☐ EXPEDITE
☒ Hearing set for:
Date: Friday, April 23, 2021
Time: 9:00 a.m.
Judge/Calendar: Judge James Dixon

SUPERIOR COURT OF WASHINGTON
FOR THURSTON COUNTY

CANDIS RUSH, JUSTIN AUTREY, GREGORY STEEN, THEODORE RHONE, and MICHAEL LANIER, on behalf of themselves and all others similarly situated, Plaintiffs/Petitioners, vs. WASHINGTON STATE DEPARTMENT OF CORRECTIONS, a state agency; STEPHEN SINCLAIR, Secretary of the Washington State Department of Corrections; WASHINGTON STATE DEPARTMENT OF HEALTH, a state agency; and DR. UMAIR SHAH, Secretary for the Washington State Department of Health; Defendants/Respondents.	CLASS ACTION No. 21-2-00491-34 DECLARATION OF ROBERT B. GREIFINGER, M.D.

I, Robert B. Greifinger, declare as follows:

1. I am a physician who has worked in health care for prisoners and detainees for more than 30 years. I have managed the medical care for inmates in the custody of New York City (Rikers Island) and the New York State prison system. I have authored more than 80 scholarly publications, many of which are about public health and communicable disease. I am the editor of *Public Health Behind Bars: from Prisons to Communities,* a book published

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by Springer (a second edition is due to be published in 2021); and co-author of a scholarly paper on outbreak control in correctional facilities.[1]

2. I have been an independent consultant on prison and jail health care since 1995. My clients have included the U.S. Department of Justice, Division of Civil Rights (for 23 years) and the U.S. Department of Homeland Security, Section for Civil Rights and Civil Liberties (for six years). I am familiar with prisons, having toured and evaluated the medical care in more than 200 prisons and jails during my career. Among these were the prisons operated by the Washington Department of Corrections (WADOC), for whom I consulted on a master plan for health care for prisoners in the custody of the WADOC. I currently monitor the medical care in three large county jails for Federal Courts. My resume is attached as Exhibit A.

3. COVID-19 is a coronavirus disease that has overtaken the world for a whole year. According to the World Health Organization, more than 120 million people have been diagnosed with COVID-19 around the world during the pandemic and 2 million have died.[2] In the United States, more than 29 million people have been diagnosed and more than 500,000 people have died thus far.[3]

4. Prisons have also suffered from the effects of the global pandemic. In the United States, over 390,000 individuals in state and federal prisons have contracted the disease and there have been at least 2,488 verified coronavirus-related deaths. Among staff, 106,376

[1] Parvez FM, Lobato MN, Greifinger RB. Tuberculosis Control: Lessons for Outbreak Preparedness in Correctional Facilities. Journal of Correctional Health Care OnlineFirst, published on May 12, 2010 as doi:10.1177/1078345810367593.

[2] See https://covid19.who.int/, accessed March 18, 2021.

[3] https://covid19.who.int/region/amro/country/us, accessed March 18, 2021.

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have tested positive since the start of the pandemic and 194 deaths have been publicly reported.[4]

5. As explained in greater detail below, we have learned more about the effects of COVID-19 throughout the year and three vaccines have been approved to help combat the virus, but there are several factors that tell us COVID-19 is an ongoing concern. Principal among these concerns is the introduction of three identified variants of the disease. Early studies tell us that these variants may reduce the effectiveness of the vaccines, increase the severity of symptoms or the likelihood of death, and increase the potential for transmissibility. As the world moves to reopen its economy, caution needs to be taken to protect people in the most vulnerable situations.

6. A year's worth of data on the COVID-19 disease tells us how severe it can be. The disease can range from no symptoms or mild ones for most people at low risk, to respiratory failure and death, primarily in older patients and patients with chronic underlying conditions.

7. Anyone above the age of 50 or those with underlying conditions, are more likely to suffer serious illness and death from COVID-19. The U.S. Centers for Disease Control and Prevention (CDC) report that the risk of serious disease and death among those with COVID-19 increases with age, with 95% of reported deaths occurring in people over the age of 50.[5] For underlying conditions, the most frequently listed comorbidities with COVID-19 deaths are

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[4] See https://www.themarshallproject.org/2020/05/01/a-state-by-state-look-at-coronavirus-in-prisons, accessed March 22, 2021.

