IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF CONNECTICUT

DAVID TERWILLIGER, *Petitioner*, v. **ROLLIN COOK**, Commissioner, Connecticut Department of Correction, and **NICK RODRIGUEZ**, Warden, Osborn Correctional Institution, *Respondents*.	No. 3:20-cv-540 April 22, 2020

DECLARATION OF FREDERICK L. ALTICE

I, **Frederick L. Altice**, upon my personal knowledge, and in accordance with 28 U.S.C. § 1746, declare as follows:

Personal Qualifications

1. I am a professor of Medicine (Infectious Diseases), Epidemiology (Microbial Diseases), and Public Health, and a clinician, clinical epidemiologist, and intervention and implementation researcher at Yale University School of Medicine and School of Public Health. Attached as Exhibit A is my CV.

2. I received a B.A. from Texas A&M in 1982 and an M.D. from Emory University in 1986. I completed my residency in internal medicine (1989) and fellowship in infectious diseases (1992) at Yale University.

3. I am a Board-certified internist, specializing in infectious diseases. My primary research focuses on interventions and implementation science at the interface between infectious diseases and addiction, and I have conducted research in several global health settings.

4. I have extensive experience working with vulnerable populations and their exposure to infectious diseases, including people in jails and prisons, and those otherwise involved with the criminal justice system. I have also developed programs that link HIV-infected inmates to community health care when they leave prison.

5. For the past 29 years, I have been the Director of the HIV in Prisons Program at Yale University School of Medicine, which consults with the Connecticut Department of Correction and treats inmates with HIV, viral hepatitis, tuberculosis, and other infectious diseases. This program conducts research and provides expert consultation for criminal justice systems in over 30 countries worldwide.

6. I am a board member of the Health in Prisons Program for the World Health Organization, a member of the Health in Prisons Program for the United Nations and a founding member and on the steering committee for Worldwide Prison Health Research & Engagement Network (WEPHREN). We develop and write guidance for healthcare delivery systems in prisons and jails globally. Additionally, I have the highest number of publications in the world related to infectious diseases in prisons, including in high impact journals such as *The Lancet, the Journal of the American Medical Association, American Journal of Public Health* and others.

7. I have provided expert opinion in a number of legal cases, including serving as the plaintiffs' lead expert in *Henderson v. Thomas*, 913 F. Supp. 2d 1267 (M.D. Ala. 2012) (addressing discrimination against Alabama prisoners based on their HIV status) and *Tribble v. Greene*, No. 2013 CA 003237 B (D.C. Super. Ct. 2016) (awarding damages for a wrongfully convicted man who suffered serious medical conditions while incarcerated). I have also been a court-appointed monitor in several cases including, *Doe v. Meachum*, Civ. No. H-88-562 (PCD) (class action suit addressing the delivery of HIV prevention and treatment in Connecticut) and others.

Current Information on COVID-19

8. In an infectious disease pandemic, there are three drivers of infection: a) the agent (in this case COVID-19); b) the vulnerability of the host (age and medical comorbidity increase risk for the most severe form of the disease); and c) the risk environment (proximity, physical distancing, sanitation). Effective interventions in such situations include the development of herd immunity after a substantial number of people get infected (yet this strategy results in marked levels of death and burden on hospitals), vaccination (unlikely in the next 12-18 months, physical distancing (showing some impact already) and ability to maintain a sanitary environment when not physically distancing.

9. COVID-19 is a novel coronavirus. It is a highly infectious disease that spreads from person-to-person and is a serious national and global public health risk. It is 10-times more deadly than the common flu (Influenza A). Unlike Influenza A and other flu-like viral infections, COVID-19 can be infectious 24-48 hours before symptoms develop, making transmission possible before we are able to identify infection and institute self-quarantine measures. Moreover, it now appears that it is transmissible in persons without symptoms, making screening strategies using symptoms alone insufficient to prevent transmission. All 50 states have reported cases of COVID-19 to the CDC, including outbreaks in prisons and jails. I am aware that, as of April 21, 2020, there have been 20,360 reported cases in Connecticut alone, with 1,423 confirmed deaths.

Within the United States, as of April 21, approximately 776,093 total cases of COVID-19 have been reported, with 41,758 fatalities attributed to the virus. As of April 21, 2020, at least 222 DOC staff members have been diagnosed with COVID-19 along with 308 inmates; these numbers only reflect those persons who have sought care and were able to undergo screening, which is still limited in Connecticut. And as of April 21, at least ten inmates at Osborn CI had tested positive for COVID-19 and were then transferred to Northern Correctional Institution.

10. Older adults – those over 50 years of age – and people with serious underlying medical conditions such as heart disease, hypertension, HIV, diabetes, obesity, lung disease, and other respiratory maladies are at a substantially higher risk of developing severe illness, including hospitalization, intensive care needs and death, from contraction of the COVID-19 virus. As of April 9, 2020, approximately 66% of individuals who have contracted COVID-19 in the United States were over 45 years old; nearly half (48%) were 55 years of age and older. A substantial number of patients with COVID-19 do not appear to have any of the list of co-morbid conditions making it impossible to fully secure the safety of individuals.

