CONFIDENTIAL SUPPLEMENTAL 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
April 2, 2014

Confidential Information – Subject to Protective Order

I have reviewed the 125 medical records that Dr. Mendel consulted in developing his opinion about the Arizona prison health care delivery system.[1] According to Dr. Mendel, the information he reviewed, including these patients' charts, "shows incontrovertible evidence of [ADC's] ability to identify and resolve major challenges" and to operate "within the standard of care for correctional systems." Mendel Report at 49. Having reviewed the same records, it is my opinion that the evidence contained in them contradicts his wholehearted endorsement of the ADC's healthcare system. In addition, I have also reviewed recent records for named plaintiff Shawn Jensen, and these records likewise reveal a health care system that is seriously flawed.

I. Records Reviewed by Dr. Mendel

The medical records that constitute one of the bases for Dr. Mendel's expert opinions are notable for several reasons. First, the records clearly contradict and undermine data that Dr. Mendel presented in his initial report and cited in support of his contention that patients with chronic conditions are well controlled. Second, like the records that I reviewed at the Arizona prisons I visited, they revealed ongoing healthcare delivery problems, including poor scheduling and follow-up for ordered tests, lack of timely access to care, uninformed treatment decisions, failure to deliver ordered medications, and inadequate access to specialty care. Because of these serious and ongoing barriers to care, some Arizona prisoners are suffering unnecessary pain and bad outcomes, and all are subject to an unreasonable risk of serious harm. Third, they are an

[1] Because defendants did not start to produce these records until ten weeks after Dr. Mendel submitted his report, I was unable to address them in my earlier rebuttal report.

odd assortment: there is an unusual number of HIV patients, and the scope of many of the records was limited. Fourth, as was true of all of the ADC patient charts I have reviewed, these records were incomplete and very poorly maintained.

A. The Records Dr. Mendel Reviewed Refute Corizon Chronic Care Data

Dr. Mendel relies heavily on a single-page report, produced by Corizon, that purports to list outcome measures for patients with diabetes, patients taking blood thinners, and patients with HIV. ADC_M00001. The report is the centerpiece of his argument that ADC cares for its patients appropriately.

I found the report's outcome measures to be questionable on their face and based on my independent review of Arizona prison medical care, as I described in my rebuttal report. After being provided copies of the medical charts that Dr. Mendel reviewed, I was able to explore his conclusions regarding outcome measures in relation to the information he had to compare them with. I found that the patient charts clearly demonstrate the utter unreliability of the outcome measures.

1. HIV Management

According to Corizon's report, in the third quarter of 2013, 100% of HIV positive patients taking antiretrovirals in Arizona prisons had an undetectable viral load. The medical records Dr. Mendel reviewed conclusively establish that this is false. For example, [redacted] is HIV-positive and also suffers from profound psychosis that is well managed on medications. Like many HIV-positive patients, [redacted] has been treated with a combination of antiretroviral medications that was, for quite a while, effectively managing his condition. The disease management data in his

record demonstrates excellent clinical outcomes for his HIV early in this medical record. On January 30, 2013, his viral load was undetectable and his immune system was in excellent shape with a CD4 count of 498. He was tested again on May 1, 2013, and his viral load then was undetectable and his CD4 was done but the result is illegible.

However, after Corizon began providing the healthcare, they apparently adopted a practice of distributing HIV medications as Keep On Person (KOP) medications (i.e., the patient is provided a supply of medications a month at a time to manage on his or her own), rather than administering each dose as was previously done for [redacted]. There are a number of HNRs in [redacted] medical record where he complains that he is not receiving his HIV or mental health medications (ADC232654, p. 139; ADC232656, p. 141; ADC232658, p. 143). There are also notes from his mental health provider on September 17, 2013, that indicate the patient reported he has not received his medications "in a while" (ADC232703, p. 188). I attempted to correlate the patient's allegations with the Medication Administration Records (MARs) in his medical record but the record-keeping is so inadequate as to fall below standard of care for medication administration documentation and they provide no guidance on whether he did or did not receive his HIV medications (Sustiva and Truvada) or his mental health medication (Trilafon). What is bizarre about [redacted] management is that his critical medications are KOP and some of his other non-critical medications (Benzotropine and Gabapentin) are Direct Observe, and the nurses document his compliance for these non-critical medications daily. If the system makes him come to the window to get his medications every day, why not administer his critical medications to him at the same time?

What we do know from the record is that this previously stable patient suffered virologic failure (dramatically increased HIV viral load despite an ongoing HIV treatment regimen) as evidenced by an HIV viral load of 86,708 (log 4.94) on August 22, 2013, and that on the same date his CD4 count crashed to 284, which is a dramatic decrease over just a few months. When HIV-positive patients hit a CD4 of 200, the immune system is generally considered to be so compromised that preventative antibiotics are initiated. Corizon's failure to recognize that psychotic prisoners, and indeed any prisoner with mental illness or developmental delays, may require an individualized medication plan for life-sustaining prescriptions is shocking. What is even more shocking is that after [redacted] markedly abnormal viral load and decreased CD4 result became known in August, nobody within Corizon investigated why he is failing therapy or attempted to implement any corrective action.

