PRISON LAW OFFICE
General Delivery, San Quentin, CA 94964
Telephone (510) 280-2621 • Fax (510) 280-2704
www.prisonlaw.com

VIA EMAIL ONLY

October 15, 2015

Ms. Lucy Rand, Assistant Attorney General
Office of the Arizona Attorney General
1275 West Washington Street
Phoenix, AZ 85007-2926
Lucy.Rand@azag.gov

RE: *Parsons v. Ryan*, CV-12-0601-DMD
Notice of Substantial Non-Compliance

Dear Ms. Rand,

Pursuant to Paragraph 30 of the parties' Stipulation, we write to notify you of Defendants' substantial non-compliance with the terms of the Stipulation. Also pursuant to Paragraph 30, we request that Defendants meet with us telephonically or in person no later than November 16 to attempt to resolve this dispute. Rather than spending the next 30 days disputing individual cases or drafting blanket denials and objections to our letter (*see, e.g.* 8/20/15 Rand letter, *generally*), we believe that a more productive use of time would be to use this Notice as a starting point to talk with us in a collaborative manner to address the continued systemic and serious problems with the delivery of health care to ADC prisoners.[1]

We look forward to the opportunity to work productively with ADC to find a way to resolve these problems. However, if that does not promptly occur, we will request formal mediation with the court and prepare a motion to enforce the Stipulation pursuant to Paragraph 31. We do not wish to return to court, but we will not hesitate to do so if Defendants will not cooperate or negotiate in good faith. Our goal from the start of litigation, which we hope Defendants share, is that prisoners are provided humane and constitutional health care so that they do not needlessly suffer unnecessary death or injury.

One year after the Stipulation was signed and almost seven months after its effective date, the health care provided by ADC and its contractors has not improved and is plagued by systemic deficiencies. This noncompliance is shown in ADC and Corizon documents produced by Defendants; interviews with prisoners, custody staff, and health care staff; our review of prisoners' medical files; and our observations during tours. Since February 17, 2015, we have notified Defendants of many of these deficiencies through our written tour reports, 78 advocacy letters, and verbally during tours.

[1] We have identified numerous practices at ADC prisons that show substantial noncompliance with the requirements related to prisoners housed in isolation units; a Notice regarding these problems will be sent to you separately.

However, there is no system in place for us to learn if the individual deficiencies we identified have been addressed, and to date, Defendants have provided no meaningful response. Rand 4/3/15 letter at 6; Rand 8/20/15 letter at 4-6. When we notify you, pursuant to our ethical obligations, of class members we believe are in immediate need of medical, dental, or mental health care, Defendants do not provide any response other than a cut-and-pasted form email sent by litigation counsel acknowledging receipt of our letter, and sometimes provide no response at all.[2]

With regard to the systemic deficiencies we have identified, Defendants refuse to produce any Corrective Action Plans (CAPs) on the grounds that CAPs are not "ready" when printing out the CGAR reports for a given month; and have not retrospectively produced the CAPs even when they subsequently become "ready" for production. Rand 8/20/15 letter at 6. For example, according to CQI meeting minutes, Lewis "has 30 performance measure corrective action plans for the month of May." ADCM121079. Defendants have not produced any of those CAPs.

Defendants' substantial noncompliance falls into two broad categories. First, Defendants' monitoring methodology is fatally deficient in multiple respects and does not yield valid results. Second, even taking Defendants' monitoring results at face value, Defendants are seriously and chronically out of compliance with a large number of Stipulation requirements.

I. Defendants' Monitoring Methodology Calls Into Question Many Findings of Compliance

A problem permeating the entire reform effort is that ADC's monitoring process is profoundly flawed, inadequate to capture the contractors' degree of compliance or non-compliance, and must be completely overhauled. The audits are inaccurate, not standardized, and monitors do not have written instructions or methodology to follow to ensure consistent assessments across the institutions. We have raised this concern before, (*see* 7/14/15 Eidenbach letter, at 2, 4-6), and requested that Defendants work with us to develop written guidelines and protocols for the monitors. Our offer to work cooperatively on such an effort was rebuffed, and we were told that since we agreed to these performance measures in the Stipulation, Defendants could monitor in any way they pleased and plaintiffs could not object – a nonsensical position. *See* 8/20/15 Rand letter at 1-2, 6-7. You informed us that the only methodology needed was the list of source documents in Exhibits C and E to the Stipulation, and vaguely referred to the ongoing development of guidelines. *Id*. Such guidelines, if they exist, have not been produced to us.

A. Failure to Monitor Certain Outcome Measures

In violation of the plain language of the Stipulation, Defendants have unilaterally decided not to monitor certain Measures at certain complexes and units. This refusal is clear noncompliance. Examples include:

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[2] Defendants also have taken the indefensible position that the only prisoners whose health treatment is relevant to the case are the ten whose files are reviewed each month by ADC monitors. *See* 8/20 Rand letter at 5.

- Failure to monitor Mental Health # 8-14 at a number of units, including but not limited to Eyman-SMU I, Eyman-Browning, Florence-Central, Florence-Kasson, Lewis-Rast Max, Tucson-Minors, and all of ASPC-Phoenix.[3] (June 2015 CGARs)
- Failure to monitor Mental Health # 4, 20, and 21 at ASPC-Phoenix. (*Id*.)
- Failure to monitor Mental Health # 22 at ASPC-Safford. (*Id*.)
- Failure to monitor any Mental Health measures at Lewis-Sunrise, Florence-Globe, or Phoenix-Inmate Worker units. (*Id*.)
- Failure to monitor any Mental Health measures (with the exception of Mental Health # 26) at Phoenix-Alhambra. (*Id*.)
- Failure to monitor Chronic Care # 6-8 measures at any prison, and Female Care # 4 measures at prisons housing women. (Rand 8/20 letter at 9)

Defendants furthermore have taken the position, and falsely state, that with regard to requirements codified in the body of the Stipulation, "[t]he parties specifically discussed that these measures would be hard or impossible to track and, therefore, the parties intentionally omitted these items from the Performance Measures to be measured and tracked using the CGAR." (Rand 8/20 letter at 9). This is false: Plaintiffs made no such agreement during the negotiations, and Defendants cannot unilaterally decide that they do not need to document or monitor compliance with the requirements of the Stipulation. For example, Defendants take the position that Paragraph 14 of the stipulation, which requires language interpretation[4] at all health care encounters, "does not require the use of language interpreters to be measured or reported," a position that would eviscerate the entire purpose of having such a requirement in the Stipulation. (*Id*. at 8). As detailed below in Section D, Defendants are in substantial noncompliance with the requirements of Paragraph 14.

Defendants have similarly unilaterally decided to disregard the requirements of Paragraph 15. It states that "[i]f a prisoner who is taking psychotropic medications suffers a heat intolerance reaction, all reasonably available steps will be taken to prevent heat injury or illness. If all other steps have failed to abate the heat intolerance reaction, the prisoner will be transferred to a housing area where the cell temperature does not exceed 85 degrees Fahrenheit." We continue to receive many complaints about extreme heat in the housing units. We observed many prisoners sweating profusely, and many report sleeping on the floor in a desperate attempt to escape the heat. Protecting prisoners from heat injury is a matter not of luxury or comfort, but of life and death. *See Ball v. LeBlanc*, 792 F.3d 584

[3] By a letter dated Oct. 13, 2015, Defendants stated that they would begin to evaluate these performance measures at ASPC-Eyman Browning and SMU-I units and ASPC Florence, Central and Kasson Units, beginning with the September CGARs. (10/13/15 Rand Letter).

[4] Defendants appear not to be aware that American Sign Language is a language completely distinct from English. Defendants' position that ASL does not count as a language to which this Stipulation provision is applicable, and that deaf persons who communicate using ASL would not be entitled to the same interpretation as prisoners who speak only Spanish or Chinese or any other spoken language, is meritless. (8/20 Rand letter at 8). *See* USHHS, NIH National Institute of Deafness and Other Communication Disorders, at http://www.nidcd.nih.gov/health/hearing/pages/asl.aspx ("ASL is a language completely separate and distinct from English. It contains all the fundamental features of language—it has its own rules for pronunciation, word order, and complex grammar.")

(5th Cir. 2015); *Graves v. Arpaio*, 623 F.3d 1043 (9th Cir. 2010); Holt, *Heat in US Prisons and Jails*: *Corrections and the Challenge of Climate Change* (Columbia Law School, Sabin Center for Climate Change Law, August 2015), *available at* https://web.law.columbia.edu/sites/default/files/microsites/climate-change/holt_-_heat_in_us_prisons_and_jails.pdf.