11. The illness occurs in two phases. The first may be asymptomatic but often involves basic symptoms like cough, congestion, inability to smell or taste and fever. Viral transmission during this phase is especially high. Later, for about 20% of infected patients, their symptoms become more life-threatening as they develop progressive lung disease requiring hospitalization. Approximately 40% of those requiring hospitalization require mechanical ventilation in an intensive care unit and develop and multi-organ failure. Nearly all of those requiring mechanical ventilation die and for those who don't, they often remain critically ill for extended periods of time. While it can be difficult to report death rates with total accuracy, initial global estimates of death rates were 3.5% in China; 0.8% in China, excluding Hubei Province; 4.2% overall among a group of 82 countries, territories, and areas; and approximately 4.3% thus far in the U.S.

12. Transmission of COVID-19 is thought to occur mainly from person-to-person; specifically, between those who are in close contact with each other and become exposed when an infected person coughs or sneezes, passing the virus through respiratory droplets. Mostly, these droplets may travel as far as 6 feet and land on surfaces where the virus can live for several days if not sanitized. Relatively new data suggest that the virus is more contagious than thought previously and can in some cases be aerosolized, leading to governmental recommendations that all persons wear protective face coverings. Most transmission of the virus can occur when a person comes into contact with surfaces or objects that contain the virus. COVID-19 can remain in the air and on surfaces for several hours to several days, respectively. Consequently, the virus is more likely to spread rapidly in congregate settings like healthcare settings, nursing homes, cruise ships, homeless shelters, schools, workplaces, and any closed detention setting including prisons and jails.

Unique Vulnerabilities to Infectious Disease in Carceral Settings

13. Prisons and jails are congregate settings that are particularly susceptible to the spread of infectious diseases like COVID-19. For example, other infectious diseases, such as HIV, Hepatitis B and C virus, and tuberculosis are substantially concentrated in prisons and jails relative to the community-at-large and have resulted in impressive outbreaks of infectious diseases. Of the 10.5 million people incarcerated annually in the U.S., approximately 4% have HIV, 15% have hepatitis C, and 3% have active tuberculosis. These prevalences are far higher than found in the general population.

14. Spread of infectious diseases is a serious problem within prisons worldwide. In addition to HIV, viral hepatitis and tuberculosis, we have previously experienced endemic outbreaks of strains of staphylococcus aureus bacteria that are resistant to methicillin (MRSA), which occurs in crowded, congregate settings. Even now, early COVID-19 outbreaks in correctional settings have been reported among both prisoners and staff, including deaths. There is the perception that carceral settings are impervious to COVID-19 because they are able to stop visitation and separate beds by 6 feet. In most carceral setting, bunk beds are common and it is impossible to separate individuals by 6 feet when sleeping. Strategies separating individual beds (not bunkbeds) alone is insufficient because of the inability to truly physically distance people in these settings, the inadequacy of shared common spaces, the regular connection to the community by officers and medical staff and the lack of personal protective equipment for personnel and prisoners alike.

15. Carceral settings are dense facilities with generally poor and unsanitary conditions. Due to overcrowding, people in prison are in close proximity to one another on a constant basis. High density of people exists within common areas, dining areas, bathrooms and showers. Cells are generally small areas that people in prison must share with one or multiple other individuals, often sleeping in bunk beds. Due to overcrowding, people in prison are often housed in dormitory settings. Furthermore, people in prison often must share limited showers, toilets and urinals, and sinks with hundreds of other people in prison on a regular basis.

16. It is almost inevitable that COVID-19 will enter carceral settings more widely than reported already in the pandemic in the U.S. Prisons are porous, congregate settings where a number of people enter and exit regularly. The dynamics of 10.5 million people entering and leaving jails and prisons annually alongside the 2.2 million people who are housed there on a daily basis make these settings especially vulnerable. Entry and exit of massive numbers of correctional and medical staff who enter and leave prisons three shifts per day increases the likelihood of a COVID-19 outbreak. Settings like these are a formula for disaster for spread of COVID-19. Physical distancing is absolutely necessary to reducing the spread of the virus to prevent a public health crisis; however, this can be nearly impossible in prison without swift action now. At almost any given time, people in prison are always within a couple feet of other people in prison (whether it is where they sleep or through shared common spaces), increasing the likelihood that infected persons will quickly spread the virus to other people in

prison and correctional and medical staff.

17. Prisons are poorly equipped to handle COVID-19 when it makes its way into prisons. Generally, outbreaks of tuberculosis in prisons, a bacterial infection that is much less infectious relative to COVID-19, has proven hazardous and in some cases deadly in prisons due to lack of ability to efficiently diagnosis, isolate and treat people in prison. COVID-19 differs substantially from tuberculosis due to its higher prevalence in the community, its more efficient mode of transmission, the inability to rapidly isolate people with or at risk for COVID-19, and the increased likelihood that correctional officers and staff will be at substantially higher risk for COVID-19 than for TB.

18. Recent outbreaks of COVID-19 underscore challenges that arise when the infection is introduced. In one facility, transmission occurred in over 400 people, including those who were incarcerated and correctional staff. Lack of COVID-19 testing has thwarted our ability to understand the extent to which outbreaks are occurring, but the observation that people who are incarcerated are dying of this disease suggests that these deaths are the tip of the iceberg. Once introduced, COVID-19 may have devastating consequences including widespread transmission between people who are incarcerated and to correctional staff. This transmission extends to the community as infected individuals are transported to hospitals and correctional staff return to their homes.