This patient is currently being managed by a Physician's Assistant (PA) who does not even make mention of his elevated HIV viral load in the clinic note dated October 8, 2013 (ADC232520, p. 5). Clearly the PA cannot competently manage this complex patient. Based on the medical records in this chart, [redacted] is currently in danger of rapid progression toward AIDS. Fortunately, the PA has requested an Infectious Disease consult to help manage [redacted] care. I hope that the ordered consult has occurred and resulted in the appropriate interventions to provide life-saving treatment that has been lacking.

The above case demonstrates failures on many levels. The medical care is deficient, mental health care is ineffective, nursing care does not comply with basic

standards of nursing documentation, the medication management (nursing and pharmacy) is failing to maintain continuity of care. The significant increase in this patient's viral load clearly demonstrates the overall failure of management as well as contradicting Corizon's outcome measure.

Another case in Dr. Mendel's records with similar results is that of [redacted] who has been on prescribed HIV medications. He had an HIV viral load of 104,659 (Log 5.02) on September 10, 2013. This lab result is indicative of total virologic failure and no definitive management of that problem is evident in the chart. [redacted] needs urgent management to avoid potentially damaging long-term consequences. Continuing to provide HIV medications that clearly are ineffective is medically inappropriate and financially wasteful. See also [redacted] another HIV-positive patient who was on medications during the third quarter of 2013 and did not have in undetectable viral load (ADC234186).

These three HIV patients had elevated viral load results reported in the third quarter of 2013. Obviously the lab report that Dr. Mendel relied on that claimed that 100% of HIV patients on medications in the third quarter of 2013 had undetectable viral loads is not accurate, something Dr. Mendel knew or should have known from his record review.

2. Diabetes Management

In his report, Dr. Mendel states that he believes that diabetes care is the best overall measure of the effectiveness of a correctional healthcare system (Mendel Report at 27) and that one lab value report can therefore determine the efficacy of the system. I

don't agree with that oversimplification of a complex healthcare system any more than I would agree that the health of a patient can be summarized with one vital sign. However, I am willing to entertain his hypothesis and to test it against the patients he reviewed.

There were not many diabetic charts to examine. Given his reliance on diabetes as a single measure of success of ADC, it is surprising to me that Dr. Mendel did not select more diabetic patients for his chart review. Remarkably, out of the 125 charts that he claims to have reviewed, only three patients were insulin-requiring diabetics and only three were non-insulin dependent diabetics.

The evidence of care contained in these few charts bolsters my opinion of substandard care in Arizona prisons and undermines Dr. Mendel's conclusions.

a. Insulin-Requiring Diabetics

With respect to the insulin-requiring diabetics, none of them was within acceptable clinical control and appropriate chronic care management. [redacted] had reasonable blood glucose control (HgA1c of 6.7%) but his blood pressure was significantly elevated (180/98) with no intervention by the medical staff. Blood pressure control is critical to minimize the complications of diabetes and this patient is poorly managed. Furthermore, this patient is on phenytoin for a seizure disorder. Phenytoin is a medication that requires monitoring of blood levels and there is not a single order or result to check his phenytoin level. This case is an example of poor medical management and poor nursing management of a diabetic patient. Based on the information available in this chart, Dr. Mendel's hypothesis that acceptable diabetes care predicts effective healthcare across the board is not supported.

Another insulin-requiring diabetic in Dr. Mendel's chart set is [redacted]. He is a very poorly controlled diabetic with HgA1c levels ranging from 8.9% to 12.9% and he has significant end-organ compromise from his diabetes in the form of diabetic retinopathy, renal failure, and severe neurologic compromise of his feet. Despite his extremely poor control of his diabetes and all of his complications, he is still being managed using only intermediate- and short-acting insulin. This is remarkably rudimentary medical management given what is available in today's healthcare marketplace for patients like this. In this case, the opposite of Dr. Mendel's hypothesis is proven: this patient has very ineffective diabetes care as well as very ineffective medical care.

A third insulin-requiring diabetic in this chart series is [redacted] I am familiar with [redacted] care from having encountered him on my tours. I reviewed his master chart and I saw him personally to confirm his issues. His overall healthcare was so concerning to me that I specifically identified him to the staff at Yuma and attorneys for the State and Corizon as a patient who was in serious medical trouble. According to the data available in the chart that I reviewed, [redacted] HgA1c was 8.7% on May 19, 2013. Dr. Mendel indicates that he reviewed this patient's chart, but what was provided to him was a highly truncated version that covers only 44 days of care from October 6, 2013, to November 20, 2013. Apparently he was not shown the earlier care where this young patient's diabetes was completely out of control, his liver function was seriously compromised, and two of his three basic blood cell types (white cells and platelets) were at critically low levels. Instead, Dr. Mendel was shown a few pages of

records that did not reveal the extent of this patient's mismanagement. This case fails to support Dr. Mendel's hypothesis as well.