Although we have asked Defendants to describe the steps that are taken to identify prisoners who suffer a heat intolerance reaction, (*see* 7/14/15 Eidenbach letter, at 20), we have not received a response. In fact, it is apparent that no such steps are being taken. The Lewis FHA told us that at that complex, with more than six thousand prisoners, there were *no* prisoners on heat precautions. The CGARs for Lewis and other prisons similarly noted that there have been no heat intolerance incidents.

The file of Lewis prisoner [redacted] was reviewed by the monitor and found to be compliant with Mental Health Measure # 8. ADCM120856. However, his file also reveals that he is SMI, and is prescribed buspirone, perphenazine, phenytoin, and levetiracetam. On 6/9/15 Ms. Qualls notes that the patient is saying that the cell is hot and is causing him to become ill because of his medications; he reported suffering two seizures, dizziness and headaches. These facts are flatly inconsistent with Defendants' implausible assertion that *no* Lewis prisoners suffered a heat intolerance reaction in May, June, or July of 2015.[5] ADCM 121223-121246. Defendants are not in compliance with the requirements of Paragraph 15. *See* Appendix A, pages 3-4,7 for more examples of prisoners who are suffering a heat intolerance reaction due to their psychotropic medications.

Defendants apparently take a similar position regarding Paragraph 16 of the Stipulation, refusing to monitor or report their compliance with that provision, which requires:

> Psychological autopsies shall be provided to the monitoring bureau within thirty (30) days of the prisoner's death and shall be finalized within fourteen (14) days of receipt. When a toxicology report is required, the psychological autopsy shall be provided to the monitoring bureau within thirty (30) days of receipt of the medical examiner's report. Psychological autopsies and mortality reviews shall identify and refer deficiencies to appropriate managers and supervisors including the CQI committee. If deficiencies are identified, corrective action will be taken.

Finally, we were told on our tours of Eyman, Florence, and Lewis that those facilities receive as direct intakes about 10 to 15 parole violators a month, and the parole violators do not first go

[5] We also spoke with multiple prisoners on psychotropic medications who reported stifling heat in their housing units affecting them. Many of these interviews were conducted cell-front, and Plaintiffs' counsel personally experienced heat well in excess of 85 degrees in the housing units. For example, we brought to Defendants' attention a SMI prisoner we encountered on 9/1/15 while touring Florence-North Unit – Yard 3 ("Tent City") who multiple other prisoners had advised us was floridly psychotic, frequently experienced audio and visual hallucinations, and often smeared feces on himself and the inside of the tent. *See* 9/16/15 Kendrick letter, attached hereto as Appendix C. Counsel observed that the tent he was housed in, Tent # 28, was stifling hot at mid-morning, and he was lying in his bed, crying, moaning, and stating that the heat was bothering him. *Id*.

through the Phoenix-Alhambra reception center. If this is the accurate, then all of the measures related to intake (Stipulation Measures # 33-34; Intake # 1-2, Mental Health #3-4) must be audited at prisons that directly admit parole violators. When we negotiated the performance measures, we were told that the only institutions that had intake were Phoenix (males), Perryville (females) and Tucson (juvenile males). Having immediate health screenings for parole violators is important, given that some of the behaviors that may have led to violation could include the abuse of drugs and alcohol, and these people will be going through detox. Mental health screenings are similarly critical, given that a mental health crisis may have precipitated the violation, and some violators will be taking psychotropic medications that must be continued.

B. Failure to Accurately Monitor What the Measures Require

In many cases, Defendants are simply not monitoring what the measures require. The most fundamental flaw involves Defendants' monitoring of the more than 30 measures requiring that a given action be performed every X days, or within Y days of a referral or request. For these types of measures, the Defendants' starting point is only the universe of all files in which the required action was completed.[6]

In monitoring these measures, Defendants typically remove from their sample all files in which the required action was not performed in the month being monitored. Cherry-picking only those files in which the required action was performed in the last month obviously excludes at the outset a large number of noncompliant files. By using this limited group of completed actions as the starting point, the monitors do not capture the requests, referrals, or appointments that are pending or never occurred. For example, the Florence CQI 6/18/15 meeting minutes discuss how the clinical coordinator reported that she "has 70 inmates that need appointments. She has completed 60 just in the last 3 days…the approval rate is approximately 20 a day. She has 8 on backlog … She has 12 follow-ups that have been resubmitted." ADCM121016. None of these 70 prisoners would have been included in a June audit of timeliness of specialty referrals, because they are not yet completed.

Second, Defendants sometimes count as "compliant" files in which the required action has not actually been performed. An example given by Ms. Raak during our September 11, 2015 telephone call will illustrate. Mental Health # 14 requires "MH-3D prisoners shall be seen a minimum of every 90 days by a mental health clinician for a minimum of six months after discontinuing medication." Ms. Raak stated that if she were auditing for the month of June, and the prisoner had been seen on May 1, she would count that file as compliant, because 90 days had not yet elapsed since May 1.[7]

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[6] These include **Access to Care** Measures # 2, 4, 5, 6, 9; **Chronic Care** Measure # 2; **Dental** Measures # 3, 4; **Female Care** Measure # 1; **Medical Diet** Measure # 1; **Medical Records-CO** Measure # 1; **Medical Records** Measures # 10, 11; **Mental Health** Measures # 1, 5, 8, 9, 10, 11, 12, 14, 15, 16, 17, 18, and 20; **Quality Improvement** Measure # 1; **Specialty Care** Measures # 1, 2, 3, 4, 5, 7, 8.

[7] Defendants also fail to provide the date the file was reviewed by the monitor, making it impossible for Plaintiffs to check the accuracy of their findings. We previously brought this problem to your attention, (*see* 7/14/15 Eidenbach letter at 19), but it has not been corrected.

Taken together, these practices dramatically (and falsely) inflate Defendants' compliance figures. As long as these practices persist, Defendants' findings of compliance are meaningless. We offer below specific examples of how these practices result in overinflated and inaccurate compliance percentages.

For example, for the Lewis June 2015 CGAR for Specialty Care # 3 (urgent specialty consultations and diagnostic services will be scheduled and completed within 30 days), the Lewis monitor "reviewed 17 charts of inmates who had urgent consults done during the audit period."[8] ADCM120868. She then looked in those prisoners' files backwards in time to measure timeliness compared to the date of the urgent request, and found 16 of the charts, or 94%, compliant.[9] However, by limiting herself to the universe of completed specialty requests, she does not capture the urgent specialty requests that were pending or scheduled, but not yet occurred as of June 30 (the day the CGAR shows she did her analysis). With regard to the June CGAR finding, the "To Be Scheduled and Scheduled" Specialty Care Appointments chart (ADCM120999-121012) lists four urgent referral requests that were made by providers prior to May 31 (thus 30 days before the June 30 date she did her review) that as of mid-August, when the report was printed, were still listed as "Scheduled" appointments.[10] Lewis also appears to have been noncompliant at the time of our tour: there were 19 urgent referrals made prior to 7/18/15 (30 days before date of list) that are pending or scheduled. (ADCM121005-12). This included one prisoner for whom the provider requested an urgent hematology/oncology consult on March 5, 2015. See Appendix A, pages 12-13 for complete details.[11]

The monitor used a similar methodology for Specialty Care # 4 (routine consultations scheduled and completed within 30 days) in the Lewis June CGARs, finding compliant 64 of 70, or 91% of the routine specialty appointments completed in June. However, this finding is called into question by the "To Be Scheduled and Scheduled" Specialty Care Appointments chart that we were provided prior to the tour. The report also shows an apparent lack of certain specialists, as consults approved as far back as February are listed as not yet scheduled. Specifically, there are ten (10) requested and approved referrals to rheumatology that are still listed as "Pending" and not "Scheduled," and seven (7) of them were requested so long ago that they are noncompliant at the time the report was created. There are 15 requested and approved referrals to infectious disease that are still listed as pending, and eight (8) of them were requested so long ago that they show noncompliance at the time the report was created.[12] However, since these specialty consults have not yet been

[8] The CQI minutes list 21 urgent specialty consults occurring in June. ADCM121101-03.

[9] We were unable to spot-check the accuracy of her conclusions, as she does not list in the CGAR which files were reviewed, and we were not provided her worksheets, despite our pre-tour request for all worksheets used by the monitors.

[10] In a meeting with the clinical coordinator, she stated that as each specialist appointment occurs and the specialist reports are received, she removes its designation as Scheduled.

[11] This Appendix, and all other documents served with this Notice of Substantial Noncompliance, are fully incorporated herein by reference.

[12] This apparent inability to have Lewis prisoners seen in a timely manner by infectious disease specialists is extremely problematic, given the following statistics from the CQI meeting minutes

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completed, they would not appear in the pool of files that the monitor uses as the starting point for the audit. See Appendix A, pages 12-13 for more information.