[5] See https://covid.cdc.gov/covid-data-tracker/#demographics, accessed March 22, 2021.

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influenza and pneumonia (45%), hypertension (19%), diabetes (16%), Alzheimer disease and other dementias (14%), and sepsis (9%).

8. We have also expanded the list of underlying medical conditions that can cause increased risk for severe illness from the coronavirus. Notably, these conditions place adults of *any age* at increased risk: Cancer, chronic kidney disease, Down syndrome, heart conditions, people with weakened immune systems, obesity and severe obesity, pregnancy, sickle cell disease, smoking, and type 2 diabetes.[6]

9. Even after a whole year of this ongoing COVID-19 pandemic, we still do not understand how the disease impacts every pre-existing medical condition. Based on what is currently known, adults of any age with the following conditions *might* be at an increased risk for severe illness: asthma, cerebrovascular disease, cystic fibrosis, hypertension or high blood pressure, people with weakened immune systems, neurologic conditions such as dementia, liver disease, people who are overweight, pulmonary fibrosis, thalassemia, and type 1 diabetes.[7]

10. But the threat is not limited to only people of advanced age or with underlying medical conditions. In the United States, younger adults with COVID-19 have been severely affected by the disease as well. While people under the age of 18 have not made up any large percentage of coronavirus cases or deaths, the data do show that people between the ages of 18-64 make up 74% of positive cases and 19% of deaths.[8]

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[6] See https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html, accessed March 22, 2021.

[7] Ibid.

[8] See https://covid.cdc.gov/covid-data-tracker/#demographics, accessed March 22, 2021.

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11. We have learned that there may be symptoms that impact individuals for several weeks to even months after the initial onset of COVID-19. This is called PASC, an acronym for post-acute SARS-CoV-2 infection. Some of the most reported long-term symptoms include, *inter alia*, fatigue, brain fog, loss of sense of smell and/or taste, shortness of breath, cough, joint pain, chest pain, difficulty thinking or concentrating, depression, muscle pain, intermittent fever, and heart palpitations.[9]

12. These long-term complications can affect different organ systems in the body including cardiovascular, respiratory, renal, dermatologic, neurologic, systems and mental processes.[9]

13. So far, COVID-19 reinfection appears to be rare, but there is no consensus whether COVID-19 will become a seasonal experience and drive infection rates similar to those experienced this past winter. What is known is that there are reports of patients falling ill again with symptoms similar to what they experienced the first time around. One study based on COVID-19 testing in Denmark concludes that people aged 65 and older are at a higher risk of reinfection. This is primarily because it appears as though people over the age of 65 retain only about 47% protection against reinfection compared to about 80% protection among younger patients.[10] These studies will be ongoing for years to come, but it demonstrates a clear and continuing need for mitigation efforts to keep controling the spread of COVID-19.

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[9] Seattle times article: https://www.seattletimes.com/seattle-news/health/first-covid-then-psychosis-bainbridge-island-man-faces-most-terrifying-thing-ive-ever-experienced/
See https://www.cdc.gov/coronavirus/2019-ncov/long-term-effects.html, accessed March 22, 2021.

[10] See https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)00575-4/fulltext, accessed March 22, 2021.

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14. While the world was grappling with and studying reinfection rates, producing and distributing vaccines, there was also the introduction of three known variants of the SARS CoV-2 virus. These three strains have been identified in the U.S. as recently as December and January 2021.[11]

15. The first variant is known as the B.1.1.7 and it is associated with increased transmissibility; reports from the United Kingdom suggests it may be associated with an increased risk of death. The second variant is B.1.351; currently there is no evidence to suggest that this variant has any impact on disease severity. The third variant is the P.1; there is evidence to suggest that some of the mutations in the P.1 variant may affect its transmissibility and antigenic profile, which raises concerns of a potential increases in transmission or a propensity for reinfection.[12]