19. Many of the people in prison who contract the virus – particularly those who are most vulnerable to exposure to COVID-19 – will need to be transported to community hospitals and likely to intensive care units (ICU) beds at high rates as prisons do not have the adequate facilities or equipment to treat seriously ill patients. Most prison health care systems are more akin to outpatient health care clinics. They do not have the necessary level of emergency medical equipment, personal protective equipment and other necessary supplies to treat those in respiratory distress. Community health systems are likewise not prepared to handle this influx of patients from prisons and this influx could be substantial, as we have seen from skilled nursing facilities, should an outbreak start.

20. Physical distancing, the practice of increasing the physical space between people to avoid spreading illness, is among the most important measures that can be taken to curb the spread of a highly infectious and contagious disease like COVID-19. Staying at least six feet away from other people lessens your chances of catching or transmitting COVID-19 to others. This strategy, however, cannot be effectively accomplished in any prison setting by virtue of the arrangement of beds, the use of bunkbeds where distance between persons is maximally 3 feet, and the inability to create physical barriers between beds, the use of common space like dining halls, showers, bathrooms, the lack of sanitary equipment to regularly disinfect surfaces, the lack of personal protective equipment for personnel and prisoners alike, and the inability to identify infectious persons before they become symptomatic, should they become symptomatic at all.

21. COVID-19 has created an extraordinary public health emergency, which will require an extraordinary response now to prevent widespread fatalities in prisons and the community. As such, urgent and drastic action is required to immediately reduce the prison population. Reducing the prison population immediately is the primary way to achieve recommended physical distancing within those facilities. This, in turn, will reduce exposure to COVID-19 prisoners and the staff who work there and the need for providing life-saving medical care.

Current Understanding of Osborn Correctional Institution

22. Osborn Correctional Institution (Osborn CI) is a medium-security, Level 3 prison located in Enfield, Connecticut. It houses one of the largest populations of inmates in the state, with 17 inmate-housing units. As of April 1, 2020, 1,249 individuals were incarcerated at Osborn CI, 10.2% of those in Connecticut state custody. Only two Connecticut state prisons (Carl Robinson CI and MacDougall CI) house more inmates than Osborn CI.

23. In addition to its inmate population, Osborn CI has 426 staff members that work at the facility. They enter and leave the facility three shifts per day, seven days per week, so anyone with COVID-19 and without symptoms could transmit the virus to others for 24-48 hours before they could reasonably be diagnosed and asked to self-quarantine.

Recommendations for Osborn Correctional Institution

24. As an immediate first step, carceral settings should prioritize immediately releasing individuals most at-risk of harm from COVID-19, specifically older individuals and those with health risks that would increase their likelihood of an adverse medical consequence. Not only would this strategy immediately reduce the risk of spread of the disease to other people in prison and staff alike, but would have the greatest impact on reducing transmission to those at the highest risk for hospitalization, intensive care use utilization and death, and consequently reduce further burden to the already substantial amount of community resources should they fall ill.

25. Releasing people in prison now will reduce prison density and thus the likelihood that infected people in prison will expose other people in prison to the virus. As an added physical distancing precaution, prisons should also consider further reducing total population density by releasing other younger individuals in prison who may not experience substantially elevated risk for morbidity or mortality from complications from COVID-19, especially considering more recent reports showing that many COVID-19 carriers are asymptomatic, especially those who are younger with intact immune systems. Substantially reducing the number incarcerated in such crowded places will provide added physical distancing and further reduce the public health risk that prisons pose to fellow people in prison, custodial staff, and the community in light of the COVID-19 crisis. Decisions about who to release among this population at

elevated, but lower risk, should balance the benefits between public health (i.e., blunting the volatile COVID-19 epidemic) and public safety risk (i.e., risk for criminal harms) these individuals pose when returned to the community. Many places nationwide are already doing this successfully.

26. The U.S. healthcare system is poorly equipped to handle a widespread outbreak of COVID-19. For reasons stated, utilizing Influenza A preparedness strategies is likely to fail. A burden on hospital beds already exists. Prisons could significantly contribute to the stresses on currently inadequate health care resources. Furthermore, prisons are often located in rural or outlying areas, where access to healthcare facilities and hospitals with appropriate levels of equipment and staff are already scarce. These hospitals are also least likely to be prepared for managing patients with COVID-19, especially those who must have custodial supervision at their bedside.

27. Additionally, prisons, absent reduction of the population, are not equipped to address a COVID-19 outbreak. Internally, they lack essential health care equipment needed to treat infected patients, such as sufficient numbers of isolation rooms and ventilators, which seldom, if ever, exist in prisons. Even on a more basic level, prisons lack the capacity to identify or treat an outbreak. For example, they do not possess personal protective equipment for staff and other people in prison that is necessary to protect themselves from transmission of the virus. There are essentially no testing kits and even assessing staff for symptoms is inadequate given that transmission may occur in those without symptoms or before symptoms develop. Custodial and medical staff rotates through the prison typically on 8-hour shifts and return to families, many of whom are susceptible to adverse health outcomes if infected with COVID-19.