Additional defective monitoring practices include:

Infirmary Care # 8 (IPC patients have properly working call bells or nurses do 30 minute welfare checks). The June 2015 Florence CGAR stated that 54 of 54 call bells at the infirmary were found to be compliant. ADCM120786. When we spoke with Ms. Franklin and asked if she tested all 54 bells, she admitted that she only picked four or five randomly to test, and extrapolated from that spot check that all 54 were functioning and therefore there was 100% compliance. The performance measure says nothing about sampling and extrapolating, and this is problematic given the Florence May CQI meeting minutes included a corrective action plan for this same measure, stating that call bells were going to be installed on May 26. ADCM121044. The May CGAR found that 43 of 46 infirmary beds had functioning call bells, and the April CGAR found that there were no functioning call bells in any of the infirmary units, and that nurses were not doing 30 minute welfare checks. ADCM056673.

Mental Health # 14 requires that "MH-3D prisoners shall be seen a minimum of every 90 days by a mental health clinician for a minimum of six months after discontinuing medication." Defendants fail to monitor whether the required contacts occur for a minimum of six months.

Mental Health # 20 requires that "MH-3 and above prisoners who are housed in maximum custody shall be seen by a mental health clinician for a 1:1 or group session a minimum of every 30 days." Similarly, Mental Health # 21 requires that "Mental health staff (not to include LPNs) shall make weekly rounds on all MH-3 and above prisoners who are housed in maximum custody." Although these two Measures plainly apply to "MH-3 and above prisoners," Defendants exclude MH-4 and MH-5 prisoners from the sample for compliance monitoring purposes.[13]

Mental Health # 22 requires that "All prisoners on a suicide or mental health watch shall be seen daily by a licensed mental health clinician or, on weekends or holidays, by a registered nurse." Defendants fail to monitor compliance with this Measure if the prisoner's watch spans more than a single month. For example, if the prisoner was placed on watch on May 15 and removed on June 2,

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showing prisoners with infectious diseases not receiving treatment:

- June meeting, statistics for May 2015: 26 out of 30 HIV positive prisoners receiving treatment, 4 out of 1,990 HCV positive prisoners receiving treatment. ADCM121072.
- July meeting, statistics for June 2015: 30 out of 34 HIV positive prisoners receiving treatment; 4 out of 1,858 HCV positive prisoners receiving treatment. ADCM121092. (It is unclear how the number of HCV positive prisoners dropped by 132 in one month.)
- August meeting, statistics for July 2015: 31 out of 35 HIV positive prisoners receiving treatment; 0 out of 1,836 HCV positive prisoners receiving treatment, 7 new HCV diagnoses. ADCM121113.

[13] Even with this narrowed universe to sample, Defendants' own CGARs show noncompliance with Mental Health # 20 month after month. *See* pages 30-31, *infra*.

defendants will monitor compliance with this measure only on June 1 and 2, and will record the file as "compliant" even if the prisoner was not seen at all May 15-31.

Mental Health # 23 requires that "Only licensed mental health staff may remove a prisoner from a suicide or mental health watch. Any prisoner discontinued from a suicide or mental health watch shall be seen by a mental health provider, mental health clinician, or psychiatric registered nurse between 24 and 72 hours after discontinuation, between seven and ten days after discontinuation, and between 21 and 24 days after discontinuation." There are multiple defects in Defendants' monitoring of this measure. First, Defendants fail to verify and document that the patient was removed from watch by licensed mental health staff, as the measure requires. Second, Defendants record as "compliant" cases in which the three required post-watch encounters have not taken place. Third, Defendants record as "compliant" cases in which the patient was transferred to another facility after being taken off watch, without regard to whether the three required post-watch encounters have occurred.

Mental Health # 26 requires that "Mental Health HNRs shall be responded to within the timeframes set forth in the Mental Health Technical Manual (MHTM) (rev. 4/18/14), Chapter 2, Section 5.0." That section of the MHTM sets forth five categories of mental health HNRs, with response times ranging from "immediately" to 14 days. Defendants exclude "emergency," "urgent," and other HNRs from their monitoring samples, and monitor only whether those requiring psychology contacts are seen within 5 days. This is plainly inconsistent with the requirements of the Measure.[14]

C. Misinterpretation of the Plain Language of the Performance Measures

There were several measures in which the plain language of the performance measures is being misinterpreted in such a way that the measure is either rendered moot, or by virtue of how the measure

[14] Even with this narrowed universe to sample, Defendants' own CGARs show noncompliance with Mental Health # 26 month after month. *See* page 32, *infra*. In addition, some of the statistics reported by Corizon that we would hope to use to cross-check CGAR conclusions are self-evidently wrong. For example, relevant to the performance measures of Mental Health # 26, the Lewis CQI minutes show the following at ADCM121104 and 121124:

July stats/August meeting
MH HNRs received – 283
MH appts as result from HNR – 190
Average wait time in days – 0

June stats/July meeting
MH HNRs received – 321
MH appts as result from HNR – 179
Average wait time in days – 0

An average wait time of zero (0) days in a sample of 369 appointments is literally impossible.

is being interpreted by Defendants, results in automatic 100% compliance findings. While the parties drafted an exhibit to the Stipulation that included definitions for some of the words used in the Stipulation and the outcome measures, Plaintiffs did not think it was necessary to define every word in every measure. However, we need to discuss how the monitors are interpreting some of the measures, and come to a common understanding of what words mean.

We found that monitors are not properly interpreting the language of Specialty Care # 1 and 2 measures, which relate to whether Utilization Management ("UM") is sending denial decisions for specialty care to the requesting provider within 14 days and placing a record of the denial in the patient record, and whether the patient is apprised of the denial. For the months of March through July 2015, the CGARs do not identify a single UM denial of specialty care at ***any*** of the ten prisons, which initially suggested to us that either that the UM process is not documenting this information, or that the monitors do not know how to find this information. *See* Eidenbach letter at 4. One of the monitors, Ms. Franklin, told us at Florence that she has never seen a denial of a specialty consult at any facility during any month, and there is no form or list of denials because there are no denials. We were also given a similar response during the Perryville tour in early June from the monitor there.

However, after speaking at length with monitoring and Corizon staff at Lewis about this issue and these performance measures, we now have determined that this all is a matter of semantics. When Corizon UM denies a provider's request for a specialty referral, they call it an "alternate treatment plan" instead of a "denial." Apparently Corizon staff and monitors claim that since the specific word "denial" is not used to describe this action by UM, this means that there are no denials of specialty care referrals, and thus there is nothing to measure. This willful misinterpretation of the word "denial" does not demonstrate good faith. Simply put, Defendants cannot nullify this requirement by using a different word. It doesn't matter what name Corizon uses for UM's decision: the so-called "alternate treatment plan" is a decision by UM ***to not approve the provider's requested consult***, and such a decision clearly meets the dictionary definition of a denial.[15] Thus, rather than simplistically conclude that there are no "denials" to measure or review, the monitors should review the files of prisoners who were given "alternate treatment plans" to see if there is compliance with these performance measures. We found many examples of ATPs documented in medical files and other reports.

In fact, information contained within the Lewis CQI notes document that in June there were 261 specialty consults requested, and 234 approved, and in May there were 276 specialty consults requested, and 249 were approved. ADCM121101, ADCM121079-80. In terms of possible methodology for monitoring the performance measure, the monitor could get the list of the month's requests that were not approved to get the names and numbers of prisoners, and then look in those prisoners' medical record to see if the chart shows compliance with the requirements of the two outcome measures. The clinical coordinator at Lewis said that one of her tasks is to compile all of the ATP responses, so she (and other institutions' clinical coordinators) presumably would be able to

[15] See http://www.merriam-webster.com/dictionary/denial, last reviewed 10/7/15 ("denial (noun) *de-ni-al*: […] the act of not allowing someone to have something […] SYNONYMS: […] rejection, […] ANTONYMS: […] approval, grant […]")

compile a list of all names and numbers for prisoners with ATPs for the prior month and provide it to the monitor for auditing purposes.

Dental #1 requires that prisoners awaiting routine dental care are not removed from the list if they receive urgent care in the meantime. The statewide dental monitor, Dr. Karen Chu, indicated that it is "impossible" to find files that meet the criteria for this measure. With regard to Dental # 2 (dental assistants take inmate histories, vital signs, and radiographs (as ordered) by the dentist), Dr. Chu reported in the June CGARs for both Florence and Lewis (and other prisons) that "no records found to meet these criteria." *See, e.g.*, ADCM120833. We asked her to explain this statement, and she told us that she originally had interpreted this measure to require her to check whether inmate histories, vital signs, and x-rays had been done. However, she explained, after she used this method for CGARs prior to June,[16] Kathy Campbell and Richard Pratt told her that her sample should include only those patients for whom the Dentist wrote an order to the dental assistant in the dental chart to perform one of those tasks, and her job is to verify whether the dental assistant complied with the written order. Dr. Chu is herself a dentist, and reported that this is not how dentists practice; they would not write such an instruction in the chart. Such an instruction would be made verbally, similar to the way that a medical provider would not write out an order to a nurse directing the nurse to take a patient's vital signs prior to an appointment. Therefore, every month there would be no dental charts that included a written order by the dentist. She stated that the way she was instructed to interpret the performance measure made no sense, and renders the performance measure moot.

