensure that the disease's disproportionate effect on communities of color is given full consideration when allocating vaccines.

Thank you for your attention to these matters of life and death.

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