CONFIDENTIAL REBUTTAL REPORT OF TODD RANDALL WILCOX, M.D., M.B.A., C.C.H.P.-A

Parsons, et al. v Ryan, et al.
No. 2:12-cv-00601-NVW
January 31, 2014

Confidential Information – Subject to Protective Order

I have reviewed the report of Dr. Lawrence H. Mendel submitted in this case. I believe many of the facts underlying his opinion are unexplained, undocumented, unproven, and in many cases clearly incorrect. I also find his reasoning and medical opinions seriously flawed in several areas.

I. Outcome measures

Dr. Mendel relies on two sets of outcome measures in drawing his sweeping conclusions about Arizona prison healthcare: data from diabetic patients and mortality rates. I agree that relevant outcome measures can be extremely helpful in evaluating system performance. I would have welcomed the opportunity to review such data for my report, but when I requested it, I was informed by plaintiffs' counsel that it had not been provided. I therefore reviewed with interest Dr. Mendel's outcome measures.

I was disappointed in what I saw. Outcome measures are only useful to the extent they are based on reliable data. It is therefore essential to take basic steps to assess the validity of the data before drawing conclusions from it. Unfortunately, Dr. Mendel does not appear to have performed even an elementary review of the numbers he cites. As a result, he has made several key errors and overlooked profound flaws that render his conclusions utterly unreliable.

A. Diabetes care

Diabetes care, in Dr. Mendel's view, is "the best overall measure of the effectiveness of a correctional healthcare system." Confidential Expert Report of Lawrence H. Mendel, D.O., FSCP, CCHP, December 18, 2013, at 27 (hereafter "Mendel Report"). I agree that it is a reasonable barometer of several interconnected healthcare processes in correctional settings. Dr. Mendel and I differ, however, on how to measure whether a system provides community standard of care in this area. His approach is to look solely at outcome measures -- HgA1c and LDL levels -- and not at any individual patient care, and his results demonstrate the risks of such a limited methodology.

The most famous diabetes study ever conducted is called the Diabetic Control and Complications Trial (DCCT). The conventional therapy group for the DCCT, under a treatment regimen very similar to that employed by ADC, had a median HgA1c of 9.1%. The intensive therapy group, with a far superior treatment regimen than that employed in ADC, had a median HgA1c of 7.2%. DCCT Research Group, "The Effect of Intensive Treatment of Diabetes on the Development and Progression of Long-Term Complications in Insulin-Dependent Diabetes Mellitus," New England Journal of Medicine, vol. 329, no. 14 (Sept. 30, 1993). See also "The Diabetes Control and Complications Trial/ Epidemiology of Diabetes Interventions and Complications Study at 30 Years: Overview," Diabetes Care, vol. 37, pages 9-16 (January 2014). This was an academic study that demonstrated that even under tight clinical management very few diabetics can achieve sustained HgA1c levels below 7%.

Another important data point is the Geisinger Diabetes Group. Geisinger is a private healthcare network that is the national benchmark for preventative practices and diabetic control in large populations. Their diabetes control program is considered state of the art, and includes many things unheard of in a correctional environment, such as nutritional counseling, individual meal plans, carbohydrate counting, exercise plans, diabetic education, disease support groups, and endocrinology consultations (http://www.geisinger.org/services/endocrinology/diabetes.html). Under the most rigorous medical, dietary, and behavioral management they are able to achieve HgA1c levels of less than 7% in fewer than half of their diabetic patients. Bloom et al., "Redesign of a Diabetes System of Care Using an All-or-None Diabetes Bundle to Build Teamwork and Improve Intermediate Outcomes," Diabetes Spectrum, vol. 23, no. 3 (2010). See also Ali et al., "Achievement of Goals in U.S. Diabetes Care, 1999-2010," New England Journal of Medicine, vol. 368, no. 17 (April 25, 2013) at 1613-24 (after a decade of diabetic management progress, only approximately half of diabetics achieve HgA1c levels of less than 7%).

Against this backdrop, Dr. Mendel's claim that more than 70% of diabetics in ADC have achieved HgA1c levels of less than 7% over six months is not credible.

The Low Density Lipoprotein (LDL) values presented by Dr. Mendel are similarly difficult to believe. The National Health and Nutrition Examination Survey (NHANES) studies showed only 56.8% of the study group were able to achieve an LDL less than 100. Ali et al., "Achievement of Goals in U.S. Diabetes Care, 1999-2010." Corizon reports, and Dr. Mendel repeats without question or explanation, that 61% of its diabetic management group achieves an LDL less than 100. Mendel Report at 30. The results from academic studies occur under intense dietary and medical management. I saw no evidence of any similar efforts at ADC in my tours and review of the charts. Consequently, results better than the literature are difficult to believe without corroboration.