Another example is Chronic Care # 1, which requires that chronic disease treatment plans be developed and documented within 30 days of the identification of a chronic disease. The monitor reviewed only 24 files for this measure for the June 2014 Florence CGAR, and the only files that she reviewed were those of new intakes to Florence. We asked Ms. Franklin to explain why she only reviewed new intakes' files, and she said she did not know why she was doing it this way, but that another monitor, Erin Barlund, had instructed her to only look at newly-arrived prisoners' files. This is clearly inconsistent with the plain language of the measure.[17]

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[16] The April 2015 CGARs showed 70% compliance at Florence and 61% compliance at Lewis. ADM056716, 056777. Also related to dental treatment, the Lewis July CQI meeting minutes state that during the NCCHC inspection process, a problem was identified "that dental had no efficient way to track no shows." ADCM121106.

[17] Moreover, the need to look at all prisoners newly identified as having chronic diseases, and not just intakes, is illustrated by the fact that Florence has a difficult time identifying and tracking which prisoners have chronic diseases. According to the June CQI meeting minutes, "The CQI and dump report are timely and one inaccuracy was found. This is in regards to eomis not being able to identify AIDs patients. We believe we have 11 patients that need clarification, whether HIV or AIDs." ADCM121015.

In the 8/13/15 CQI meeting, statistical reports attached to the minutes show 0 prisoners with HIV and 0 with AIDS at every yard, indicating that the system still was not identifying prisoners with HIV or AIDS. ADCM121059-60. It also shows 22 prisoners with HIV, but this only shows data from North Unit – there is no data from other units. ADCM121058. Similarly, other reports attached to the notes have all zeros for many chronic diseases, both in terms of how many prisoners have the disease,

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The fact that almost every prison is listing 100% compliance month after month for Emergency Response # 1 (first responder trained in Basic Life Support responds and adequately provides care within three minutes of an emergency) raises the question of how monitors audit this measure.[18] We asked the Lewis monitor how he measured compliance with it, as the measure received 100% compliance in the CGARs.[19] He explained that he interpreted this measure to have two parts: (1) is a person trained in BLS responding within three minutes to an emergency, and (2) is that person adequately providing care.

With regard to the question of whether a person trained in BLS responds within three minutes, since a correctional officer is mandated to be trained in BLS, and a correctional officer is in fact, the

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and how many are receiving treatment. ADCM121059-65. According to the 8/13/15 meeting notes, there are 279 prisoners with Hep C at the institution, and 0 are receiving treatment. This number of 279 is not accurate because it only shows the numbers for Globe and North Units. ADCM121058. In order to have an adequate system of chronic care, as an initial matter, the medical staff must be able to track the number of prisoners with such a serious disease.

[18] Upon review of Exhibit A to the Stipulation, it appears the parties inadvertently did not include definitions for any of the terms used in this performance measure. Given the monitors' confusion, we recommend that the parties discuss adding such definitions, and suggest using as a starting point the California Correctional Health Care Services' definitions for their Emergency Response System Policy (Vol. 4, Ch. 12, Part 1), available at http://www.cphcs.ca.gov/docs/imspp/IMSPP-v04-ch04.12.1.pdf at page 2 (attached herein as Appendix D). For example, some of the relevant definitions in the policy include:

> **Basic Life Support**: Emergency care performed to sustain life that includes CPR, automated external defibrillation, control of bleeding, treatment of shock, and stabilization of injuries and wounds.
> **First Aid**: Emergency care administered to an injured or sick patient-inmate before Health Care Staff is available.
> **First Responder**: The first staff member certified in BLS on the scene of a medical emergency.
> **First Responder Response Time**: The time interval starting at the placement of the first call for an emergency medical response and ending with the arrival of treating personnel trained in CPR at the scene of the incident.
> **Medical Emergency**: A medical emergency as determined by medical staff includes any medical, mental health, or dental condition for which evaluation and treatment are necessary to prevent death, severe or permanent disability, or to alleviate disabling pain. A medical emergency exists when there is a sudden marked change in a patient-inmate's condition so that action is immediately necessary for the preservation of life or the prevention of serious bodily harm to the patient-inmate or others.

[19] The monitor who audited this measure at Florence, Jen Fontaine, was on medical leave and unavailable during our tour.

person who first declares that there is an emergency, there cannot possibly be anything but 100% compliance with the 3-minute requirement. With regard to the qualitative analysis for the second part of his assessment (whether care was adequately provided), Mr. Allred said he looks at the morning reports[20] that list the previous day's activities and emergencies to see if the correctional officer either (a) called the medical clinic for help, or (b) actually rendered aid to the individual having an emergency. Either one equates, for his purposes, to adequate care. Therefore, if a custody officer calls for help within three minutes of learning of a medical emergency, there is compliance. However, the sole act of picking up a phone to make a call to health care staff is not "adequately provid[ing] care" as required by the plain language of the measure.[21]

Finally, the ability of custody officers to provide adequate care is called into serious question by the CQI [redacted] meeting minutes, which discusses the death of [redacted] from a heart attack. The minutes noted that "Dr. Malachinski stated moving forward we do not stop CPR until EMS arrives regardless of custody stating to stop. Per Dr. Malachinski custody instructed those performing CPR to stop effort x 3 and each time efforts were stopped and restarted after an extended amount of minutes." ADCM121093.[22]

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[20] It is unclear if these "morning reports" are the same as the Serious Incident Reports that are listed as the source for the review. Stipulation, Exh. C, at Measure # 24. Angel Nieblas, the DON, reported that nurses record their responses in eOMIS on an ICS encounter screen but that there is no way to record when an ICS was initiated in eOMIS – this is recorded on Serious Incident Reports.

[21] Again, it is instructive to look at how another prison system assesses if a first responder provided adequate aid. The CCHCS Emergency Response System Procedures, available at http://www.cphcs.ca.gov/docs/imspp/IMSPP-v04-ch04.12.2.pdf (attached as Appendix D), describe the role of first responders and/or custody officers:

> "A FR shall evaluate the situation and initiate appropriate First Aid and/or BLS measures, including establishing airway, breathing, circulation, controlling bleeding, and administering CPR. The FR shall also:
>
> a. Briefly evaluate the patient-inmate and situation, then immediately notify health care staff of a possible medical emergency, and summon the appropriate level of assistance.
> b. Inform the health care staff of the general nature of the emergency including the general status of the patient-inmate. This may include whether the patient-inmate is conscious, breathing, bleeding, or other observable patient-inmate conditions and complaints.
> c. Immediately initiate CPR if appropriate.
> d. Initiate community EMS activation if necessary. If CPR is not initiated due to the condition of the patient-inmate, the reason(s) must be clearly documented.
>
> […] In medical emergencies, the primary objective is to preserve life. All peace officers who respond to a medical emergency shall provide immediate life support until medical staff arrives to continue life support measures."

[22] Despite the fact that CPR was stopped three separate times, the mortality review states

> "What could have been prevented: No
> What can we improve upon: N/a"

It also calls for no corrective action. *Compare* with Medical Records-CO # 2 (Stipulation # 31) ("Mortality reviews will identify and refer deficiencies to appropriate managers and supervisors,

(continued next page…)

D. Questionable Source Data Used or Source Data Contradicted by Other Documentation

Even putting aside the numerous serious methodological defects described above in Sections A-C, we identified multiple performance measures where the underlying numbers are highly suspect, or are contradicted outright by other documentation. Our spot-checking of the medical records reviewed by monitors also reveals that Defendants' findings of compliance are frequently erroneous.

For example, in the June CGARs for Florence prison, Access to Care # 5, (urgent referrals to provider seen within 24 hours) the monitor found 100% compliance for the nine urgent referrals for the month in an institution of more than 4,000 prisoners. ADCM120769. Jen Fontaine, the monitor who compiled this performance measure, was out on medical leave and unavailable to interview regarding the source of the data. Given the size of the institution, having only nine documented medical emergencies in a month is extremely low and raises a concern that either nursing staff are not properly recording data, and/or the nurses are designating very few patients as urgent. Illustrative of the possibility that data is not properly recorded on all yards, at the Globe Unit, which only has a few hundred prisoners who all must have low medical scores and no chronic conditions, they reported 3 urgent referrals, one-third of those documented for the entire Florence institution. By way of comparison, according to the Lewis June CGAR, there were 54 urgent provider referrals that month. ADCM120825. Additionally, that same month of June, there were 46 urgent dental referrals at Florence in comparison to only nine urgent medical referrals. ADCM120780.