28. Other methods for addressing a highly infectious disease like COVID-19 in prisons, aside from a vaccine that we do not expect to be available for another 12 to 18 months, will not be successful for containing the virus in any meaningful way. For instance, isolating people once they are screened has already proven futile in other settings; notably, the quarantining of individuals on cruise ships. In my opinion, efforts to isolate people in prison will likely fare far worse than cruise ship isolation efforts. Cruise ship efforts included taking measures like restricting people to their cabins and having helicopters available to drop off test kits. Restricting people in prison to their living units will not contain the virus because many prisoners live in dormitory-style housing and they share many common public spaces like showers, meals and restrooms. Providing massive testing in prison, as was done on cruise ships, has many logistical challenges in prisons and is a luxury that will not be afforded to most people in prison.

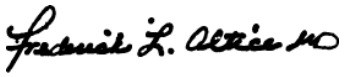
29. Release from prison is a necessary strategy for increasing physical distancing and reducing the risk of a fatal outbreak of COVID-19. It needs to be done thoughtfully, however, by balancing public health and public safety. People released from prison must have a safe place to go for an extended period of time upon release. Physical distancing will need to continue while they are in the community as well and steps will have to be taken to ensure that can occur. Prisons will need to educate those being

released as to these best practices and plan for how resources can be provided to assist this population to remain in safe settings where physical distancing can happen.

30. With Connecticut being one of the national epicenters of the COVID-19 pandemic, its response is going to serve as a test case for how the country addresses widespread outbreak of this infectious disease. If the DOC takes bold action and thoughtfully incorporates into their response plan the exceptional but necessary public health recommendation to reduce the prison population, many lives can be saved.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my information and belief.

Executed this 22 day in April 2020 in New Haven, Connecticut.



Frederick L. Altice, M.D.
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New Haven, CT 06510
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Exhibit A

CURRICULUM VITAE
Frederick Lewis Altice, M.D., M.A.

Education:

Bachelor of Arts, Biology and Spanish (*Summa Cum Laude)*
Texas A & M University

Master of Arts, Spanish Literature
Universidad de Santiago de Compostela, Spain

M.D. (*Magna Cum Laude)*
Emory University School of Medicine

Master of Arts and Sciences, Honorary
Yale University

Career:

1986 - 1989	Internship and Residency, Department of Internal Medicine Yale University School of Medicine
1989 - 1992	Fellowship, Section of Infectious Diseases Yale University School of Medicine.
1991 - 1992	Quantitative Clinical Epidemiology Robert Wood Johnson Clinical Scholars Program Yale University School of Medicine
1992 - present	Attending Physician, Yale-New Haven Hospital
1992 - 1993	Clinical Instructor Section of Infectious Disease. Yale School of Medicine
1993 - 1999	Assistant Professor of Medicine Section of Infectious Diseases, Department of Internal Medicine, Yale School of Medicine
1999 - 2008	Associate Professor of Medicine, AIDS Program Section of Infectious Diseases, Department of Internal Medicine, Yale School of Medicine
2008 – present	Professor of Medicine, AIDS Program Section of Infectious Diseases, Department of Internal Medicine, Yale School of Medicine
2011 – present	Professor of Epidemiology and Public Health Division of Epidemiology of Microbial Diseases, Yale School of Public Health
1991 - present	Director, HIV in Prisons Program. Yale School of Medicine

1993 - present	Director, Community Health Care Van, Yale School of Medicine
1994 - 1997	Firm Chief, Atkins (HIV/AIDS) Medical Service, Yale-New Haven Hospital
2001	Acting Director, Nathan Smith Clinic, Yale New Haven Hospital
2001, 2004	Acting Director, AIDS Program. Section of Infectious Diseases, Department of Internal Medicine, Yale University School of Medicine
2001	Acting Chief, Atkins Medical Service. Yale New Haven Hospital
2004 - present	Director, Yale Center for Clinical and Community Research, Yale School of Medicine
2009 – present	Board of Permanent Officers, Yale School of Medicine
2009 – present	Academic Icon Professor of Medicine, Centre of Excellence on Research in AIDS, Infectious Diseases Unit, Department of Medicine, Faculty of Medicine, University of Malaya
Board Certification:	American Board of Internal Medicine, Internal Medicine, 1989 American Board of Internal Medicine, Infectious Diseases, 1992 American Board of Prevention Medicine, Addiction Medicine, 2002

Grants: Federal, State, and Foundation Grants exceed $120 million

1992-1998	State of Connecticut, Department of Correction; *HIV in Prisons Program (Infectious Diseases Consultation Services)*; **F. Altice, Director**.
1993-1996	National Institute of Drug Abuse and Health Research and Services Administration; *Access to and Utilization of Health Services by HIV+ Drug Users*; **F. Altice, Principal Investigator**.
1993-1996	U64/CCU109686. Centers for Disease Control and Prevention; *HIV Infection and Risk Behavior Among Incarcerated Women*; **F. Altice** and P. Selwyn, **Co-Principal Investigators**.
1994-1997	Connecticut Department of Public Health; *Project TLC: Evaluation of Transitional Case Management for HIV+ Prisoners*; **F. Altice, Principal Investigator**.
1994-1999	R01 DA08999. National Institute of Drug Abuse; *Studies of TB Among Drug Injectors in Connecticut*; P. Selwyn, PI and **F. Altice, Co-Principal Investigator**.
1994-1996	HJKF 78 93-1646. Kaiser Family Foundation; *Improving Health Care Utilization and Access for Drug-Injecting Women with or at Risk for HIV Infection*; **F. Altice** and P. Selwyn**, Principal Investigators**.