16. These variants are a cause for concern, principally because of their potential to reduce the effectiveness of the existing vaccines, particularly the B.1.351 variant. Ongoing efforts are underway to study the effectiveness of the vaccines against these variants. For example, preliminary results from the United Kingdom demonstrate that the Pfizer-BioNTech vaccine was highly effective (85–86%) during a period when B.1.1.7 was the predominant circulating strain. Similarly, high Pfizer-BioNTech vaccine effectiveness (92%) against infection was observed in Israel in the context of multiple circulating strains. However, preliminary studies from the U.S., Brazil, and South Africa suggest the Johnson & Johnson vaccine may have reduced overall efficacy against the B.1.351 variant.[13]

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[11] https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)00575-4/fulltext, accessed March 22, 2021.

[12] Ibid.

[13] See https://www.cdc.gov/coronavirus/2019-ncov/more/fully-vaccinated-people.html, accessed March 22, 2021.

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17. Until recently, the only way to mitigate the rapid spread of COVID-19 was to use scrupulous hand hygiene, personal protective equipment (PPE), social distancing, self-quarantine for individuals who may have been exposed, and isolation at home or a care facility for those who have been infected. The only tools available to health care providers and individuals who encounter those exposed to, or infected with, COVID-19 was PPE (gloves, masks, and gowns). However, the emergency FDA approval of three different coronavirus vaccines is a turning point in this pandemic. The currently available vaccines are the Pfizer-BioNTech, Moderna, and Johnson & Johnson vaccines.

18. The benefits of being fully vaccinated include: being able to gather indoors with fully vaccinated people without wearing masks; gather indoors with unvaccinated people from one other household (for example, visiting with relatives who all live together) without masks, unless any of those people or anyone they live with has an increased risk for severe illness from COVID-19; and not need to quarantine, isolate, or get tested if exposed to someone who has COVID-19, unless there are symptoms.[14] While other mitigation efforts should continue to be practiced, these vaccines will help reduce the strain on our medical facilities, which in turn will promote public health, and begin the return to normal life.

19. The CDC introduced guidelines on how to conduct allocation of the vaccine in light of the urgency in distributing the vaccine and the initial scarcity in supply. These guidelines were created by an independent panel of medical and public health experts called the Advisory Committee on Immunization Practices (ACIP). Generally, these guidelines recommended that healthcare personnel and residents of long-term care facilities should be

[14] See https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated.html, accessed March 21, 2021.

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offered the first doses of COVID-19 vaccines, followed by frontline essential workers, people aged 65 and older, and people aged 16-64 who have underlying health conditions. As the supplies of vaccine increased, the CDC envisioned the recommendations would expand to include more groups. Each state's approach is unique, but generally follow the CDC's guidelines.

20. Against all these developments, a primary concern of medical and public health experts and public officials is the effect that the pandemic is having and will have on health care systems. Because severe COVID-19 cases require extended hospitalization and intensive medical care, an acute number of COVID-19 cases can overwhelm a health care system. This is true in urban areas but is particularly true in rural areas where health care facilities have far more limited.

21. Early in the pandemic and throughout the year, Washington State was one of the epicenters of the outbreak of COVID-19. As of March 18, 2021, more than 331,000 people in the state have tested positive for the COVID-19 virus, with 5,156 confirmed deaths.[15]

22. Washington's carceral system was not sheltered from the impacts of COVID-19. As of March 18, 2021, the WADOC has confirmed 6,185 cases of COVID-19 and 14 deaths among its residents; WADOC staff has 1,139 confirmed cases and two deaths.[16]

23. Residents and staff of correctional institutions are at a particular risk of harm from exposure and spread of COVID-19. Prisons are crowded congregate environments where people live, eat, and sleep in close quarters. By structural design, people in correctional

[15] See https://www.doh.wa.gov/Emergencies/COVID19/DataDashboard, accessed March 18, 2021.

[16] See https://www.doc.wa.gov/corrections/covid-19/data.htm#confirmed, accessed March 18, 2021.

