EXHIBIT 13

UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Victor Parsons; Shawn Jensen; Stephen Swartz; Dustin Brislan; Sonia Rodriguez; Christina Verduzco; Jackie Thomas; Jeremy Smith; Robert Gamez; Maryanne Chisholm; Desiree Licci; Joseph Hefner; Joshua Polson; and Charlotte Wells, on behalf of themselves and all others similarly situated; and Arizona Center for Disability Law, Plaintiffs, v. Charles Ryan, Director, Arizona Department of Corrections; and Richard Pratt, Interim Division Director, Division of Health Services, Arizona Department of Corrections, in their official capacities, Defendants.	No. CV 12-00601-PHX-NVW (MEA)

CONFIDENTIAL
SUPPLEMENTAL EXPERT REPORT OF:

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REGARDING
DENTAL CARE AT THE ARIZONA DEPARTMENT OF CORRECTIONS

FEBRUARY 24, 2014

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I. BACKGROUND

I was provided dental records and other material Dr. Dovgan used in preparing his report shortly before the deadline for my reply report and was unable to analyze them at the time. The records included both records I had not seen before and updated recorded that I reviewed on site during prison tours. I have now had the opportunity to analyze these records. For the reasons set forth below, my opinions have not changed—except to become stronger.

II. ADC'S FAILURE TO MONITOR THE DENTAL PROGRAM

The October 2013 MGARs continue to raise substantial concerns that evidence systemic deficiencies in ADC's ability or willingness to manage its contractor, even if compliance might be better than it was at its worst.[1]

Before October, ADC had not reviewed the Oral Care measures for nine months. This itself is inadequate care because a well-functioning dental system needs consistent, comprehensive, and reliable monitoring to be successful. Further, without consistent monitoring, the quality of dental care is likely to decline and any positive inertia that might have been gained can be lost easily. That ADC might monitor dental care periodically does little to alleviate the risks I identified in my previous reports.

In addition, the monitoring procedures continue to suffer from deficiencies I identified in my earlier reports. The measures are skewed toward non-clinical clerical reviews rather than analysis of the underlying care. For example, the reports ask whether patients with "911" issues are seen within 24 hours, not whether patients are correctly assessed as having urgent or emergency issues.[2] Similarly, the reports ask whether x-rays are taken, not whether they are correctly assessed by a dentist. What is more, the October MGARs do not indicate that ADC has eliminated the substantial risks of serious injury I previously identified. ADC's inadequate monitoring, therefore, continues to be a serious problem with ADC dental care.

[1] In my opening report I stated that the there was no follow-up evaluation of the Oral Care measures. The October MGARs were first produced on January 27, 2014. I understand that conditions after September 27, 2013 may or may not be considered at trial, but to the extent those conditions are considered, I offer these opinions with regard to the October monitoring report only, not having seen any additional related information.

[2] Although the MGAR uses the term "emergency exam" to mean what ADC Dental Procedure 770.2 refers to as Priority 2 (or Urgent) Care, this performance measure does not align with the contractual requirement that urgent requests be seen within 72 hours. The October Corrective Action Plan for Safford addresses this, "Reinforce with dental staff of the added specialty in CDS of urgent care and use only emergency specialty for true emergencies." [ADC210535] However, if this measure is restricted to Priority 1 ("emergencies" per ADC Dental Procedure 770.1) there will be no measure for Urgent Care (that is, that prisoners be seen within 72 hours)—a highly problematic deficiency.

III. DR. DOVGAN'S SAMPLE CONFIRMS MY FINDINGS REGARDING SYSTEMIC PROBLEMS WITHIN ADC

A. Methodology

Dr. Dovgan reviewed 149 records, 59 of which I also reviewed for my opening report.[3] Of the remaining 90 records he reviewed, 20 (22.2%) did not have an HNR and a corresponding progress note (most had never sought dental care or had submitted an HNR which had not resulted in an appointment). As a result, they are only marginally useful for the purposes of analyzing ADC dental care and useless for analyzing wait times. Omitting these records leaves only 70 unique records—an effective sample size of 128. This illustrates a flaw in Dr. Dovgan's methodology that I raised in my supplemental report—his sampling method yielded numerous records that provided no useful information of about dental care provided by ADC, Wexford, and Corizon/Smallwood.