1995-1999	R01 DA10186. National Institute of Drug Abuse; *Provision of Needle Exchange-Based Health Services*; **F. Altice, Principal Investigator**.
1996-1996	Bristol Myers-Squibb, Inc.; *Factors Associated with Antiretroviral Therapy Adherence in Correctional Facilities*; **F. Altice, Principal Investigator**.
1996-1996	APT Foundation; *Prevention Case Managers for Drug Users*; **F. Altice, Principal Investigator**.
1996-1997	Connecticut Department of Public Health; *STD Screening Among Incarcerated Women;* **F. Altice, Principal Investigator**.
1/1/97-6/30/98	HJKF 78-96-1994. Kaiser Family Foundation; *Organizing HIV Care for Prisoners*, **F. Altice, Principal Investigator**.
1997-1998	Connecticut Department of Public Health; *AIDS Health Education Risk Reduction Prevention Case Manager for Drug Users;* **F. Altice, Principal Investigator**.
1997-2001	R01 DA10186. National Institute of Drug Abuse; *Needle Exchange-Based Health Services as a Comprehensive Community Prevention Program*; **F. Altice, Principal Investigator**.
1999-2004	R01 DA121120 National Institute of Drug Abuse; *Increasing Drug User's Adherence to HIV Therapeutics.* R. Broadhead and **F. Altice, Co-Principal Investigators**.
2000-2005	R01 DA13805. National Institute of Drug Abuse; *Directly Observed Antiretroviral Therapy Among Active Drug Users.* **F. Altice, Principal Investigator**.
1999-2001	Abbott Pharmaceutical Inc; *Randomized, Double-Blind, Phase III Study of ABT-378/Ritonavir.* **F. Altice, Principal Investigator**.
1999-2001	Abbott Pharmaceutical Inc; *Randomized, Open Label, Phase III Study of ABT-378/Ritonavir.* **F. Altice, Principal Investigator**.
2000-2006	State of Connecticut, Department of Public Health; *AIDS: Prevention Case Management for Drug Users.* **F. Altice, Principal Investigator**.
2000-present	Liberty Community Services, Inc.; Addressing Housing for People With or at Risk for HIV. **F. Altice, Principal Investigator**.
2002-present	Ryan White Title I. *Funding for primary care, early intervention services, case management and addiction treatment*. **F. Altice, Principal Investigator**.
1999-2004	University of Connecticut Correctional Managed Healthcare. *Infectious Diseases Consultation Services in the CTDOC*. **F. Altice, Director**.

2001-2002	Yale University of CT Schools of Nursing. Program for the Study of Health Care Relationships. *The Central Role of Trust Between HIV Infected Drug Users and Their Clinician*. **F. Altice, Principal Investigator**.
2001–2002	State of Connecticut. *Health Care Service Delivery for Undocumented Persons.* **F. Altice, Principal Investigator**.
2003-2013	K24 DA017072. Mid-Career Development Award for Patient-Oriented Research. *Enhancing Health Outcomes Among HIV+ Substance Abusers.* **F. Altice, Principal Investigator**.
2003–2008	Substance Abuse and Mental Health Services Administration (SAMHSA). *Targeted Capacity Expansion for Substance Abuse Treatment and HIV/AIDS Services*. **F. Altice, Principal Investigator**.
2005-2008	Boehringer-Ingelheim Pharmaceuticals. *Directly Observed Therapy for HIV+ Community Released Prisoners.* **F. Altice, Principal Investigator**.
2003-2007	R01 MH066684. National Institutes on Mental Health. *Changing Antiretroviral Therapy Adherence Behavior*. J. Fisher, PI; **F. Altice, Co-Investigator**.
2004–2009	R01 DA13805. National Institutes on Drug Abuse. *Directly Observed Antiretroviral Therapy Among Active Drug Users*. **F. Altice, Principal Investigator**.
2004-2009	R01 DA017059. National Institutes on Drug Abuse. *Directly Observed Therapy for Community Released HIV+ Prisoners*. **F. Altice, Principal Investigator**.
2003-2008	U01 DA017378. National Institute on Drug Abuse. *HIV and the Sexual Networks of IDUs and Drug Using MSM.* L. Ouellet, Principal Investigator. **F. Altice, co-investigator**.
2004–2009	H97 HA03800. Health Resources and Services Administration (HRSA). *Special Project of National Significance: Integrating Buprenorphine into HIV Clinical Care Settings.* F. **Altice, Principal Investigator**.
2003-2006	Health Resources and Services Agency (HRSA). *Translation of Options/Opciones into Standard of Care*. New York State Department of Health – AIDS Institute. (PI- Cornman, Deborah, Ph.D., University of Connecticut). **F. Altice, Co-investigator.**
2005-2007	R21 DA019843. National Institute on Drug Abuse. Improving Health Outcomes for Released HIV+ Prisoners. **F. Altice, Principal Investigator**.