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institutions cannot achieve the social distancing necessary to prevent the spread of COVID-19. Additionally, much like social distancing, effective masking cannot always take place. When people go to shower, eat, sleep, or simply forget, these individual gaps in mitigation efforts are not isolated incidents. Instead, they compound with every single person who may be doing the same activity at any given time inside the facility. Like other congregate environments, such as nursing homes and cruise ships, diseases like COVID-19 that can spread by air or touch, can spread more rapidly. This fact alone means that any resident of such facility has a heightened risk.

24. Prisons and jails are also populated with people who disproportionately have serious underlying medical conditions such as chronic infections that render them immunocompromised – the very conditions that put people at a markedly increased risk of becoming severely ill or dying from COVID-19. As such, not only is the virus more likely to spread within prisons and jails, but the outcomes are more likely to be particularly severe and even deadly.

25. Washington's vaccine allocation plan has generally reflected the CDC's recommendations.[17] However, Washington's plan has omitted the CDC's recognition that outbreaks in correctional and detention facilities are often difficult to control due to the inability to physically distance, limited space for isolation or quarantine, and limited testing and personal protective equipment resources.[18] In omitting these key facts about correctional facilities, Washington's plan ignores the CDC's encouragement to vaccinate staff and

[17] See https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/VaccinationPhasesInfographic.pdf, accessed March 20, 2021.

[18] See https://www.cdc.gov/coronavirus/2019-ncov/community/quarantine-duration-correctional-facilities.html#print, accessed March 24, 2021.

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incarcerated/detained persons of correctional or detention facilities *at the same time* because of their shared increased risk of disease.

26. Instead, Washington has prioritized staff for initial doses of the vaccine, along with limited numbers of people who are at increased risk due to age and comorbidities.[19] As vaccine availability has increased, Washington has expanded eligibility, but not allocation, to anyone with two or more comorbidities, anyone between the ages of 60-64, anyone living in congregate settings (correctional facilities, group homes for those with disabilities, those experiencing homelessness, etc.), and additional workers in congregate facilities (restaurants, manufacturing, construction).

27. At the same time, the CDC has been updating its guidelines for many groups. For example, the CDC is currently recommending schools (K-12) implement social distancing requirements of 3 feet, not 6 feet. This recommendation stems from studies showing that even when students were placed less than 6 feet apart in classrooms, COVID-19 transmission was limited *when other layered prevention strategies were consistently maintained*; notably, masking and student cohorts. The CDC also points out that physical distancing between adults is still six feet and greater physical distancing (at least six feet) should be prioritized whenever masks cannot be used.

28. For correctional facilities, the CDC continues to recommend 14 days of quarantine for staff and residents of correctional facilities. This is due to the fact that people in carceral settings may not be able to comply with mitigation measures to reduce post quarantine transmission (e.g., mask wearing and social distancing). The CDC acknowledges that reducing

[19] See https://medium.com/wagovernor/inslee-announces-extension-of-eviction-moratorium-expansion-of-vaccine-eligibility-long-term-635b34eb0ca, accessed March 20, 2021.

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the time spent in quarantine may save a number of resources including staff, physical space, and money, but the risk does not outweigh the benefits. Failure to detect post-quarantine transmission could result in a repeated cycle of medical isolation and quarantining close contacts, resulting in an even higher burden on staff, and further stretching limited medical resources and space constraints. This recommendation applies to anyone living or working inside of detention facilities and has been exposed to someone with suspected or confirmed COVID-19, regardless of whether they have been fully vaccinated because of the risk posed by congregate settings. However, staff that are not showing any symptoms may avoid quarantine as long as testing and routine screening continues.[20]

29. Another notable phenomenon impacting prisons is the number of staff nationwide refusing to take the vaccine. Early reports from various states including Florida, Massachusetts, California, Rhode Island, and Iowa are showing that the acceptance rate among correctional staff is generally around 50% or less. The reasons for refusing the vaccine are no different than what could be found among the general public, but correctional staff take on greater significance.[21] Given correctional staff's status as essential workers, their movement into and out of the facilities, and their movement within the facilities, they are prime sources for transmission between communities outside and inside of prisons. With the existing shortages in staffing, physical space, and effective mitigation efforts, this trend among staff threatens to undermine efforts to contain and eliminate the COVID-19 disease both inside and outside prisons.