Additional lab data in the documentation produced with Dr. Mendel's report exhibit similar unreliability. In the same Corizon lab monitoring report, HIV management is cited as perfect—100% of HIV patients who have been on HAART (Highly Active Anti-Retroviral Therapy) for 12 weeks or more have an undetectable viral load in the third quarter of 2013. ADC_M000001. This result suggests that every HIV patient in the system is perfectly managed and has a perfect clinical response to treatment. In my clinical experience and to my knowledge of the literature, this result is not an achievable outcome measure across a large population. In my review of HIV-positive patients in ADC I found the care to be disorganized, illogical, poorly executed, and beneath the standard of care in some cases. I found several cases of poor management where HIV viral loads had been ordered but never carried out, and therefore the extent of the mismanagement was not documented objectively. As such, I find the claim of 100% perfection in this difficult and complex patient population to be unbelievable.

B. Mortality rates

The other outcome measure relied on by Dr. Mendel is the ADC's mortality rate, compared to the national average in prisons and jails. Mendel Report at 31-32.

Dr. Mendel's analysis misses the mark: comparisons of crude mortality rates, without controlling for other factors that drive mortality, tell us nothing. The single greatest driver of mortality rates overall is age. Other factors with significant impact on death rates that should be controlled in any cross-population comparison include gender, ethnicity, and length of prison stay. Without controlling for these factors, we cannot draw any conclusions as to why ADC's mortality rate might be lower than the national average. See Curtin and Klein, "Direct Standardization (Age-Adjusted Death Rates)," U.S. Department of Health and Human Services/Centers for Disease Control and Prevention/National Center for Health Statistics (March 1995).

Even if comparing the mortality rate of the plaintiff class with the national average in prisons and jails were a useful exercise, Dr. Mendel's conclusions would still be wrong: the mortality rate for the plaintiff class in this case is in fact very close to his cited national average, and rising steadily. We obtain different numbers because his calculations appear to include ADC prisoners in both state-run and private prisons. (It is difficult to tell, since he does a poor job of citing his data sources.) This lawsuit, however, includes only ADC prisoners in state-run facilities. In 2012, there were 84 deaths in state-run facilities, out of an average population of 33,089.[1] In 2013, there were

[1] I obtained the total number of 2012 deaths in custody from ADC_M000207. That document reports a total of 87 deaths in custody, which includes deaths that occurred in private prisons. I reviewed the accompanying documents for each death and excluded the three that occurred in private prisons, found at ADC_M000268, ADC_M000274, and ADC_M000290. I obtained the average population in state-run facilities for 2012 by taking the average of the monthly population reports issued by ADC in that year. See PLTF-PARSONS-031580-031591.

87 deaths in state-run facilities, out of an average population of 33,664.[2] Thus the mortality rate for the relevant population was 253.9 per 100,000 in 2012 and 258.4 per 100,000 for 2013. Those figures demonstrate that contrary to Dr. Mendel's statements, the mortality rate in ADC prisons is increasing under Corizon's involvement and it is very near the national average.

II. Faulty reasoning

Many of Dr. Mendel's sweeping conclusions about healthcare in the ADC are flawed. He argues that care is adequate because staffing is improved, wait times are better, grievances are minimal, and Arizona prisons are accredited by the NCCHC. I examine each of these points in turn, along with his review of the few individual cases he discusses.

A. Staffing

Dr. Mendel offers a graph to demonstrate staffing improvements. Mendel Report at 20. The graph is confusing and misleading, however. For one thing, the vertical axis is not labeled with any units of measure. I am assuming, from a review of the cited data, that it refers to Full Time Employee Equivalents, but I cannot be sure. For another, Dr. Mendel makes the elementary mistake of graphing his staffing numbers, which are discrete data, using a continuous data method. Staffing numbers go up or down in blocks, not in gradual slopes. It is misleading, for this type of data, to connect the dots and color in the graph beneath the line you create. Moreover, the layering of the different elements (mid-levels, staff physicians, and medical directors) on top of each other improperly aggregates the data, producing a graph that does not match up to any stated

[2] I could not obtain the total number of 2013 deaths in custody from the same source as I found 2012 deaths, since the documents produced to me were not complete to the end of the year. I therefore reviewed all the public announcement of 2013 deaths in custody by ADC, excluding executions and deaths occurring at private prisons. PLTF-PARSONS-031631-031717. I obtained the average population in state-run facilities in 2013 by taking the average of the monthly population reports issued by ADC in that year. See PLTF-PARSONS-031592-031603.

data source. For example, if you read this graph literally, in October 2013 ADC had almost 45 units of whatever-is-being-measured of medical directors. That result does not correlate with any data disclosed.