2006-2008 UR6 PS000391. Centers for Disease Control and Prevention. *HIV Prevention Research with HIV+ Incarcerated Populations.* **F. Altice, Principal Investigator**.

2006-2008 R21 DA021093. National Institute on Drug Abuse**.** *A Healthy Transition for Newly Released HIV Infected Prisoners*. **F. Altice, Principal Investigator**.

2007-2012 H97 HA08541. Health Resources and Services Agency (HRSA). *Special Project of National Significance: Comprehensive Interventions for HIV+ Inmates Transitioning from Jail.* **F. Altice, Principal Investigator**.

2008-2009 Connecticut Dept of Public Health. *Risk Reduction for Released Prisoners.* **F. Altice, Principal Investigator**.

2008-2013 Substance Abuse and Mental Health Services Administration (SAMHSA). *Expanding HIV/AIDS and Substance Abuse Treatment Services to Released Prisoners. Targeted Capacity Expansion Program for Substance Abuse Treatment and HIV/AIDS Services.* **F. Altice, Principal Investigator**.

2008-2013 R01 DA025943 National Institutes on Drug Abuse. *Intervention of HIV, Drug Use and the Criminal Justice System in Malaysia*. **F. Altice**, **Principal Investigator**.

2008-2012 R01 DA25932 National Institutes on Drug Abuse*. Drug Interactions in Substance Abusers with HIV Infection and Other Co-morbid Conditions.* Friedland, PI. **F. Altice**, **Co-Investigator**.

2008-2012 U01 DA016194 CJ-DATS 2, National Institutes on Drug Abuse. *Criminal Justice Drug Abuse Treatment Studies.* L. Frisman, PI. **F. Altice**, **Co-Investigator**.

2009-2014 R01 AA18944 National Institute on Alcohol Abuse and Alcoholism**.** *Alcohol Pharmacotherapies Among Released Prisoners.* **F. Altice** and S. Springer, **Co-Principal Investigators**.

2010-2011 R43 DA027247. *Online Buprenorphine Training for Outreach Workers and Case managers.* J. Simmons (PI) **F. Altice (consultant)**

2010-2020 R01 DA029910. National Institutes on Drug Abuse. *Prison Interventions and HIV Prevention Collaboration: Criminal Justice HIV Research in Former Soviet Union States*. **F. Altice, Principal Investigator**.

2010-2015 R01 DA030762. National Institutes on Drug Abuse. *Naltrexone for Opioid Dependent Released HIV+ Criminal Justice Populations*. **F. Altice** and S. Springer, **Co-Principal Investigators.**

2010-2015	R01 DA030768. National Institutes Drug Abuse. *HIV, Buprenorphine, and the Criminal Justice System.* **F. Altice**, **Principal Investigator**.
2011-2016	R01 DA032106. National Institutes on Drug Abuse. *HIV Testing and Treatment to prevent onward HIV Transmission among high-risk MSM in Peru*. A.C. Duerr, **F. Altice Co-Investigator**.
2012-2014	R01 DA030768 *NIDA-diversity supplement to R01 DA030768 HIV, Buprenorphine, and the Criminal Justice System*. **F. Altice, Principal Investigator**.
2012-2017	U01 AA021995 National Institute on Alcohol Abuse and Alcoholism. *HIV/AIDS & Alcohol-Related Outcomes: Translational Evidence-Based Interventions*. PI: P. Molina, **F. Altice, Coinvestigator.**
2012-2017	R01 DA032290 National Institutes on Drug Abuse. *Secondary HIV Prevention and Adherence Among Drug Users.* Copenhaver, **F. Altice, Co-Investigator.**
2012-2022	R01 DA033679 National Institute of Drug Abuse. *Expanding Medication Assisted Therapies in Ukraine.* **F. Altice, Principal Investigator.**
2012-2016	R01 HD075630 National Institutes on Human Development. *ART Adherence and Secondary Prevention of HIV.* **F. Altice, Co-Investigator** (Petry, PI).
2012- present	R25 TW009338 Global Health Scholars and Research Training. National Institutes on Allergy and Infectious Diseases. **F. Altice, Co-Investigator** (Riley, PI).
2012-2017	H97 HA24963 Health Resources and Services Agency. Special Project of National Significance: *mHEALTH: Medical Home Engagement and Aligning Lifestyles and Transition from Homelessness*. **F. Altice, Principal Investigator.**
2013-2014	Elton J Charitable Foundation, *Pilot Study Grant for HIV Prisoners.* **F. Altice, Principal Investigator.**
2014-2019	H79 TI025889 Substance Abuse & Mental Health Services Administration (SAMHSA). *mCHARTS: Mobile Co-location of HIV-related Activities with Resources and Transitional Services*. **F. Altice, Principal Investigator.**
2014-2015	MK5172-062 Merck Sharp & Dohme Corp. *MK5172 in combination with MK8742 A Phase III Open-Label Clinical Trial to Study the Efficacy and Safety of the Combination Regimen of MK-5172/MK8742 in subjects on Opiate Substitution Therapy*. **F. Altice, Principal Investigator.**