b. Non-Insulin Dependent Diabetics

One of the diabetics whose chart was reviewed by Dr. Mendel who does not require insulin is [redacted] His HgA1c on June 5, 2013, was 6.4%. Under Dr. Mendel's theory of care, this result establishes that the rest of his healthcare is adequate. However, review of his chart indicates that this patient is also HIV-positive and seriously mentally ill. The medical record is replete with systemic errors of care. There are multiple examples of the patient's not receiving his critical chronic care medications from the pharmacy on time and being without medication. The Medication Administration Records in this chart are not completed in accordance with the standard of nursing documentation so it is not possible to determine whether and when he received certain medications. In addition, this patient is on HIV medication that should be monitored for efficacy periodically. According to his medical record, his critical HIV labs (CD4 and HIV viral load) were ordered by the clinicians five separate times: June 7, 2013 (ADC245368); September 11, 2013 (ADC245367); November 20, 2013 (ADC245364); December 12, 2013 (ADC245365); and January 25, 2014 (ADC245364). Despite these five orders for labs, not a single lab result is in his chart or mentioned in his clinical notes. The failure of the system to carry out provider orders puts the providers in an impossible situation: they cannot manage their patients safely. This patient's records similarly disprove Dr. Mendel's hypothesis.

[redacted] is another diabetic who does not require insulin whose chart is on Dr. Mendel's list. While his diabetes care is under good management, he had significantly poor care for his hand fracture in November 2013. At that time he was diagnosed with an open fracture of his fifth metacarpal and he was sent to the emergency room on November 6, 2013. The emergency room stabilized him and sent him back with recommendations for care including pain management and an urgent follow-up visit with the hand surgeon within one week. Unfortunately this was not done. A notation in the chart indicates that this urgent consult was not even requested until November 19, 2013, and it would not be scheduled to occur until December 19, 2013—a full five weeks after the hand surgeon had thought it necessary he be seen. An open fracture requires skilled emergency management to ensure appropriate treatment and to safeguard against a significant bone infection. The treatment in this case falls well below the standard of care for this condition. Again, this is a case where the patient's diabetic management shows success but that success cannot be generalized to the overall success of the healthcare delivery system.

The last patient in this series who has diabetes that does not require insulin is [redacted] She has moderately controlled diabetes and her most recent hemoglobin A-1 C is 7.1% as of January 2014. ADC 239663. Review of her chart demonstrates multiple deficits of care that show substantial delay in her healthcare management. She had labs drawn on October 29, 2013, that showed multiple abnormal values, but those labs were not signed off by a provider within ADC until January 3, 2014. ADC239665. Additional labs were drawn on January 15, 2014 and they also contain significant abnormal results.

Those labs were not signed off until February 13, 2014. ADC239661. Again this case does not support Dr. Mendel's hypothesis—her diabetic care might be close to target but the systemic delivery of care in her case is well below the community standard.

As I have previously discussed in my rebuttal report, Dr. Mendel relies on HgA1c data produced by Corizon that reports clinical outcomes with diabetics that greatly exceed the best of the best in healthcare—their stated results are just too good to be possible. As we see in the analysis of the charts, the HIV results Corizon reports as perfect turned out not to be nearly as good as they claim and not a single one of the diabetics in this series had acceptable healthcare globally. As such, the evidence simply does not support Dr. Mendel's arguments.

B. The Records Dr. Mendel Reviewed Reveal a Broken System

After reviewing Dr. Mendel's charts, my prior opinions are strengthened: Arizona prisoners are at serious risk from dangerously inadequate medical care.

1. Patients Suffer From Delayed Care

In my review of the healthcare system in Arizona prisons on site tours, on-site chart reviews, off-site chart reviews, and additional documentation review, I have found the most pervasive theme throughout the entire system to be that of delay. I have described in great detail the poor care I found in many cases, with serious delay as a significant component of the treatment deficits. Far from being isolated or anecdotal, it is clearly pervasive, affecting major business practices and healthcare transactions throughout the ADC. Below are some illustrations of this profound deficit that I found within the charts Dr. Mendel reviewed.

[redacted] illustrates many of the issues faced by patients within the ADC who have serious chronic medical conditions. [redacted] suffers from Factor VIII Deficiency (Hemophilia A) and frequently has significant bleeding episodes that require Factor VIII infusion to stop. These episodes are extremely painful. The patient has had so many significant bleeding episodes that have required emergency trips to the hospital that the providers within ADC have attempted to stock Factor VIII for emergent use within the prison system. Unfortunately, the pharmacy has been unable to supply this common treatment. As a result, [redacted] has had multiple episodes where he bleeds significantly into his muscles and develops large painful hematomas (bruises) that ultimately require Factor VIII infusions. To treat his pain, the ADC providers have placed him on Vicodin, a standard oral pain medication. However, as noted on January 4, 2013, by Dr. Laura Brown, the pharmacy that services ADC is unable supply the Vicodin in sufficient amounts, so Dr. Brown put [redacted] on a pain medication ration that cut his dose down significantly and effectively provided no meaningful pain relief for his condition. ADC234522. Her instructions about this to the nursing staff are written in a memo and she indicates that "He will just have to toughen up as narcotics are not always available." ADC234783. I find her memo, and the attitude it expresses, to be untenable. She had multiple options available to her for substitute medications, but instead of attempting to advocate for her patient, she resigned herself to the systemic problem and left her patient to suffer needlessly.