Perhaps the most misleading aspect of Dr. Mendel's graph is that it gives the impression that all three important staffing levels – medical directors, physicians, and mid-level providers – have increased significantly under Corizon's management. However, when I looked at the underlying data, I found that that is not the case. Although in this period Corizon did increase the woefully inadequate number of mid-level providers, it also reduced the woefully inadequate numbers of physicians and medical directors. All three job categories remain below the contractually required levels.

The graph is also, in one area, dead wrong. Dr. Mendel's graph shows the aggregate staffing level for May 2013 for his three groups at 31 or 32 (my guess at the breakdown, based on a purely visual review of the graph, would be Medical Directors 6, Staff Physicians 10, and Mid-Level Providers 16). He cites ADC117064 for the May 2013 figures, but that document shows the aggregate staffing levels for these groups to be below 25 (Medical Directors 5.5, Staff Physicians 4.5, Nurse Practitioners 14.75[3]). That same document indicates that Corizon has secured only 0.77 FTEs of Medical Director staffing, 0.9 FTEs of physician staffing, and 3.47 FTEs of nurse practitioner staffing from various temporary agencies which still leaves them well short of contract minimums.

B. Access to care: waiting times

Dr. Mendel states that "significant progress" has been made in recent months, after my tours and document reviews, such that nearly every facility has a "provider wait time" of less than eight days, with a statewide average of seven days. Mendel Report at

[3] "Mid-Level Providers" are not listed as a category in this document (ADC117064). The only staffing category that could be considered a mid-level provider is Nurse Practitioner, so that is the number I have used.

9-10. I looked at the underlying data Dr. Mendel cites and found it questionable at best. According to a document cited by Dr. Mendel, there were no provider HNRs and no wait time at all to see providers at Perryville in the month of May 2013.[4] Mendel Report at 10; ADC122017. What can this mean? How is it possible? The same document has no provider information from Lewis at all in May 2013. The same document also shows a four-month wait time to see a provider at Eyman, and Yuma appears to be so short-staffed with providers that it is projected to take 1-2 months for the system to see a mere 34 patients who have requested provider healthcare. *Id.* Another document Dr. Mendel cites for his chart (ADC155093) shows no Provider HNRs at Winslow in September 2013. Yet another document (ADC203348) shows no scheduled provider appointments and zero provider wait time at Phoenix in November 2013. The data that Dr. Mendel uses to defend the care at ADC is all over the map, incomplete, internally inconsistent and it exemplifies in one report the systemic issues in this case. Quite simply, Corizon and ADC are unable to describe their own operation accurately with statistical performance numbers. As such, it is illogical to attempt to defend the system using reports that are so glaringly inaccurate and incomplete.

A review of the Health Needs Request report for October 2013 (ADC203032), a document not cited by Dr. Mendel, provides some insight into the ongoing Health Needs Request problems in the ADC. According to that report, 17,367 medical HNRs were submitted by prisoners statewide in October 2013. Out of that number, a total of 7,513 (43.3%) were scheduled to see a nurse and 3,478 (20.0%) were then scheduled to see a provider. While the reported decrease in wait times is laudable, the real problem is that the majority of patients requesting healthcare are not seen by anybody. Out of 17,367 requests for treatment, only 7,513 were scheduled to be seen even by a nurse, leaving

[4] He fails to define his terms, so it is difficult to tell what exactly he is claiming. What exactly does the "provider wait time" measure? The time from the filing of an HNR to its triage? From the triage to a nurse's line? The nurse's line to a provider line? The entire stretch, from the filing of an HNR until a patient is seen by a provider?

9,854 requests for care with no face-to-face review. We have no information about why they were not seen and do not know if leaving the majority of patients with no face-to-face evaluation is appropriate. I strongly suspect it is not.[5]

Another disturbing aspect of this October 2013 data is what I call "throughput" to the providers – how many patients filing HNRs get seen at a higher level than a nurse? The 20% figure in October 2013 seems extremely low to me, given my experience of patients' written requests and my review of HNRs from ADC prisoners' files. This rate varies by facility: at Douglas, only 12.3% of HNRs result in a provider visit, Tucson runs at 9.7%, and Perryville has only 8.2% provider throughput.