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[20] See https://www.cdc.gov/coronavirus/2019-ncov/community/quarantine-duration-correctional-facilities.html#print, accessed March 20, 2021.

[21] https://apnews.com/article/us-prison-guards-refuse-vaccine-despite-covid-19-outbreaks-522775575fc815ee2354e97c3428dce0, accessed March 21, 2021.

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30. Based on my experience working on health care in correctional facilities, my review of the literature concerning coronavirus, and for the reasons outlined in this declaration, it is my opinion that prisons in Washington are not capable of preventing and containing outbreaks of the COVID-19 virus due to the way COVID-19 spreads, and the combination of factors that reduce the effectiveness of mitigation strategies and promote the spread of the disease. Therefore, to improve the effectiveness of mitigation efforts against transmission of COVID-19, Washington should prioritize the allocation of the coronavirus vaccine to prisons for voluntary administration to staff and residents.

31. For an airborne disease such as this, the most effective mitigation strategy to limit the spread of the virus inside of carceral settings is to immediately allocate the vaccines needed for all residents. In prison, even if each resident, infected or not, is isolated in a single cell, there is still an increased risk of transmission among prisoners and staff because the institutional design requires the delivery of food, cleaning supplies, documents, and other items. However, the reality is that in most prisons, individuals are not isolated in a single cell, or housed in an environment where social distancing is an option. This further increases the risks of transmission and an outbreak in the prisons.

32. Making the vaccine readily available to everyone inside of WADOC will reduce the likelihood of transmission of COVID-19 and will increase the effectiveness of existing mitigation measures to help reduce the intramural transmission of COVID-19, such as providing cleaning supplies to prisoners and frequent laundering of towels and clothes. This increase in effectiveness can stop or slow the spread of infection and accelerate the likelihood of a return to normal conditions, to the benefit of both residents and staff.

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33. Moreover, allocating sufficient vaccine and supplies for immediate availability to all residents will further protect those who are particularly vulnerable to exposure to COVID-19 – people who are elderly and those with underlying health conditions – by reducing the likelihood that this group of individuals will contract the virus, from other residents or from staff. Individuals in this category are at the highest risk of developing severe complications from COVID-19 and, as noted earlier, an acute outbreak will require access to community hospitals, using scarce community resources, including ventilators and intensive care unit (ICU) beds. Taking steps to prevent the spread of the disease is an important contribution to overall community health.

34. Allocating sufficient vaccine to make it available to everyone inside WADOC should be of paramount concern to restrict spreading of COVID-19. As seen throughout the country, a large effort has been undertaken to educate everyone on the vaccine and to discredit false information. However, these efforts are not convincing everyone, and correctional staff members are no exception.

35. There are certain contraindications to receiving the vaccine, including inter alia, having had a severe allergic reaction to a component of the vaccine or a prior dose and children, until there is FDA approval.

36. While the general public can take proactive steps to continue to effectively social distance and continue masking, people inside correctional facilities do not have those same opportunities. Correctional facilities, by design, cannot maintain social distancing or masking at all times. The longer a prison population remains unvaccinated, coupled with the large numbers of staff members who continue to refuse to get the vaccine, the greater the likelihood that the virus, or its variants, will cause yet another outbreak.

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37. WADOC should be planning on how to protect residents who decide to not take the vaccine, address individual concerns about the vaccine, and ensure unvaccinated staff are not imposing an unnecessary risk to unvaccinated residents. Failure to plan for people who refuse to take the vaccine poses an obvious risk to the institution, its residents, and thereby to the public health.

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

DATED this 28th day of March, 2021 in New York, New York.

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Physician consultant with extensive experience in development and management of complex community and institutional health care programs. Demonstrated strength in leadership, program development, negotiation, communication, operations and the bridging of clinical and public policy interests. Teacher of health and criminal justice.