[redacted] housed at ASPC-Lewis, is another patient who has experienced significant delays. He originally submitted an HNR on April 21, 2013, for a

mass on his neck. He was seen 18 days later on May 9, 2013. An urgent consult for an ultrasound was filled out but not completed until May 21, 2013. Based on the results of that ultrasound, a biopsy was scheduled which took three months to approve and accomplish. The biopsy results showed that he had Hodgkin's Lymphoma. Following that result, the patient was set up on September 24, 2013, with an oncology appointment to develop a plan of care. This appointment took five weeks to set up and the note from that visit with 21st Century Oncology indicates that they will be closing their prisoner clinic and that [redacted] care will need to be accomplished at another clinic in the future. ADC238026. The patient was eventually seen in another oncology clinic on November 6, 2013, for his lymphoma. In total, it took ADC seven months to work up and initiate treatment on an obvious case of Hodgkin's Lymphoma. That deviates significantly from the standard of care for this condition and places this patient at serious risk of harm. Unfortunately, this case is remarkably similar to that of [redacted] as described in Dr. Cohen's 2/24/14 Supplemental Expert Report. In that case, [redacted] developed a neck mass that was suspicious for Hodgkin's Lymphoma in October 2012. He received no treatment for his highly treatable condition, and died [redacted] Cohen Supplemental Report at 19-25.

[redacted] is a patient with a number of complicated issues. He has severe coronary artery disease, he is suffering with chronic unstable angina, he has had four stents placed previously, and he has a left below-knee amputation. His chart epitomizes ADC's delay in care in managing a complicated chronically ill patient. He was seen by orthopedics in May 2011 and they recommended a bilateral shoulder MRI to

evaluate his bilateral shoulder pain. That order was not placed into the system until almost seven months later in January 2012. It took another six months for the order to be carried out: it was completed on June 15, 2012. The MRI showed significant rotator cuff tears bilaterally and an orthopedic consult was entered into the system on August 1, 2012, to evaluate the possibility of surgery for this patient. It has taken 16 months for him to finally see orthopedics back in return and he had a completed orthopedic consult on December 19, 2013. It has taken ADC 31 months to do a simple work-up for bilateral rotator cuff tears in a patient who is significantly compromised as a result of his leg amputation. That is unreasonable and far below the standard of care. Even after 31 months the problem has yet to be resolved and the surgery has not been completed.

In addition, [redacted] was not supplied with baby powder, the usual method of avoiding damaging friction between his skin and the sleeve of his prosthesis. As a result, he had breakdown of his prosthesis which ultimately caused breakdown of his skin on the stump in his leg. This is a terrible and easily avoidable outcome for this highly compromised patient. Dr. Merchant admitted that the patient's medications and his management have been inappropriate due to a pharmacy error. (ADC245917). On April 10, 2013, a consult for the repair of his prosthesis to minimize the damage to his stump was entered. That prosthesis repair was completed on January 10, 2014 -- a full nine months after it was put in to the system. That is unreasonable and caused [redacted] to suffer needless pain.

Additional examples of delay and fragmentation of care in Dr. Mendel's records include numerous cases where patients have been unable to receive timely diagnostic

imaging to receive required treatment. See, e.g., [redacted] (recurrent shoulder dislocations; MRI took three months to schedule); [redacted] (x-ray order to be completed on August 7, 2013; not done, no results in chart); [redacted] (complained of acute ankle pain on June 8, 2013; took two and a half months for x-ray); [redacted] (June 25, 2013, order for a thyroid ultrasound; never completed); [redacted] (diagnosed with a left testicular cyst, referred for repeat ultrasound; never done).

Similarly, providers order lab tests, often essential to the management of chronic illnesses, and they are not completed or they are done late. See, e.g., [redacted] (HIV-positive patient had appropriate monitoring lab work ordered on April 3, 2013, but not drawn until four months later; additional lab work ordered on February 5, 2013, but never drawn); [redacted] (pregnant patient arriving in ADC had a blood sugar of 155, which is significantly high and requires monitoring and workup; a lab test was ordered but never completed and no further monitoring was done for her gestational diabetes mellitus for three months); [redacted] (HIV-positive patient with multiple HIV labs ordered but never completed); [redacted] (HIV-positive patient had labs ordered May 16, 2013, but no record that they have been drawn or completed; he remains on medication, which is irresponsible treatment); [redacted] (HIV-positive patient with viral load ordered on June 19, 2013; no result in chart); [redacted] (HIV-positive patient with no labs ordered for first six months in prison and two-month delay after labs finally ordered);

[redacted] (mentally ill HIV-positive patient on HIV medication with no monitoring since January 1, 2013).