To me, the primary issue is not the wait times for those who do see providers but rather overall access to care within the system. This data confirms my opinion that access to healthcare is extremely constrained and staffing is inadequate to meet the demands of the system.

C. Grievances

Dr. Mendel's reliance on grievances as probative evidence of the adequacy of health care is ill-advised. In my experience evaluating and operating correctional healthcare systems I have found that prisoners frequently refrain from filing grievances for many reasons, including fear of retaliation, frustration with what they see as a meaningless process, and low literacy levels. In Arizona, prisoners might feel reluctant to share their healthcare needs on a document that is seen by custody staff. See Deposition of Juliet Respicio-Moriarty, September 23, 2013, at 10:14-11:25. An inadequate grievance tracking process might also yield a smaller number of grievances in the records than were in fact filed. Thus, the fact that only a small number of grievances was produced to Dr. Mendel does not automatically connote satisfaction with the

[5] Dr. Mendel makes the questionable assumption that "patient requests have been triaged and prioritized based upon the acuity of the medical need." Mendel Report at 10. He provides no support for this statement. ADC's own monitors have found exactly the opposite to be true, as I did and described at length in my report.

responsiveness or efficacy of the system – in fact, it might demonstrate the exact reverse. There is much more we need to know about this information source before we can use it to draw conclusions about the healthcare system. For these reasons, I do not place much credence in an analysis that concludes that a lack of grievances demonstrates satisfaction with the healthcare available.

D. NCCHC standards

I agree that the National Commission on Correctional Health Care serves a valuable purpose in helping correctional facilities improve healthcare for prisoners. I am well aware of the accreditation process and I agree that in general it is a positive achievement for a facility to become accredited. However, I am also well aware of the significant shortcomings of the accreditation survey process. In Arizona, several of the prisons that are accredited have not been surveyed on site since 2010, and obviously a great deal has changed since then. In addition, while some of the prisons retain accreditation, they are technically on probation because of significant deficiencies found on their last survey. As such, being accredited does not always mean that the healthcare is being delivered in accordance with prevailing standards. A prime example of this disconnect occurred in Maricopa County, Arizona. The jail system there had been accredited for a long time, yet the court ultimately found in *Graves vs. Arpaio* that many of the core elements of care did not meet prevailing standards and the court ordered remedies to bring the jail into compliance.

E. Individual cases

Dr. Mendel states that he did review a few of the medical charts that I referred to in my expert report. Unfortunately, it is clear that he performed a very selective review of information and in many cases he missed the entire point for why that patient's management fell beneath the standard of care, as a close examination shows:

- Shawn Jensen (032465) had a confirmed elevation in his prostate specific antigen (PSA, a marker of cancer) on August 30, 2006. It took two years

and 10 months for ADC to get him seen by a urologist and the biopsy took three years and two months from the initial abnormal lab test. No reasonable clinician would endorse a three-year cancer workup with an elevated PSA as reasonable and meeting the standard of care. The fact that he did not have metastatic disease at the time of his surgery, a fact Dr. Mendel relies on, is hardly a defense for this extraordinarily delayed workup and treatment. Mendel Report at 11-12.

In addition, Dr. Mendel disputes my finding that it was inappropriate for a nurse to complete a Foley irrigation for Mr. Jensen. Mendel Report at 12-13. His dispute is based on his misreading of the chart, however. While nurses frequently do manage Foley catheters within their scope of practice, this was a somewhat different case. The Foley catheter was actually a surgical drain strategically placed by the physician. It is well established in the medical community that surgical drains are managed by doctors only; thus, no nurse should have manipulated Mr. Jensen's catheter regardless of level of licensure.

- [redacted] is a diabetic patient who complained of vision loss on 12/12/12. As of my tour on 7/29/13 he had never been seen by an optometrist. In addition, he became critically sick with critically abnormal labs between 3/2013 and 6/2013. His critical lab values were signed off late and no follow-up monitoring was ordered. His diabetes was poorly controlled in prison with a HgA1C of 8.7% on 5/19/2013, which was a significant increase over his long established baseline. He was so sick I felt the need to inform Dr. Williams of the extreme risks to this patient under his current management. Dr. Mendel, however, indicates in his report that he reviewed this patient's chart and makes no mention of the violations of

the standard of care. Instead, he appears to defend the care by affirming that he was finally seen by an optometrist. Mendel Report at 23.