We asked the Florence Director of Nursing Nicole Lane whether nursing staff have been trained on or provided nursing guidelines on what situations constitute an "urgent" referral. She said nurses learned what an urgent referral would be when they originally studied to be nurses. Such a circular response does not clarify if nurses know how to designate an urgent referral in eOmis. Finally, when we toured Perryville in early June, the monitor there said that it was impossible to measure this performance measure when we asked why a CGAR report listed "N/A". ADCM037131.

At Lewis, we discovered that the monitor did not actually review cases of urgent referrals made by nursing in the previous month, and it is unclear how he is picking medical files to review. We did a spot-check audit of the charts he reviewed for the June CGAR finding on Access to Care # 5. The 18 files we checked were the ones he reviewed for Rast (7), Stiner (10) and Eagle Point/Sunrise (1). ADCM122153, 122155.[23] In the June CGARs Rast is listed as 10/10 compliant (100%), Stiner is

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(continued from previous page…)
including CQI committee, and corrective action will be taken.") The Lewis June CGAR found 50% compliance for this measure, because the committee failed to discuss one prisoner's death, but not apparently due to the shockingly deficient care received by Mr. Davis. ADCM120850. See Appendix A, page 11 for additional discussion of mortality reviews.

[23] Eagle Point and Sunrise are two separate units. https://corrections.az.gov/location/98/lewis. Accordingly, they may not be combined for monitoring purposes, as the monitor apparently did here; a separate sample must be drawn from each unit.

listed as 9/10 compliant (90%), and Eagle Point as 1/1 (100%) compliant.[24] ADCM120825. We found that in fact, *none* of the records reviewed at these two yards were relevant to the urgent referral performance measure: the monitor counted five dentist appointments as urgent provider encounters, and numerous return from specialty care follow-up and regularly scheduled chronic care appointments as urgent provider referrals.[25] Given this gross mistake in interpreting what an "urgent referral" means, it calls into question (1) the accuracy of the monitor's review of the other prisoners' medical files that we didn't have a chance to review, and (2) what, if any, training he received on auditing the measure. It is unclear how he identifies records applicable to the measure, which again illustrates the need for a more robust methodology and clear and consistent instruction to all monitors across the institutions. *See* Appendix A, pages 14-15 for details of our review.

Similar to our finding at Florence on Access to Care # 5 that the monitor relied upon a very small universe of applicable cases, the Florence June CGARs on Access to Care # 6, (emergent referrals to provider seen immediately) found 100% compliance with only two emergency referrals complex-wide for the month. ADCM120770. Again, this seems very low, especially when the small Globe unit was the source of one of these two referrals. More significantly, this number may be contradicted by other documents. According to the June 2015 Emergency Transport report, there were 12 prisoners transported off-site due to emergencies. ADCM12155. The CQI minutes indicate that there were 16 emergency transports in June. ADCM121036. While it is possible that prisoners may be transported off-site without first being seen by a provider, if there truly were only 2 out of 12 (or 2 out of 16) emergencies seen by a provider, then such a scenario raises the questions of (1) are there a sufficient number of providers, and (2) if not providers, then who is making the decision to send the patient off-site emergently? The discrepancy among these three documents calls into question the monitor's methodology. Finally, similar to Access to Care # 5, it also calls into question whether the nurses have any training on how to make a record of these emergent referrals in eOmis.

At Lewis we also did a spot check of some of the files reviewed for Access to Care # 6 for the June CGARs. We reviewed the four files listed in the worksheet by the monitor for Stiner Unit (ADCM122154), and discovered that one of the four prisoners' file reviewed was not relevant to the performance measure. In that case, the referral actually was marked as urgent, and not emergent, and should not have been considered under Access to Care # 6, but rather under # 5.

As described above, the Florence monitor identified a number of urgent or emergent referrals that seemed extremely low given the size of the prison. Similarly, when measuring the June CGAR for Quality Improvement # 1 (responses to HC grievances), the monitor stated that only nine grievances were filed institution-wide and they were 100% compliant. ADCM120810. Given the size of Florence, that is absurdly low. The CQI meeting minutes said there were 8 grievances filed in the month of June (3 from South and 5 from East), which is a discrepancy, but more importantly, the CQI

[24] The monitor found 49 of 54 (91%) urgent referrals compliant prison-wide. ADCM120825.

[25] We found similar widespread mistakes where the Lewis monitor's worksheets did not reflect the content of prisoners' medical charts for Access to Care # 4 (routine provider referrals within 14 days) and Access to Care # 7 (follow up sick call within timeframe specified by provider). *See infra* pages 24-27.

minutes indicate that the grievances from Central/Kasson, North, and Globe are either not being tracked, or are not making it to medical staff. ADCM121035.[26] The CQI minutes state that "We currently have a total for the year of 93 grievances and last year that this time we had 223." *Id*. During the tour, we spoke to multiple class members on the four yards who reported never receiving responses to their grievances regarding health care, leading them to believe that they were either not being collected or processed.

Similarly, the Lewis June CGAR for Quality Improvement # 1 stated that only 20 grievances were filed the month of June at the entire institution – and supposedly no grievances were filed at the Bachman, Buckley, and Eagle Point units; and only one grievance each at Barchey and Morey Units. ADCM120867. The failure to have any grievances, or only one per yard, would tend to indicate that they are not being tracked or collected properly. Furthermore, the data kept by Corizon contradicts the monitor's findings: the CQI minutes state that in June, 52 grievances were filed institution wide, and the discrepancy between the two reports is summarized below. ADCM121089-90

Unit	# Grievances Filed June 2015 (according to CGAR)	# Grievances Filed June 2015 (according to CQI minutes)
Bachman	0	5
Barchey	1	2
Buckley	0	13
Eagle Point / Sunrise	0	0
Morey	1	3
Rast	14	22
Stiner	4	4
Total	**20**	**52**

There are similar discrepancies between the Lewis July CGAR (ADCM135586) and CQI data (ADCM121110-11).

Unit	# Grievances Filed July 2015 (according to CGAR)	# Grievances Filed July 2015 (according to CQI minutes)
Bachman	1	4
Barchey	0	2
Buckley	17	28
Eagle Point / Sunrise	1	1
Morey	0	0

[26] Again in July, there was no record of grievances documented for these three yards in the CQI minutes, ADCM121056, and according to Corizon data, 10 grievances were filed from the South (7) and East (3) Units. The July CGAR, on the other hand, indicated that 13 grievances were filed – six at South, six at East, and one at Central. ADCM135531.

Unit	# Grievances Filed July 2015 (according to CGAR)	# Grievances Filed July 2015 (according to CQI minutes)
Rast	21	24
Stiner	1	1
Total	**41**	**64**

Another example of the questionably small number of documents reviewed can be seen in the April 2015 Tucson CGAR Access to Care # 1 (HNR screened by RN or LPN), where the monitor reviewed only eight (8) HNRs for the entire institution for the entire month, and found 100% compliance. ADCM037242. A sample size of eight was also used for the months of May and July. ADCM072066, 137506. (Those months also are listed as having 100% compliance). This does not comport with the Stipulation requirement that a sample of ten be taken from each unit of a prison complex, and that the only time there are fewer than 10 reviewed is when there are less than 10 examples for the month. Given the size of Tucson, and the number of prisoners with serious medical and mental health needs, it is overwhelmingly likely that more than eight HNRs were filed institution-wide.[27] Again, the use of a sample size that on its face is absurdly small calls into question the accuracy of the finding.

At Florence, we spot-checked the monitor's findings for Mental Health # 8 (MH-3A prisoners seen at least every 30 days by a mental health clinician). The June MGAR found 28 out of 30 files compliant, for a rate of 93% compliance. ADCM120799. However, we reviewed the ten files from East Unit and found that four of them were in fact not in compliance, lowering compliance to at least 80% (24 out of 30). This calls into question the accuracy of the review of the other 20 prisoners' files that we were unable to review. In May, the monitor again found 28 out of 30 files compliant for a 93% compliance rate. ADCM071832. Again, we spot-checked some of the files that had been reviewed, and found at least two that were in fact noncompliant. *See* Appendix A, page 1.

The spot check of Lewis June CGARs for Mental Health # 8 found at least two prisoners who are listed as having clinical contacts, when in fact the encounters had been cancelled. ADCM120856. This lowers the monitor's finding of compliance from 47/70 (67%) compliance to at least 45/70 (64%). *See* Appendix A, page 2.[28]

At Lewis, we spot-checked the June CGARs for Mental Health # 9 (MH-3A prisoners on psychotropic medications will be seen at least every 90 days by a mental health provider). The monitor found 33 out of 54, or 61% of records compliant. ADM120856-57. However, five of the 33 files listed as compliant (not all 33 files were reviewed) actually had not had mental health provider encounters at 90 day intervals, and a sixth file listed as compliant belonged to a prisoner who

[27] Tucson has eight units, and it is conceivable that the 8 of 8 refers to each unit. However, the methodology set out in the Stipulation, and used at other facilities, requires 10 records per unit, not one per unit.