When labs are done and the results are abnormal, follow-up is often untimely or non-existent. See, e.g., [redacted] (three separate positive tests for blood in his stool on February 13, 14, and 15, 2013; no follow-up for very ominous finding); [redacted] (chest x-rays done to monitor his lung disease with documented abnormalities; took three weeks before provider signed off on result); [redacted] (unusual laboratory finding on complete white count (monocytosis) required a pathologist to determine the validity of the results; test has never been completed and the evaluation of this patient's potentially ominous lab results remains incomplete).

The records also document numerous delays for patients seeking primary care for serious conditions. See, e.g., [redacted] (submitted HNRs for genitourinary issues; no record of healthcare professional evaluation or treatment); [redacted] (submitted HNR for care for acute shoulder injury, not seen for three weeks); [redacted] (Hepatitis C patient submitted 10 HNRs over 13 months regarding his condition; never seen by provider in response); [redacted] (patient with cardiac rhythm abnormalities and palpitations waited for eight months for a provider to see him regarding his stated complaint); [redacted] (complained of chest pain; not seen for five days and then only by a nurse and never worked up appropriately for the chest pain); [redacted] (year and a

half wait for a provider evaluation for knee and ankle pain following surgery, despite numerous HNRs).

Some patients who require specialty consult care are unable to receive it. See, e.g., [redacted] (cardiac patient referred for appropriate cardiology consult denied with no justification); [redacted] (patient with history of lung cancer denied oncology evaluation for possible recurrence, in the one-month period of records provided); [redacted] (patient with left testicular cyst referred for urology consult on May 11, 2012, but there is no evidence in the chart that the consult has been completed); [redacted] (HIV-positive patient referred to Infectious Diseases on April 10, 2013; September 9, 2013; September 17, 2013; and October 2, 2013, all without success).

Prisoners with serious chronic conditions must be provided their life–sustaining medications on a consistent basis. The records Dr. Mendel reviewed show that medication lapses happen too often in Arizona prisons, and because ADC's medication administration records are rarely complete, it is impossible to verify whether prescriptions that are timely renewed are actually provided to the patients. Medication lapses are particularly problematic for patients receiving treatment for HIV, as lapses in these medications can lead to acceleration of the disease, development of resistance, increased side effects, and difficulty in disease management long-term. See, e.g., [redacted] (multiple instances where HIV medications were not delivered timely); [redacted] (multiple medication lapses, including a three-week period in the fall of 2012, when CD4 count plummeted from 600 to 300).

2. ADC Patients Reviewed During Expert Site Visits Continue to Receive Poor Care

During my visits to ADC facilities during the summer of 2013, I encountered a number of medically compromised patients who were in danger because of the poor health care they were receiving. These patients included [redacted], a very fragile patient with end-stage liver disease at Yuma. At the time I met him he was very poorly managed and had complications from his disease that had resulted in multiple hospitalizations. Dr. Mendel reviewed his chart, but he was apparently provided with only 44 days of medical history spanning October 7 to November 20, 2013. However, within that small amount of charting, it is clear that [redacted] care continues to be inadequate. During that time, he had a critical ammonia level that took five days for anyone to evaluate (ADC240336). That is clinically unacceptable and it places the patient at grave risk. This is purely a systemic process issue and staffing issue and it is emblematic of the problems that exist within the ADC.

[redacted] is another Yuma prisoner who has received grossly substandard care for his complicated condition and is now suffering complications as a result. [redacted] suffers from a very serious type of Crohn's Disease which causes fistulas (tunnels) to develop through the walls of his intestines and into other organs. He has been hospitalized many times for this condition and he has required many surgeries. When I saw him, I was surprised to discover that he was not on Remicade, the standard medication used for this condition. He reported to me that he had been started on Remicade, but Corizon had denied it long-term due to cost. The denial was confirmed in

his medical record. I was so concerned about him after reviewing his chart and talking with him that I identified him to prison and Corizon staff and attorneys as a very at-risk patient who needed sophisticated care beyond what was available at Yuma. Specifically, he needed Remicade and a gastroenterology/surgery treatment team experienced with managing fistulizing Crohn's Disease.

Unfortunately none of my recommendations were heeded and [redacted] continues to have substantial problems as evidenced by his record in this chart review. As with [redacted] Dr. Mendel only reviewed a few weeks of medical records for this very complicated patient. It is evident, however, even from the small timeframe of records provided, that [redacted] continues to suffer the consequences of poor care. Since I met him over the summer, he has developed a significant fistula between his rectum and his bladder and has had a major infection as a result. He has not been restarted on his Remicade and at this point is probably not even a candidate for that medication given his complications. He very badly needs to be transferred to a prison near a major medical center that has experience with dealing with his condition. Remaining in Yuma under the inexperienced care available there will be a death sentence for him.