- Desiree Licci (150051) is a breast and ovarian cancer survivor who began to experience abnormal symptoms in November 2010. It took ADC more than two years to have her seen by an oncologist. Dr. Mendel states "her medical treatment has been consistent with the applicable standards of medical care." Mendel Report at 25. I wholeheartedly disagree. No reasonable clinician thinks that a two-year workup for possible gynecological cancer recurrence is appropriate. Dr. Mendel notes that surgery was scheduled after my visit; I very much hope that this is true and that it has taken place.
- Dr. Mendel indicates that he reviewed the care of [redacted], who has suffered from a chronic leg wound that has been improperly treated over the course of many months. Dr. Mendel admits that the care was inappropriate but blames Wexford and indicates that the wound appears to be improving. Mendel Report at 40. I am not sure how he came to that conclusion since he never saw the patient. When I reviewed [redacted] care in August 2013, five months after Corizon took over, it was evident to me that Corizon was continuing a wound care treatment plan that did not meet standard of care for many months with no provider oversight and that [redacted] wound was allowed to fester and grow to the point that significant reconstructive surgery would be necessary to repair his leg. I very much hope that [redacted] wound is in fact improving, but I have very little faith in Dr. Mendel's vague statement, especially since the treatment provided [redacted] clearly had not improved in the two months after I told Dr. Williams of Corizon and the ADC and Corizon attorneys in this case that his care was dangerously deficient.

- Dr. Mendel also indicates that he reviewed the care of [redacted]. He agrees with me that the infectious disease consult for management of his advanced AIDS was delayed but claims that all of the care ordered by the infectious disease telemedicine appointment on August 21, 2013 (three weeks after I alerted Corizon's Dr. Williams and the Corizon and ADC lawyers to the serious deficiencies in his care), has been implemented. Mendel Report at 26. When I reviewed the updated chart on October 7, 2013, the care from that appointment had not been implemented. I hope Dr. Mendel has more recent information because without competent care this patient does not have long to live.

III. Additional information

I have been informed that in the last week the defendants have provided additional documents and information relied on by Dr. Mendel in issuing his report. After reviewing these documents, I may issue a supplemental report to address this recent production.

January 31, 2014

Todd R. Wilcox, M.D., M.B.A., C.C.H.P.-A

Appendix A to Confidential Rebuttal Report of Todd Randall Wilcox

In addition to the documents listed in my initial report, I reviewed the following documents for this rebuttal report:

Confidential Expert Report of Lawrence H. Mendel, December 18, 2013

ADC 2013 Inmate Death Notification (PLTF-PARSONS-031631 - PLTF-PARSONS-031717)

ADC117064-117074

ADC121178-121178

ADC122017-122017

ADC155093

ADC155099

ADC203032

ADC203036

ADC203041

ADC203348

ADC_M_000001

ADC_M_000207-000381

AGA_REVIEW_00019436

AGA_REVIEW_00020573

Mohammed K. Ali et al., Achievement of Goals in U.S. Diabetes Care, 1999-2010, New England Journal of Medicine, vol. 368, no. 17 (April 25, 2013) (PLTF-PARSONS-031614 - PLTF-PARSONS-031625)

ADC 2012 Institutional Capacity & Committed Population Monthly Reports (PLTF-PARSONS-031580 - PLTF-PARSONS-031591)

ADC 2013 Institutional Capacity & Committed Population Monthly Reports (PLTF-PARSONS-031592 - PLTF-PARSONS-031603)

Lester R. Curtin and Richard J. Klein, Direct Standardization (Age-Adjusted Death Rates), U.S. Department of Health and Human Services/ Centers for Disease Control and Prevention/National Center for Health Statistics (March 1995) (PLTF-PARSONS-031569 - PLTF-PARSONS-031579)

Frederick J. Bloom et al., Redesign of a Diabetes System of Care Using an All-or-None Diabetes Bundle to Build Teamwork and Improve Intermediate

Outcomes, Diabetes Spectrum, vol. 23, no. 3 (2010) (PLTF-PARSONS-031626 - PLTF-PARSONS-031630)

DCCT Research Group, The Effect of Intensive Treatment of Diabetes on the Development and Progression of Long-Term Complications in insulin-Dependent Diabetes Mellitus, New England Journal of Medicine, vol. 329, no. 14 (Sept. 30, 1993) (PLTF-PARSONS-031604 - PLTF-PARSONS-031613)