2016-2018	R21 DA041953 National Institute on Drug Abuse. *Modeling HIV/HCV Transmission and Treatment as Prevention in U.S. Networks of People Who Inject Drugs.* **F. Altice, Principal Investigator**.
2016-2021	R01 DA041271 National Institute on Drug Abuse. *Addiction, HIV, and Tuberculosis in Malaysian Criminal Justice Settings.* **F. Altice, Principal Investigator.**
2016-2021	R01 DA043125 National Institute on Drug Abuse. *Integrating Addiction Treatment and HIV Services into Primary Care Clinics in Ukraine*. **F. Altice, Principal Investigator.**
2017-2019	R21 DA042702 National Institute on Drug Abuse. *Prisons, Drug Injection and the HIV Risk Environment.* **F. Altice, Co-Investigator** (Meyer, PI).
2017-2019	MISP-56104 Merck Sharp & Dohme Corp. *Modeling HIV/HCV Transmission and Treatment as Prevention in U.S. Networks of People Who Inject Drugs.* **F. Altice, Principal Investigator**.
2017-2022	R01 DA044867 National Institute on Drug Abuse. *Testing an Integrated Bio-behavioral Primary HIV Prevention Intervention Among High-Risk People Who Use Drugs.* **F. Altice, Co-Investigator** (Copenhaver, PI).
2016-2020	Centers for Disease Control and Prevention (CDC). *Data to Care and Linkage to Care for People with HIV Who are Recently Out of Care*. **F. Altice** and M. Villanueva, **Principal Investigators**.
2018-2022	Health Resources and Services Agency (HRSA). Special Project of National Significance: *Clinical Transformation to Achieve Micro-elimination of HIV in People with HIV*. **F. Altice** and M. Villanueva, **Principal Investigators**.
2018-2023	U01 DA045384 National Institute on Drug Abuse. *Integrating Treatment for Mental Health Disorders in Methadone Clinics in Ukraine.* **F. Altice, Co-Investigator**. (Dvoriak, PI).
2018-2023	R01 DA047789 National Institute on Drug Abuse. *Implementation of Seek, Test, Treat, and Retain Strategies Among People Who Inject Drugs in Malaysia.* **F. Altice, Co-Investigator** (Chawarski, PI).
2019-2021	Merck Sharp & Dohme Corp. *Developing a Smartphone Application to Engage People Who Inject Drugs to Promote HCV Diagnosis, Linkage to Care and Treatment.* **F. Altice, Principal Investigator**.
2019-2022	H97HA31435 Health Resources and Services Agency (HRSA). Special Projects of National Significance: *Strengthening Systems of Care for People Living with HIV and Opioid Use Disorder*. **F. Altice, Principal Investigator.**

2019-2024	R61 AT010613 National Institute of Complementary and Alternative Treatments. *Nonpharmacological Pain Management Interventions to Increase Medication-Assisted Treatment Adherence and Retention*. **F. Altice** and D. Barry, **Principal Investigator**.
2020-2025	D43 TW011324 National Institutes of Health Fogarty HIV Research Training Program. *Malaysian Implementation Science Training (MIST) Program in HIV*. **F. Altice** and A. Kamarulzaman, **Principal Investigators.**

Professional Service:

1991-1998	Member, Mayor's Task Force on AIDS, New Haven, Connecticut
1991-present	Member, American Public Health Association, Epidemiology Section and Prison and Jail Health Subcommittee
1992-1997	Member, Institutional Review Board, Connecticut Dept. of Correction
1992-1997	Member, Formulary Committee, Connecticut Department of Correction
1992-present	Member, Advisory Board, New England AIDS Education and Training Center (NEAETC)
1993-1995	Consultant, New York Correctional Association, AIDS in Prisons Program
1993-1996	Member, Ryan White Title I Subcommittee, Evaluation of Funding Programs, Health Research and Services Administration (HRSA)
1993-present	Chair and Founder, New England HIV in Prisons Conference
1993-present	Chair and Founder, Connecticut HIV in Prisons Conference
1993-present	Member, Formulary Committee, Yale-New Haven Hospital
1993-present	Member, Hematopoietic Growth Factor Subcommittee, Yale-New Haven Hospital
1994	Member, Clinical Care Grant Review Sub-Committee, Health Research and Services Administration (HRSA)
1994-present	Member, Ryan White CARE Act Title II, Connecticut Statewide HIV Care Consortium, Department of Public Health
1995	Special Review Consultant, NIDA Special Review Committee

1995-1996	Member, Access to Care Strategic Planning Committee, Health Resources and Services Agency (HRSA)
1995-1998	Member, Connecticut AIDS Drug Access Program (CADAP) Committee
1995-present	Member, Department of Health & Human Services, Ryan White CARE Act Title I, Planning Committee
1995-present	Consultant, American Board of Internal Medicine, Reviewer for Infectious Diseases
1995-present	Member, Smith vs. Meachum Monitoring Panel, Court Appointed Medical Monitor of Prison Medical Services
1995-1996	Member, Clinical Pathway Committee, CMV Retinitis, Yale-New Haven Hospital
1996-present	Member, CT Law Revision Committee, Methadone Treatment Working Group
1997-present	Member, CT Alcohol and Drug Policy Council, Criminal Justice Committee
1997-present	Chair, National Institute of Justice, Special Committee of the National Commission on Correctional Health Care, Infectious Diseases Committee
1997-present	Chair, Advisory Committee on Prison Health, HIV Therapeutics, Bristol-Myers Squibb Pharmaceuticals
1997-present	Chair, Advisory Committee on Corrections, HIV Therapeutics, Agouron Pharmaceuticals
1998-present	Co-Editor, HIV Education Prison Project (HEPP) news, Brown University School of Medicine, Office of Continuing Education
1998-present	Advisory Committee on Corrections, HIV Therapeutics, DuPont Pharmaceuticals
1999-2002	Member - M98-863 Study Team Abbott Pharmaceutical Inc; "Randomized, Double-Blind, Study of Lopinavir/Ritonavir, Stavudine, and Lamivudine versus Nelfinavir, Stavudine, and Lamivudine in Antiretroviral-Naïve, HIV-Infected Adults."
2001-present	NIH Reviewer, Site Visit Team for General Clinical Research Center, Albert Einstein University, Bronx, New York
2001-present	Standing Member NIDA K Training & Career Development Subcommittee, National Institute on Drug Abuse Initial Review Group