In my initial report, I referred to the case of [redacted] an AIDS patient who had been referred to an Infectious Disease Specialist in May, but had not seen one by the time of my site visit to Yuma in July. According to Dr. Mendel, [redacted] was finally seen by the appropriate specialist on August 21, 2013, and the Yuma staff had implemented the consultant's recommendations. Dr. Mendel concluded

that [redacted] was receiving "appropriate specialty care" and had not been harmed by the delayed access to care. Again, Dr. Mendel was provided with only a fraction of the actual medical record: October 6 to November 20, 2013. As a result, he did not see the records that documented [redacted] truly substandard and dangerously incompetent HIV management, the failure to send him to the consultants, the failure to draw the appropriate labs, and the patient's ongoing suffering as a result of this mismanagement. He is another patient I felt compelled to raise with Corizon and ADC staff and attorneys because his life was truly at risk. After months of delay, they had him seen by an HIV specialist and his care was moving ahead appropriately until the very end of this chart that was produced when the local provider decided to stop all of his HIV medications. This was clearly the wrong decision and the reason for it is unclear. I hope it was only a temporary hiatus as this patient is at extreme risk for serious complications and death.

C. Limited Records Sample

While he criticized plaintiffs' expert reports for the size of their records sample, Dr. Mendel considered fewer records from the seven prisons that he visited than Dr. Cohen and I reviewed. In his first supplemental report, Dr. Mendel wrote that his practice is to "request records from nurse's and provider's lines for a randomly selected day, approximately two weeks prior to [the] visit." Mendel Supp. Report at 4. He further stated that he typically chose 12 or more records from each category. *Id.* However, based upon the records he provided plaintiffs, the most records he reviewed for any prison was 31 (Yuma), and at Phoenix, he reviewed only 7.

Additionally, the disease spectrum contained in the medical records does not correlate with normal disease prevalence. Specifically, there were an abundance of HIV-positive patients and a dearth of diabetic patients. It is unclear how Dr. Mendel arrived at these charts but the selection does not appear to be random. Finally, many of the records provided were quite limited, covering only one or two months of care for prisoners who had long treatment histories. Most of the short records were for patients whose complete records I had reviewed for my report and identified as experiencing serious care deficiencies. These limited record excerpts reviewed by Dr. Mendel did not provide sufficient information from which to draw meaningful conclusions about the totality of care for these patients in the Arizona system.

D. Organization of Medical Records

In Dr. Mendel's report, he states that he found the records to be "organized in a manner used by many other correctional systems." He does note that he found some isolated documentation issues but he opines that this was not a systemic pattern. While I do agree that the use of tabs is common in paper charts across medical systems and that is the system used in ADC, I found it extremely difficult to review these charts and come to an understanding of the documentation and the flow of the healthcare experience. Whenever I evaluate medical records for their adequacy I try to place myself in the position of a treating clinician using the medical record to care for patient. In that sense I find the ADC records extraordinarily difficult to use, inaccurate, incomplete, and illegible. The deficiencies are severe enough to compromise patient care. The poor quality of the medical records must inescapably have a substantial impact on the

productivity of the providers. It is even difficult simply to figure out the elements of the care being provided, given how poorly the documentation is maintained. Many of the providers and nurses within the ADC system have illegible handwriting. Illegible care plans are dangerous, and practically guarantee that follow-up care will be missed. If you can't read it, you can't follow it.

The nursing documentation contained in the charts is atrocious. Most of the documentation is in the form of the Medication Administration Records (MARs), which is the record that is supposed to document the Seven Rights of Medication Administration: right patient, right route, right drug, right amount, right time, right documentation, and right to refuse.

ADC medication administration records do not comply with the above national standard for nursing care. On the whole, the MARs are a mess. Clearly the practices vary from facility to facility throughout ADC and some nurses do document within the standard of care, whereas others take phenomenal shortcuts and there is no meaningful information that can be derived from reviewing their documentation on the medication administration record. In addition, many charts are missing several months of medication administration, so there is no way for a clinician to determine compliance. Without knowing medication compliance, a provider cannot assess why a treatment plan is not succeeding. In my review of Dr. Mendel's charts I attempted to go back and verify many treatment failures using the MARs. I found them to be wholly inaccurate, incomplete, and unusable. As such the nursing documentation within the ADC falls substantially short professional standards overall.

II. Recent Medical Records for Shawn Jensen

Dr. Mendel maintains that plaintiffs' experts have identified few cases where access to care has been a factor in the outcome of a class member's care. Mendel Report at 11. He then sets forth the case of named plaintiff Shawn Jensen, who experienced a three-year delay before his prostate cancer was diagnosed and treated in 2009. Dr. Mendel concludes that "[t]here were … no issues as a result of any delay," implying that the delay was not significant. *Id*. at 12. As set forth in my rebuttal report, a three-year delay for a cancer work-up cannot be endorsed as reasonable. Furthermore, review of recent records show clearly that the initial delay actually did cause problems that are only now being manifested.

Since submitting my rebuttal report, I have been provided and reviewed Mr. Jensen's more recent medical records. I was alarmed to find that the pattern of neglect and delay evident in the years leading up to Mr. Jensen's 2010 prostatectomy has continued, even after Mr. Jensen began showing clinical signs of recurrent cancer. Indeed, more than one year after the likely recurrence was identified, a medically reasonable treatment plan to address his probable recurrence of prostate cancer has not been developed or implemented by a qualified specialist. Instead, Mr. Jensen has once again experienced long delays in being given needed tests and approvals to see specialists. These delays increase the probability that the cancer will be more widespread and harder to treat, they put Mr. Jensen at increased risk that metastatic lesions will compromise other organ systems, and they place Mr. Jensen at increased risk for pain and decreased quality of life.