[28] Appendix A, pages 3-10 includes a summary of Lewis and Florence prisoners whose files we randomly reviewed and whose mental health treatment does not comport with various Stipulation requirements.

apparently discharged from ADC custody in 1989. Therefore, the compliance rate is lowered to at least 28 out of 54, or 52% compliance. *See* Appendix A, page 2 for more details.

Mental Health # 11 requires, in part, that "MH-3B prisoners who are prescribed psychotropic medications for psychotic disorders, bipolar disorder, or major depression [hereinafter "a qualifying diagnosis"] shall be seen by a mental health provider a minimum of every 90 days." At Florence, the monitor found compliance in 27 out of 37 cases, or 73%. However, in at least three cases, the monitor concluded the prisoners did not have an applicable qualifying diagnosis, even though the prisoners had documented diagnoses of schizoaffective disorder, psychosis, and depressive psychosis. In addition, the monitor lists a prisoner as compliant when there is no provider note on or near the date he was allegedly seen, and another prisoner listed as compliant when he is housed at Lewis, not Florence, and his record indicates he has "no history of MH services."[29] Finally, there were several entries in the Florence CGAR listed as compliant where the documented date of the encounter was in the future, or otherwise obviously incorrect. *See, e.g.*, ADCM120796 (entry dated 7/31/15 reporting prisoners were seen on 8/11/15, 8/7/15, and 4/1/47); ADCM120801 (prisoner reportedly seen on 6/1/34). *See* Appendix A, page 1. Such obvious errors cast serious doubt on the accuracy and reliability of the monitors' work.

The spot check of the Lewis June CGAR for Mental Health # 11 also showed that the medical records did not support or reflect the monitor's conclusion. The monitor had found 51 of 64, or 80%, of applicable files compliant. ADCM120857-58. In fact, four of the spot-checked records were not compliant with the measure, lowering the compliance level to at most be 47 of 64, or 73% compliant, and calling into question the accuracy for the medical charts we did not have time to review. One of the files was noncompliant because several appointments listed in the CGAR for the prisoner had not actually occurred, because they were cancelled for security reasons, or because the mental health staff did not have access to the prisoner's record.[30] *See* Appendix A, page 2 for more details.

A final example in which review of the underlying source documents shows something different than the monitor's finding is Quality Improvement # 2 (facility conducting monthly CQI meetings in accord with NCCHC standards).[31] For this measure, the monitor found 100% compliance for June at Florence, even though a review of the CQI meeting minutes show that the mental health portion is completely blank, and there are no minutes regarding dental care (indeed, the mental health

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[29] This prisoner is also listed as compliant under Mental Health # 10 (MH-3B prisoners seen a minimum of every 90 days by a mental health clinician). ADCM120800.

[30] Cancellation of mental health appointments due to security staff shortages and for other non-clinical reasons appears to be a common occurrence. It also appears that the patient's records are frequently unavailable to mental health staff. *See* Appendix A, pages 2-3 for more examples.

[31] NCCHC Standard P-A-06 defines a quality improvement committee as consisting of "health staff from various disciplines (e.g. medicine, nursing, mental health, dentistry, health records, pharmacy, laboratory)." The Discussion Notes state: "CQI minutes should provide sufficient details to guide future decisions. For example, the minutes could state the problems identified, the solutions that were agreed upon, the person responsible for carrying out the corrective action, and the time frame for taking the corrective action."

portion is entirely blank for May, June, and July, a fact that Nicole Newman, the lead psych associate, was unable to explain). ADCM120810 [CGAR]; ADCM121017 [CQI notes]. Additionally, the columns that identify "Individual Responsible for Follow Up" and "Estimated Completion Date" are not completed and left blank in all three months of the CQI meeting notes we were provided for Florence. ADCM121013-19; 121035-39; 121047-54. This failure to discuss (or document a discussion occurred) regarding dental and mental health care, or to identify individuals responsible for follow up and completion date, shows that the CQI meetings are in fact not being conducted in accord with NCCHC standards, and the 100% compliance finding is incorrect, and should instead be 0%.[32]

E. Failure to Review the Substance of Individual Medical Records

There are measures for which it is necessary to open up the encounter notes for individual prisoners in order to assess whether the performance measure is met, but the monitors are not doing so. For example, in Part D we referred to encounters that the monitor counted as occurring, but upon opening the encounter and reading the actual notes, one could see that the encounter was cancelled. We also identified multiple prisoners' records where a provider appointment ostensibly occurred, but there are no notes of any type in the SOAPE notes, and the only information at most that is documented is the prisoner's vital signs that were taken by a nurse. *See e.g.* [redacted] at Appendix A, pages 24-25, 27. We previously raised our concern about "phantom appointments" at Perryville and Eyman, (Eidenbach letter at 8-9), and it appears that such a practice occurs at Florence and Lewis as well.

Significantly, compliance with Stipulation Agreement #1 (interpretation in all health care encounters), required by Paragraph 14 of the Stipulation, is not accurate without reviewing individual entries in the prisoner's medical record. The monitors' method of measuring compliance, as explained to us by the monitors during interviews and in your letter of August 20, is to review the log of all appointments in which the language line was actually utilized and therefore unsurprisingly finding 100% compliance every month. This in no way would capture the clinical encounters where interpretation services were not used. A more accurate approach would be to select 10 prisoners who cannot communicate fluently in English and had health care appointments in the past month, and review the notes from their clinical encounters to see if there is any documentation of the use of interpreters, thus showing that effective communication was achieved.[33] We did exactly that while at

[32] In the Florence July CGARs, the monitor does assess 0% compliance for this performance measure because "there is no documentation of what is being monitored/studied. What is the problem and what process study is taking place or being updated? There are no thresholds listed. What are the QI monitoring activities?" ADCM135531.

[33] Defendants misinterpret the term of art "effective communication" in the context of a health care encounter to mean that Plaintiffs are somehow insisting that the health care staff rate the quality of the interpretation. Rand 8/20 letter at 9. We are not making such a demand; having the staff write in SOAPE notes that an interpreter was used in and of itself shows effective communication occurred, because a qualified interpreter conveyed information. In fact, at least one provider at Florence does document in her SOAPE notes when she uses an interpreter, and these include encounters that were not listed on the language log. *See* Appendix A, pages 16-19 for more details.

Florence, and in our spot-check of the monitors' finding of 100% compliance at the institution, found that the 100% figure month after month cannot be in any way accurate. While this review was for only one prison, we believe that using this methodology at other institutions would likewise show the 100% compliance rate is incorrect.

Our methodology for this review was to use the list of names of nine Florence prisoners on the March and April phone interpretation logs in order to identify prisoners who would be covered by this performance measure, and review their medical records to see if there were other health care encounters documented in the medical record that occurred after 2/18/15 and that weren't on the phone log. We found a widespread failure to provide interpretation in medical, dental, and mental health encounters. Only one of the nine prisoners whose files we reviewed had interpretation at all of his health care encounters, which if compliance were to be measured by prisoner, would result in a woeful compliance rate of 11%. If one were to add up all of the reviewed health care encounters for the nine prisoners, and calculate compliance that way, our spot-check found that the institution would still be terribly out of compliance; for the nine prisoners, 48 of their 70 health care encounters had no interpreter. This is a compliance rate of 31%.[34] *See* Appendix A, pages 16-19 for detailed notes of each prisoner's medical record.

[34] Our review of six other prisoners' records during the tours showed they did not have language interpretation at health care encounters. *See* Appendix A, page 20; *see also* Fathi letter, 8/6/15 (language interpretation not provided to [redacted]).

The number of encounters without interpretation would be higher if we relied solely upon what is documented in the medical records. On North yard, there is a RN (Julia Madrid) who prisoners said speaks Spanish, so while there isn't documentation in the SOAPE notes that she spoke to them in Spanish, those encounters are not counted against Defendants. Likewise, we were told by prisoners on the South Unit that LPN Garcia speaks Spanish, so any encounter with her is not counted against Defendants.

II. Defendants' Own CGARs Show Widespread Deficiencies and Non-Compliance

Putting aside all the deficiencies in defendants' monitoring methodology, even taken at face value the CGARs themselves show that month after month Defendants are out of compliance with many stipulation performance measures.[35] We analyzed the CGARs we have received to date, and found that substantial noncompliance is persistent and widespread. In the following pages, we identify the most critical elements to have a functional correctional health care delivery system. These include: timely access to competent health care services ("health care" = medical [including infirmary care], dental, and mental health care); a functional pharmacy and medication administration system; timely and competent management of chronic disease patients; and the use of specialty care, which includes incorporating the specialist's recommendations into the ongoing treatment plan. For the measures relevant to these essential elements of a functional health care system, there is substantial noncompliance, with no identifiable trend towards improvement..