2002 - present	Advisory Committee, Connecticut AIDS Drug Assistance Program (CADAP)
2004	Temporary Member-NIH Special Emphasis Panel, AIDS Clinical & Epidemiology Review Committee
2007	Clinical Core Committee, Center for Interdisciplinary Research on AIDS (CIRA).
2007-2012	Scientific Advisory Board, Center for Drug Abuse and AIDS Research (CDAAR) P30 grant at Tufts University, School of Medicine.
2007-present	National Advisory Committee, second Academic and Health Policy Conference on Correctional Health Care. UMass Correctional Health.
2007-present	Research Director, AIDS Project Hartford
2007-present	Editorial Board, The Open Public Health Journal
2008-present	Editorial Board, Open Infectious Diseases Journal
2008-presnt	Editorial Board, International Journal of Prisoner Health
2008-2011	Executive Board, Liberty Community Services, Inc. New Haven CT.
2008-2009	Yale School of Medicine M.D. Thesis Mentor Council. Office of Student Research
2009-present	Member, Correctional Academic Liaison Meeting (CALM), CT. Department of Corrections.
2009	Planning Committee, International AIDS Society Conference, 2009, Cape Town, South Africa.
2009-2010	Chair, World Health Organization Guidelines Committee for Treatment of HIV and Tuberculosis Among Drug Users.
2010-present	Governing Board Member, United Nations, Office Drug Policy (UNODP), Health and Human Rights in Prisoners Program
2010-2011	Guest Editor, JAIDS Special Issue focusing on HIV Linkage to Care in Jail Settings.
2012-present	Board of Directors, Academic Consortium for Criminal Justice Health (ACCJH)
2012	Member, International Center for Science in Drug Policy
2012-present	International Advisory Board, International Journal of Prisoner Health

2012	Guest Editor, Journal of the Acquired Immune Deficiency Syndrome, Special Issue: HIV Linkage to Care in Jail Settings.
2012	Associate Editor, AIDS Research and Treatment, Special Issue: Antiretroviral Treatment in Resource-Limited Settings.
2012-present	Associate Editor, Journal of Health and Justice
2012-2013	Organizing Committee, International AIDS Society 2013 Track C Committee
2013-2014	International AIDS Society 2014, Lead Rapporteur
2014-2015	Co-Director, Academic and Health Policy Conference on Correctional Health
2015	Chair, HCV Treatment Access Group, Alliance for Patient Care Access
2012-present	Governing Board Member, World Health Organization, Health in Prisons Project
2016-present	Board of Directors, World-wide Prison Health Research & Engagement Network (WEPHREN)

Professional Memberships

1992 – present	American Public Health Association
1993 – present	Fellow, American College of Physicians
1993 – present	Infectious Disease Society of America
1994 – present	International AIDS Society
1995 – present	Fellow, Morse College, Yale University
1997 – present	Society for Correctional Physicians
2001 – present	American Correctional Association
2004-present	HIV Medical Association (HIVMA)
2004	AAHIVM-American Academy of HIV Medicine
2005	American Society of Addiction Medicine
2009	Cambridge Who's Who
2009-present	Best Doctors in America, Infectious Diseases
2009	Board of Permanent Officers, Yale University School of Medicine
2009	American Board of Correctional Medicine

Honors

- Mid-Career Investigator's Award in Patient-Oriented Research (K24), National Institute on Drug Abuse.

- Appointed as Icon Professor of Medicine, Centre for Excellence in Research in AIDS, Infectious Diseases Unit, Department of Medicine, Faculty of Medicine, University of Malaya.
- Community Health Care Van (CHCV), 20th Year Anniversary, 1993-2013. Awarded the Mayor's Proclamation of Service to the City of New Haven.
- COVID-19 Recognition Award

Journal Reviewer

Addiction

AIDS

AIDS Research and Treatment

American Journal of Public Health

American Journal of Drug and Alcohol Dependence

Annals of Internal Medicine

Clinical Infectious Diseases

Drug and Alcohol Dependence

Harm Reduction Journal International Journal of AIDS and STDs

International Journal of Drug Policy

International Journal of Prison Health Care

Journal of the Acquired Immunodeficiency Syndrome

Journal of the American Medical Association

Journal of General Internal Medicine

Journal of the International AIDS Society

Journal of Substance Abuse Treatment

Lancet

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Original Articles

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