SUMMARY OF EXPERIENCE

MEDICAL MANAGEMENT AND QUALITY IMPROVEMENT SERVICES 1995-Present

Consultant on the design, management, operations, quality improvement, and utilization management for correctional health care systems.

- Recent clients include (among others) the U.S. Department of Justice Civil Rights Division, monitoring multiple correctional systems and the U.S. Department of Homeland Security Office of Civil Rights and Civil Liberties. Federal court monitor for the Metropolitan Detention Center, Albuquerque, New Mexico, Orleans Parish Sheriff's Office, New Orleans, Louisiana, and Miami-Dade Corrections and Rehabilitation Department.
- National Commission on Correctional Health Care. Principal Investigator for an NIJ funded project to make recommendations to Congress on identifying public health opportunities in soon-to-be-released inmates.
- Associate Editor, Puisis M (ed), Clinical Practice in Correctional Medicine, Second Edition, St. Louis. Mosby 2006.
- Editor, Greifinger, RB (ed), Public Health Behind Bars: From Prisons to Communities, New York. Springer 2007.
- John Jay College of Criminal Justice. Professor (adjunct) of Health and Criminal Justice and Distinguished Research Fellow 2005 – 2016.
- Co-Editor, International Journal of Prison Health 2010 – 2016.

NEW YORK STATE DEPARTMENT OF CORRECTIONAL SERVICES 1989 - 1995

Operating budget of $1.4 Billion. Responsible for inmate safety, program, and security. Sixty-nine facilities housing over 68,000 inmates with 30,000 employees.

Deputy Commissioner/Chief Medical Officer, 1989 - 1995

- Operating budget of $140 million; health services staff of 1,100. Accountable for inmate health services and public health. Directed major initiatives in policy and program development, quality and utilization management.
- Developed and implemented comprehensive program for HIV prevention, surveillance, education, and treatment in nation's largest AIDS medical practice.
- Managed the rapid implementation of an infection control program responding to a major outbreak of multidrug-resistant tuberculosis. Helped bring the nation's tuberculosis epidemic to public attention.
- Developed $360 million five-year capital plan for inmate health services. Opened the first of five regional medical units for multispecialty ambulatory and long-term care.
- Implemented a centralized and regional pharmacy system, improving quality, service and cost management.

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MONTEFIORE MEDICAL CENTER, Bronx, NY 1985 - 1989

A major academic medical center with 8,000 employees and annual revenue of $500 million.

Vice President, Health Care Systems, 1986 - 1989

Director, Alternative Delivery Systems, 1985 - 1986

Operating budget of $60 million with 1,100 employees. Managed a multi-specialty group, a home health agency, and prison health programs.

- Negotiated contracts, including bundled service, risk capitation, fee-for-service arrangements, and major service contracts. Developed a high technology home care joint venture.
- Taught epidemiology and health care organization at Albert Einstein College of Medicine. Lectured nationally on health care delivery and managed care.
- Conceived and collaborated in development of a consortium of six academic medical centers, leading to a metropolitan area-wide, joint venture HMO. Organized a network of physicians to contract with HMO's preparing for cost-containment.

WESTCHESTER COMMUNITY HEALTH PLAN, White Plains, NY 1980 - 1985

Independent, not-for-profit, staff-model HMO, acquired by Kaiser-Permanente in 1985. Operating revenue $17 million with 200 employees and 27,000 members.

Vice President and Medical Director

Chief medical officer and COO. Managed the delivery of comprehensive medical services. Accountable to the Board of Directors for quality assurance and utilization management. Practiced pediatrics.

- Accomplished turnaround with automated utilization management, improved service, sound personnel management principles, and quality management programs.
- Implemented performance based compensation program.

COMMUNITY HEALTH PLAN OF SUFFOLK, INC. 1977 - 1980

Community based, not-for-profit, staff model HMO, with enrollment of 18,000.

Medical Director

- Developed and operated clinical services. Accountable for quality of care. Practiced clinical pediatrics, and taught community health and medical ethics at SUNY Stony Brook School of Medicine.