Access to Medical Care Access to Care # 1 (HNR triage) Access to Care # 2 (24 hr NL) Access to Care # 4 (14 day PL) Access to Care # 7 (follow-up sick call timely) Infirmary Care # 4 (72 hr provider rounds)	*Pharmacy/Medication Administration* Pharmacy # 1 (newly prescribed formulary meds w/in 2 bus days or same day if STAT) Pharmacy # 2 (CC and psych med renewals) Pharmacy # 3 (CC and psych med refills) Access to Care # 10 (all meds transferred b/n prisons w/o interruption)
Access to Dental Care Staffing # 3 (statewide dental staffing) Dental # 3 (routine dental 90 days) Dental # 4 (urgent dental 72 hrs)	*Chronic Disease Management* Chronic Care # 2 (CC seen as specified, at least every180 days) Chronic Care # 3 (Disease mgmt. guidelines implemented)
Access to Mental Health Care Mental Health # 13 (MH-3D seen w/in 30 days of discontinuing meds) Mental Health # 20 (MH-3 & above seen every 30 days) Mental Health # 21 (MH-3 &above in max custody seen weekly) Mental Health # 26 (MH HNR triage)	*Specialty Care* Access to Care # 9 (hosp. discharge instructions reviewed/acted upon w/in 24 hrs) Specialty Care # 5 (specialty consult reports reviewed/acted upon w/in 7 days) Specialty Care # 7(act on abnormal values in diag. reports w/in 5 days)

[35] For the first twelve months after the effective date of the Stipulation (2/17/15), Defendants must meet or exceed a 75% threshold for every performance measure. *See* Stipulation ¶ 10(a)(i). Defendants believe the February CGARs are not relevant for measuring compliance. 8/20/15 Rand letter at 6. We disagree. In any event, the five month averages (March – July 2015) were close to the six month averages (Feb. – July 2015). We can provide six month charts if Defendants desire.

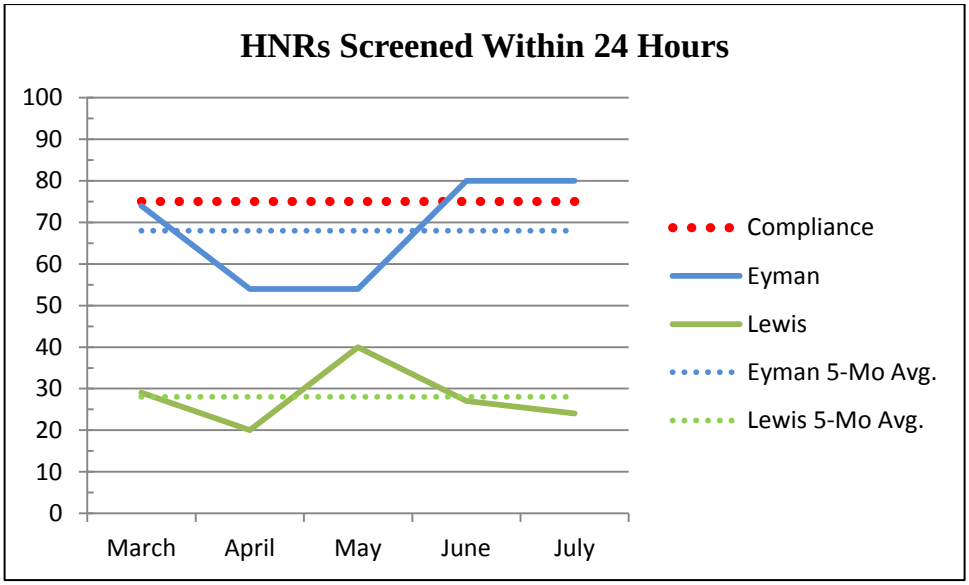
In addition to the measures listed above, there are many others documented on the CGARs where Defendants show noncompliance or no sustained compliance. The fact that they are not analyzed below does not mean that we believe Defendants are in compliance with these measures, nor do we waive our right to raise them in a future Notice of Substantial Noncompliance. Finally, we encountered numerous prisoners at Florence and Lewis during our tour whose treatment illustrates the widespread noncompliance with performance measures. A summary of the findings are at Appendix A, pages 21-28.

A. Access to Health Care

At the outset, we note that numerous prisoners we spoke with at ASPC-Lewis reported that they did not have access to blank HNR forms in triplicate held in the officers' office ("bubble") on their housing units. Prisoners at Rast, Barchey, Buckley, and Morey Units consistently described the process to get a blank HNR form was to first write an inmate letter/kite to their CO-III. Generally within two to three days, the CO-III would deliver a blank form to the prisoner's cell. The prisoner then fills out the HNR form and in the case of max and close custody units, gives the HNR to a custody officer to forward to Health Care. This practice causes delays in prisoners' ability to bring their health care concerns to the attention of health care staff, which is especially problematic with urgent or emergent medical, dental, or mental health needs, or to request refill and renewal of chronic care and psychotropic medications.

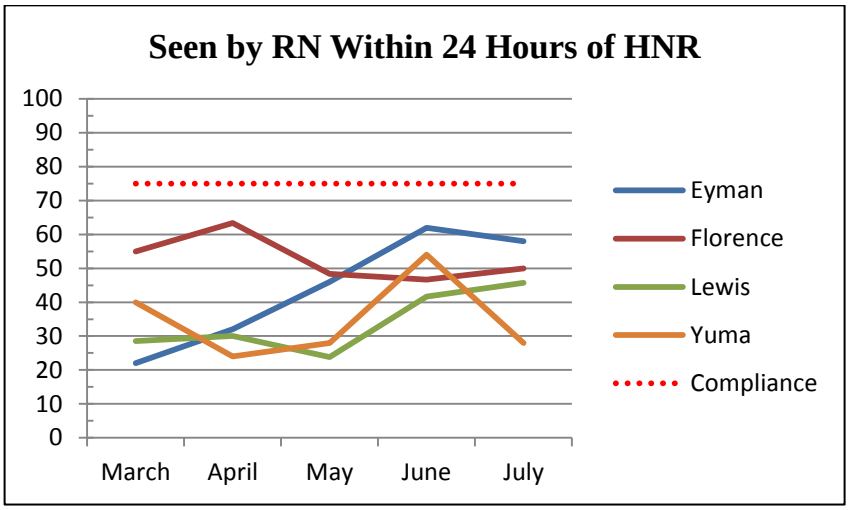
Access to Medical Care

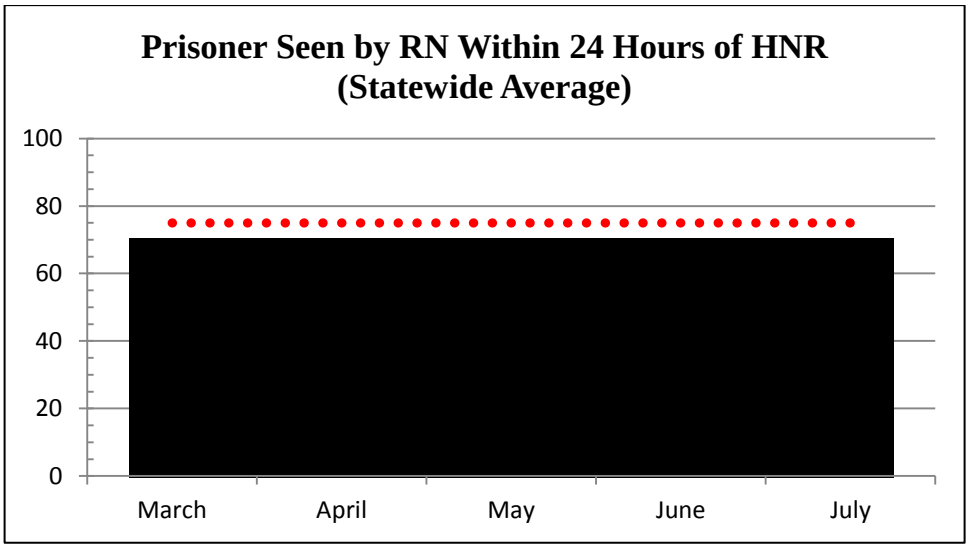
Stipulation Measure # 36 (Access to Care # 1) (HNRs screened by LPN/RN within 24 hours of receipt). Defendants are substantially noncompliant for this performance measure. Two prisons in particular, Lewis and Eyman, are significantly noncompliant with a five-month average rate of compliance of 28% at Lewis and 68% at Eyman. The CQI August meeting notes at Lewis confirm this, and state that HNRs are not being picked up and stamped as received by health care staff in a timely manner, and that there is no data on HNR timeliness from Morey and Rast Units. ADCM121116-20. *See* Appendix A, page 30 for more details.