A. Why and When to Treat Prostate Cancer

Prostate cancer is the second leading cause of cancer death in American men, behind only lung cancer, killing approximately 30,000 men a year. While prostate cancer grows more slowly than other cancers, this does not mean that it should be ignored or untreated. It is a type of cancer that often metastasizes to nearby internal organs and the bones, and can result in devastating and crippling injuries or death. For example, prostate cancer, if untreated, can metastasize to the liver, causing acute liver failure, which is incredibly painful and usually results in death. Additionally prostate cancer cells often metastasize to the bones closest to the prostate: the hips, pelvis, spine, or femur (thighbone). A metastatic lesion on such critically important weight-bearing bones can lead to catastrophic results, including crippling fractures.

After a man has been treated for prostate cancer, the standard of follow-up care is to measure his serum prostate-specific antigen (PSA) every three months to detect for signs of possible recurrence of the cancer, since many recurrences following initial treatment can be successfully treated. The PSA is an excellent tumor marker in men with an established diagnosis of prostate cancer, and is particularly useful because the majority of recurrences following radical prostatectomy or radiation treatment for localized prostate cancer are asymptomatic. When the PSA level exceeds 0.1, it means that it is probable that there is persistent or recurrent disease.

There are certain risk factors associated with more aggressive prostate cancers, as well as a more aggressive recurrence of prostate cancer. The risk of recurrence is higher in men who have a family history of prostate cancer, are older, or are overweight.

Another well-established risk factor is if a man is a Vietnam veteran who was exposed to Agent Orange or other defoliants, as these chemicals increase the risk of developing soft tissue cancers, including prostate cancer. Men with these risk factors need careful follow-up and very close monitoring. I am told Mr. Jensen was exposed to Agent Orange while serving in Vietnam. He is also older (65) and overweight.

B. Failure to Monitor and Treat Mr. Jensen for Recurring Cancer

Despite Mr. Jensen's significant risk factors for cancer recurrence, ADC has failed to appropriately monitor him, and once he showed clear signs of relapse, has failed to provide him timely and necessary treatment.

ADC has failed to perform PSA tests every three months since Mr. Jensen's 2010 surgery. It appears that Mr. Jensen had only two PSA tests performed through early 2013, and one of those tests was performed only after Mr. Jensen requested it. ADC004538, PLTF-PARSONS-32162. This failure to test his PSA level every three months is unacceptable and below the standard of care. A copy of the test results was not his medical file, but other documents in his medical file reference his level to be 1.2 in February 2013. ADC123383.

Given Mr. Jensen's elevated risk factor for recurrence and the fact that the PSA level was 12 times higher than what would have been the normal limit after a prostatectomy (1.2 versus 0.1), upon receiving the February 6, 2013, results, the provider should have immediately referred him to a qualified specialist for examination and to develop and implement a cancer treatment plan that best meets his needs and level of cancer. The two most common options for the cancer treatment plan would be either to

provide full pelvic radiation therapy or to initiate androgen deprivation therapy using a drug like leuprolide (Lupron). The typical dosage of Lupron is a shot that is administered every three months.

Neither of these courses of treatment was adopted. Instead, Mr. Jensen saw Dr. Catsoros, a primary care provider, on February 19, 2013. At that appointment, despite the elevated PSA score, Dr. Catsoros failed to refer Mr. Jensen to an oncologist. He wrote that Mr. Jensen's degree of control of the cancer was "good" and that his clinical status was "improved." ADC123382. A week later, Dr. Catsoros ordered another PSA test. ADC123381. The second PSA test confirmed that Mr. Jensen's PSA level was indeed 1.2. ADC123330.

Dr. Catsoros apparently made a request for a urology consultation on April 1, 2013, but Mr. Jensen did not see an urologist until May 20, 2013. ADC130312, ADC123318-328. The urologist's assessment was worsening prostate cancer, and he ordered an abdominal CT scan and a bone scan to stage Mr. Jensen's cancer and to determine if he had any bony metastatic disease. The purpose of the testing was to determine his status at that point in time and to develop a treatment plan for him. The urologist requested that Mr. Jensen return within three weeks to review, and reported to Corizon that he needed to be evaluated by oncology to determine the type of cancer treatment. ADC123320, ADC123328.

Mr. Jensen was tested again on June 5, 2013, after he submitted an HNR, and the level had increased to 1.9. ADC123329. Mr. Jensen had a bone scan and CT scan on June 7, 2013. ADC123309-123311. Fortunately, the scans did not show evidence that

the cancer had metastasized to his bones. Although Mr. Jensen had the appropriate staging testing completed, nobody used the results of that testing to implement an appropriate treatment plan for him.

The prison nurse practitioner sent a consultation request to Corizon headquarters on June 20, 2013, requesting the Mr. Jensen have follow up specialist appointments with a urologist and nephrologist. ADC123291-123292. He did not see Dr. Banti, the urologist, until July 17, 2013, more than two months after the previous appointment and almost a month after the consultation was requested. ADC222285-222286.