MONTEFIORE MEDICAL CENTER, Bronx, NY 1976 - 1977

Residency Program in Social Medicine, Deputy Director, 1976-1977

Unique clinical training program focused on community health and change agentry. Developed curriculum and supervised 40 residents in internal medicine, pediatrics and family medicine.

UNITED STATES PUBLIC HEALTH SERVICE 1972 - 1974

Commissioned officer in the National Health Service Corps. Functioned as medical director and family physician in a federally funded neighborhood health center in Rock Island, Illinois. Honorable Discharge.

ROBERT B. GREIFINGER, M.D.

FACULTY APPOINTMENTS

1976 - 2002
Assistant Professor of Epidemiology and Social Medicine, Albert Einstein College of Medicine

2005 - 2016
Professor (adjunct) of Health and Criminal Justice and Distinguished Research Fellow, John Jay College of Criminal Justice

NATIONAL COMMITTEE FOR QUALITY ASSURANCE

Worked with NCQA since its inception in 1980. Began training surveyors in 1989 and continued as faculty for NCQA sponsored educational sessions. Served for six years as a charter member of the Review Oversight (accreditation) Committee. Served on the Reconsideration (appeals) Committee for six years. Surveyed dozens of managed care organizations and reviewed several hundred quality management programs.

OTHER PROFESSIONAL ACTIVITIES

2012 – present	Member, Board of Directors, Prison Legal Services, New York
2012 – 2020	Member, Board of Directors, National Health Law Program
2011 – 2015	Member, Board of Directors, Academic Consortium of Criminal Justice Health
2010 - 2016	Co-editor, International Journal of Prisoner Health
2009	Recipient, B. Jaye Anno Award for Lifetime Achievement in Communication
2007-2015	Member, National Advisory Group on Academic Correctional Health Care
2007	Recipient, Armond Start Award, Society of Correctional Physicians
2005 - 2011	Member, Advisory Board to the Prisoner Reentry Institute, John Jay College
2002 - present	Member, Editorial Board, Journal of Correctional Health Care
2002 - present	Peer reviewer for multiple journals, including Journal of Correctional Health Care, International Journal of Prison Health, Journal of Urban Health, Journal of Public Health Policy, Annals of Internal Medicine, American Journal of Public Health, Health Affairs, and American Journal of Drug and Alcohol Abuse.
2001 - 2003	Member, Advisory Board to CDC on Prevention of Viral Hepatitis in Correctional Facilities
1999 - 2003	Member, Advisory Board to CDC on Prevention and Control of Tuberculosis in Jails
1997 - 2003	Member, Reconsideration Committee, NCQA
1997 - 2001	Moderator, Optimal Management of HIV in Correctional Systems, World Health Communications
1997 - 2000	Member, Reproductive Health Guidelines Task Force, CDC
1993 - 1995	Co-chair, AIDS Clinical Trial Community Advisory Board, Albany Medical Center
1992 - Present	Society of Correctional Physicians
1991 - 1997	Member, Review Oversight (accreditation) Committee, NCQA

ROBERT B. GREIFINGER, M.D.

1983 - 1985 Executive Committee, Medical Directors' Division, Group Health Association of America (Secretary, 1984-1985)

EDUCATION

University of Pennsylvania, College of Arts and Sciences, Philadelphia; B.A., 1967 (Amer. Civilization)

University of Maryland, School of Medicine, Baltimore; M.D., 1971

Residency Program in Social Medicine (Pediatrics), Montefiore Medical Center, Bronx, NY; 1971-1972, 1974-1976, Chief Resident 1975-1976

CERTIFICATION

Diplomate, National Board of Medical Examiners, 1971

Diplomate, American Board of Pediatrics, 1976

Fellow, American Academy of Pediatrics, 1977

Fellow, American College of Physician Executives, 1983

Fellow, American College of Correctional Physicians (formerly Society of Correctional Physicians), 2000

License: New York, Pennsylvania (inactive)

ROBERT B. GREIFINGER, M.D.

Updated July 2020

PUBLICATIONS

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