In addition to the records that did have information regarding dental care, I note that Dr. Dovgan's sample set has a much higher median inmate number than the set we reviewed in common (208831 v. 183917). Assuming inmate numbers are assigned in sequence, this indicates that the inmates in his set entered the system more recently. This would be a logical consequence of methodology that obtains records primarily from current wait lists, as opposed to lists of patients that have already received treatment. This confirms the bias I noted in my original report toward care provided by Smallwood/Corizon and away from care provided by ADC or Wexford.

B. Wait Time Computations

I reviewed the 149 dental records that Dr. Dovgan reviewed, and computed (as I did in my opening report) the median wait times to see a provider for patients submitting HNRs stating pain and for those requesting routine care.[4]

With regard to the records I had not seen before, the median wait times are slightly longer than, but consistent with, my original sample. The same is true of the subset of records that I had previously reviewed, as well as Dr. Dovgan's entire set of records. When I combine all of the new records with my original sample, the overall wait times remain consistent, with a slight increase for routine care.[5]

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[3] As I noted in my reply report, Dr. Dovgan's list actually included 155 inmates, but there were 6 duplicates. [Shulman Reply at 4] Of the 59 records that we both reviewed, one had HNRs, but no treatment notes, and so was excluded from wait time calculations.

[4] My methodology for calculating wait times is found in my Expert Report at 9-10.

[5] For the 59 records I had seen while touring facilities, I was now able to examine the records at greater length, and was thus able to better decipher handwriting, find missing HNRs, and otherwise correct some of the notes I took originally by hand. In addition, I added new HNRs and treatment visits since my visit to my data. These adjustments did not change any of my overall averages.

In other words, despite his emphasis on lower wait times recently reported by Smallwood, Dr. Dovgan's records do not rebut my opinions at all. The wait times were as follows:

	Dataset in Original Report	Dr. Dovgan's New Records	All Dr. Dovgan's Records	Combined Dataset
Records Containing Data	293	70	129	366
HNRs Stating Pain	6 [at 22]	7	7	6
Routine Care	78 [at 24]	87	81	83

For HNRs stating pain, I originally reported that 25 percent waited 12 or more days [the 75th percentile] and 10 percent waited 23 days or more [the 90th percentile] to be seen. [Shulman Report at 22] In the combined dataset, the wait time for the 75th percentile remained unchanged while the 90th percentile increased slightly to 25 days.

For routine care, I originally reported the median wait time for a routine care appointment was 78 days; 42 percent of the wait times were over 90 days, 30 percent were over 116 days, and 10 percent were over 210 days. [*Id.* at 24] Median wait time based on the combined dataset is 83 days, with 45 percent of the wait times over 90 days, 30 percent were over 117 days, and 10 percent were over 196 days.

In addition to finding that the median wait times did not change, the reasons for the elevated wait times remain consistent with what I have previously identified. The principal reason median wait times for HNRs stating pain are significantly higher than the 72 hour urgent care window is their assignment to the Routine Care List rather than to Urgent Care (that is, a "911 exam" or pain evaluation).

Similarly, median wait times for routine care in the new records are elevated for the same reasons I previously observed and described, including staff shortages and the practice of cancelling routine HNRs when a patient is seen for another issue.

C. Examples of Systemic Problems

The charts relied upon by Dr. Dovgan record care through October or November 2013, and provide additional insight into care provided by Smallwood. They show that the practices I described in my opening report persist, notwithstanding the reported reductions in wait times.

There are numerous examples of records that illustrate the systemic problems that he did not recognize or turned a blind eye to. Examples include:

Assigning Prisoners With Missing or Fractured Fillings to Routine Care

- **Redacted** submitted an HNR stating that a filling fell out and he was in pain and was placed on the routine care list. He submitted a follow-up HNR a month later. He was offered a filling appointment six months later.
- **Redacted** lost a filling and was in pain and was advised in September 2013 that fillings are routine care and for an emergency, there is extraction.
- **Redacted** had a filling fall out and complained that it was "sensitive" in October 2013. Two weeks later, he complained of pain when consuming hot or cold liquid, but remained on the routine care list. It is apparent by his description that his symptoms are escalating from a minor (and reversible) pulpitis to sensitivity to cold and hot suggestive of a more severe pulpitis which may or may not be reversible. In my opinion, the treatment window for this tooth is closing. Once the pulpitis becomes irreversible, the tooth will have to be extracted.[6]
- **Redacted** had a temporary restoration placed in June 2010 to replace a large fractured restoration that was causing substantial pain. The clinical note states that he was placed on the routine care list. After more than a year without an appointment, the temporary restoration fell out, leaving him in pain again. After several days, he refused a pain evaluation appointment because he wanted a filling, but while he was waiting for the filling, he was seen for a pain evaluation on an unrelated issue. This visit removed him from the routine care list.

Forcing patients to choose between pain and an extraction (the ADC Prisoners' Dilemma)

- **Redacted** submitted an HNR in May 2013, was scheduled for a '911' appointment, and refused the (recommended) extraction. The note states that he will be removed from the routine care list due to this appointment and that he was instructed to file a new HNR to get back on routine list.
- **Redacted** submitted an HNR in August 2013 indicating a missing filling and pain, and was told he must wait for routine care, or "submit another HNR if you are asking for extraction." Two months later, he asked for the tooth to be extracted. He was seen after 8 days, tooth #18 was found to have recurrent decay and "pulpitis" and it was extracted.
- **Redacted** submitted an HNR for a painful broken tooth 7/19/12 and was placed on the waiting list. He submitted an HNR for a tooth that was painful to hot and cold and was appointed for a pain evaluation which he refused. The dental assistant's note states, "[I]nmate refused appointment for "extreme pain." Keep on Routine List."

As I explain in my original report, the practices of not expediting appointments for lost or fractured restorations, rarely placing temporary restorations at pain evaluations, and removing patients from the Routine Care List when they are seen on a pain evaluations result in preventable pain, tooth morbidity and mortality. Dr. Dovgan stated (without adducing data) that

[6] The last treatment note is from July 24, 2013.

inmates frequently refuse care; however, he does not mention any of these practices, particularly the latter, as a possible explanation for refusals. [*See* Dovgan Report at 16]

D. Dental Assistant Assessment (Triage)

In my reply report I noted widespread noncompliance with ADC Procedure 787 § 5.3, which requires that records and x-rays of those inmates who received a dental assistant evaluation be reviewed and acknowledged by a dentist within 24 hours. In fact, I found a noncompliance rate of 86%. Dr. Dovgan's records were no different and reinforce my opinion. I found four occurrences of Dental Assistant Assessment in the additional records he reviewed. All the clinical notes were noncompliant; two (50%) had no signature, one of the other two had no date, and the other was dated five days after the note. The combined dataset contains 19 occurrences and demonstrates an 89% noncompliance rate. This is but one illustration of ADC's indifference to monitoring the dental program.

As I noted in my previous reports, ADC Procedure 787 § 5.3 is both substantively flawed and almost universally not complied with. [*E.g.,* Shulman Reply at 12, 26-28] The records of **Redacted**, in Dr. Dovgan's set, typify the issue. Mr. Redacted submitted an HNR for a toothache and was seen on a pain evaluation, not by a dentist—but by a dental assistant, who took an x-ray sua sponte, interpreted it, performed an oral examination, and provided antibiotics after telephonic consultation with a dentist. He was not examined by a dentist until three weeks later, when the infected tooth was extracted. Not only was the dental assistant triage performed poorly and outside guidelines, follow-up was not scheduled—but the visit did stop the clock for purposes of officially reporting Mr. Brown's wait time.

IV. CONCLUSION

Dr. Dovgan overlooks the forest for the trees. His analysis of the HNRs and clinical notes is superficial. His focus on analyzing compliance with ADC's treatment guidelines is important, but by no means the most important issue in this case. Even though he opined in his report that all treatment was within the appropriate standards of care, he ignores numerous examples of patients suffering from the policies under which dental care is delivered at the ADC. Reviewing the additional records provided to Dr. Dovgan, even weighted as they are toward patients newer to ADC without longstanding issues or complaints of pain, does not change any of the opinions I have expressed in my prior reports.