Dr. Banti's plan called for Lupron at 22.5 mg and a PSA test in three months, a clinically reasonable plan. ADC222286. Unfortunately, there is no evidence in the medical record through January 2014 that this plan was ever implemented.

In the months following, Mr. Jensen's PSA continued to rise. As of August 7, 2013, it was 2.22, and by October 9, 2013, was 2.93. ADC222295, ADC222290.

Mr. Jensen was seen by a different urologist, Dr. Goldberg, on October 29, 2013, who diagnosed prostate cancer, and reported back to Corizon that Mr. Jensen needed a bone scan "ASAP." ADC222262. This second bone scan was required because no treatment was initiated after his previous bone scan, and they had to see if the delay in care had resulted in metastasis of the cancer to his bones.

Still, his PSA continued to rise. On December 11, 2013, it measured 4.21. ADC222288. On December 18, 2013, Mr. Jensen had his bone scan. ADC222255. Again, fortunately, no evidence of cancer was found in his bones.

By this point in his care, Mr. Jensen falls into another high-risk category (in addition to the Agent Orange exposure, age and weight) for the development of metastatic disease. In the tracking of his PSA levels, his doubling time (the time for PSA level to double in value) is approximately six months. This short doubling time should be particularly concerning to those caring for him, but I found no mention in the medical record that anybody has taken this new high risk factor into consideration.

Furthermore, it is clear from the pathology report that when his initial radical prostatectomy was completed in 2010, the margins of the surgical resection contained tumor. This is yet another high risk factor for recurrence. It was known from the onset and documented that Mr. Jensen was a high risk for a recurrence, and yet I see no evidence in the record that anybody has acknowledged this or has taken it into consideration in referring him for the development of a treatment plan. ADC123294.

By the end of 2013, Mr. Jensen still had not been examined by an oncologist. On January 9, 2014, his file was apparently reviewed by Dr. Richard Kosierowski, who is an oncologist that Corizon contracts with nationally to provide guidance and second opinions regarding care plans for cancer patients in the Corizon system. PLTF-PARSONS-031985. Dr. Kosierowski apparently reviewed Mr. Jensen's chart and denied care without examining the patient and without accurate facts. Dr. Kosierowski states that Mr. Jensen "appears to have been on Lupron" and denies the prison provider's request for a urology consultation. *Id.* Dr. Kosierowski clearly has some questions and concerns about Mr. Jensen's care and his current status. These were set forth in his note, and yet as of today there is no documentation that he resolved these concerns or followed

up on the patient's management. As a result, Mr. Jensen has been left in limbo awaiting a decision from a physician he has never seen.

As of January 24, 2014, Mr. Jensen had not been examined by an oncologist, nor has he had a cancer treatment plan developed. Mr. Jensen filed HNRs on January 20 and 29, 2014, asking to have his PSA tested again and to see a cancer specialist. PLTF-PARSONS 031981-31983. I am especially concerned that Mr. Jensen reported in early February that he has sharp pains in his left hip because that is the most common clinical symptom for the presentation of a metastatic lesion in the bone. PLTF-PARSONS 031984. I have been informed that Mr. Jensen reported very recently that he has yet to be seen by an oncologist and nobody has implemented a cancer treatment plan for him.

In reviewing the records available to me in this case it is clear that Mr. Jensen's care regarding his prostate cancer is dangerously mismanaged, disorganized, and delayed, and falls well below the standard of care.

III. Conclusion

I have reviewed hundreds of medical records in this action, met dozens of patients whose care I needed to clarify following their chart reviews, toured five facilities to understand the care delivery process, met with ADC and Corizon staff, and reviewed extensive documentation of external evaluations and contract monitoring. I have also reviewed Dr. Mendel's reports endorsing the care provided by ADC. It is clear that the deficiencies within the Arizona prison healthcare system exist on both a systemic level as well as an individual care level. Throughout the system there are multiple deficiencies that cause medically necessary care to be delayed, denied, fragmented, and difficult to

access. Even when patients are able to access care, many of the providers are delivering substandard treatment. These errors are not caught because there are no satisfactory quality assurance mechanisms identified or correct them. As such, the entire health care system is failing to accomplish its mission.

If this grossly deficient health care system existed in the free market sector, the patients would grow frustrated with it and would seek care in other areas of the marketplace. Unfortunately for the prisoners, this is the only system available to them and as such it needs to be adequate to meet their basic healthcare needs. At this point, that is not the case, and the prisoners are at extreme risk for harm from the systemic substandard care.

The only path to achieve an adequate health care system involves a significant rethinking and restructuring of the healthcare entity within the Arizona Department of Corrections. Significant investment in infrastructure will be necessary, carefully structured training will be necessary to achieve a change of culture, and the business practices and systemic operational issues that plague the system will need to be redesigned and monitored closely to ensure that they meet the needs of this large population. Until that occurs patients will continue to have very poor access to health care resources, and they will continue to be at tremendous risk for negative healthcare outcomes and unnecessary death.

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