It also appears that Florence has a problem properly processing HNRs. A Director-level response signed by Richard Pratt on 6/22/15 to a grievance ([redacted] filed by a South Unit prisoner ([redacted] grants the grievance, stating that "the 16 Health Needs Requests (HNRs) you submitted dated from 3/8/15 to 6/7/15 were reviewed and 10 of them were found to be deficient." *See* Appendix B.

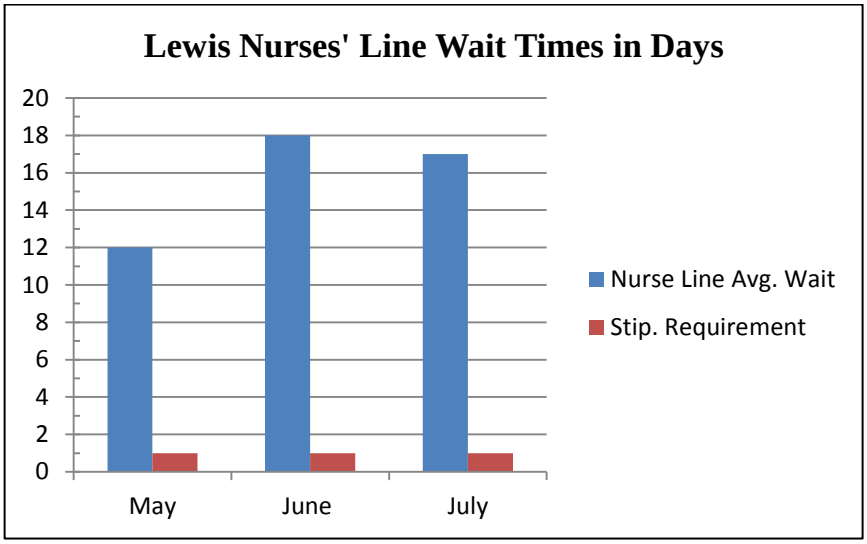
Stipulation Measure # 37 (Access to Care # 2) (Sick call inmates will be seen by an RN within 24 hours after an HNR is received). Defendants are substantially noncompliant for this performance measure. ADC's statewide average compliance level every month was below 75%, and the five month average statewide compliance level was 64%. Six prisons averaged less than 75% compliance over the five months.[36] Four of the largest prisons (Eyman, Florence, Lewis, and Yuma) have been out of compliance every single month since monitoring began. *See* Appendix A, page 30 for a detailed summary of each prison's performance for each month.



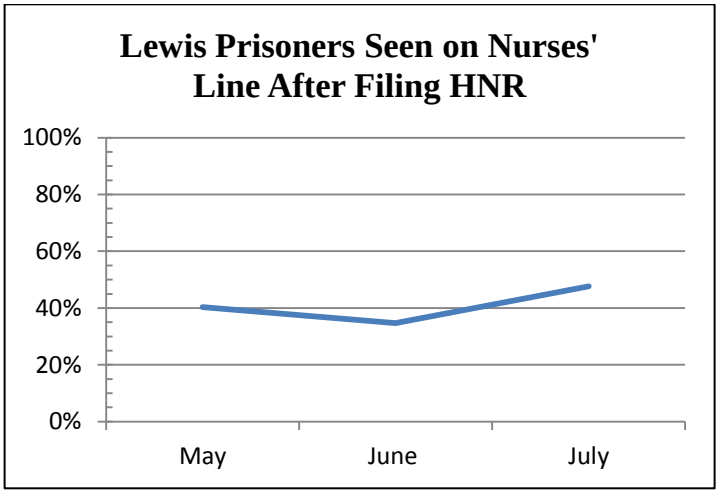


[36] Eyman (44%), Florence (53%), Lewis (34%), Tucson (67%), Winslow (73%), and Yuma (35%).

When we spot-checked the June 2015 CGAR for Lewis Complex, Stiner Unit, using the monitor's worksheets, (ADCM122153), we found that the compliance level recorded on the CGAR was overstated. The monitor found compliant 25/61 (41%) of files reviewed institution-wide, and that 2/10, or 20%, were compliant at Stiner Unit. ADCM120824. However, a review of the records for prisoners [redacted] and [redacted] showed that a LVN, not a RN, conducted this face-to-face triage. Therefore, Stiner unit's compliance rate should have been 0 of 10 (0%) and assuming all other records were accurate, at most the complex-wide compliance level should have been 23 of 61 (38%). Furthermore, the CQI minutes for Lewis prison quantified the extent of the problem of delays in prisoners being seen on nursing line. In May, the average wait time for nurses' line was 12 days; in June, 18 days; in July, 17 days. ADCM121073, 121092, 121114-15. This performance measure requires a wait time of no more than 1 day.

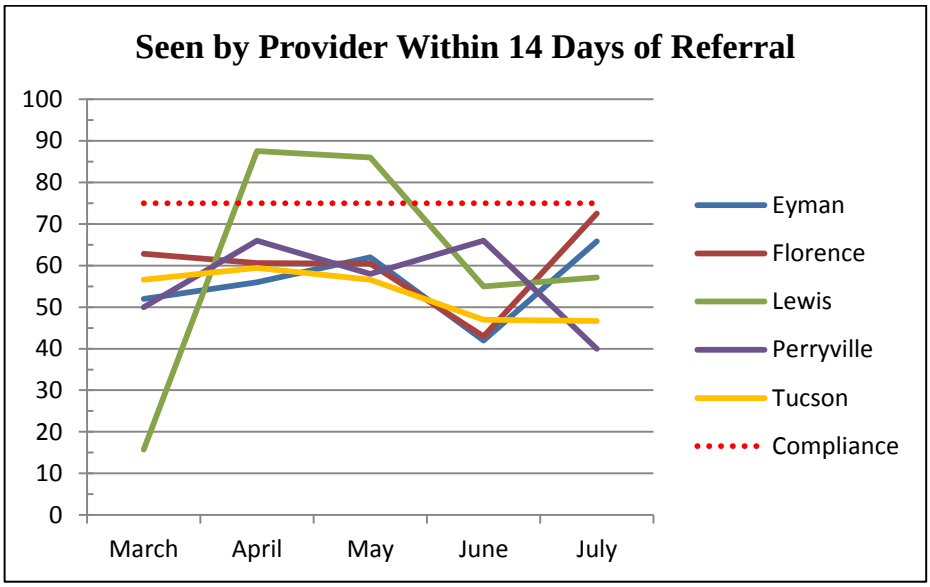


CQI minutes documented that each month at Lewis, less than half of the HNRs submitted resulted in a nurse's line appointment. ADCM121073, 121092, 121114-15. While many may be requesting prescription refills since Defendants do not have an automated refill system (*see* pages 33-34, *infra*), this raises the possibility that many of the HNRs seeking medical care are not being scheduled for sick call.



While touring Florence-Central, we asked DON Nicole Lane if she had any insight into the prison's score of 47% in the June CGARs for Access to Care # 2 (sick call inmates seen within 24 hours by a RN). ADCM120768. She said that nurse lines are run seven days a week and on days when there are no custody issues, 15 to 20 patients are seen each day. She stated the Central yard goes down frequently for security reasons, and when it does, patients are not escorted to the building. We asked Deputy Warden Morris about disruptions to medical escorts. Mr. Morris stated the medical escort positions are fully staffed five days/week, and are not diverted, so escorts should not be disrupted. He reported the medical escort position is filled by regular shift staff on Saturdays and Sundays. He said this would be reflected in "incident sheets." At our request, he collected all of the "incident sheets" from Central Unit for the month of August for our review. We received the documents, called "Information Reports" on Friday, 9/4/15, after leaving Florence and could not follow-up with questions for custody or medical staff about the information in the reports. We received reports for nine days. ADCM122196-213. It is unclear if no medical escorts occurred the other 22 days of the month, but Mr. Morris had said we would be given every report for the month. The documents contradicted the DON's assertions, and show that the sampled finding of 47% compliance underestimated the extent of the problems. The documents show that even on the nine days where there was activity at the clinic, there were very few nursing, provider, mental health or dental lines run. *See* Appendix A, page 29 for a detailed analysis. Our file reviews also found many cases where prisoners were not seen on sick line in response to HNRs. *See* Appendix A, pages 21-28.

Stipulation Measure # 39 (Access to Care # 4) (Routine provider referrals will be addressed by a provider within 14 calendar days). Defendants are substantially noncompliant for this performance measure. ADC's statewide average compliance level was below 75% three out of five months. Four prisons have been out of compliance every month since monitoring began, and five have a five-month average compliance rate of less than 75%.[37] *See* Appendix A, page 31 for a detailed summary of each prison's performance for each month.

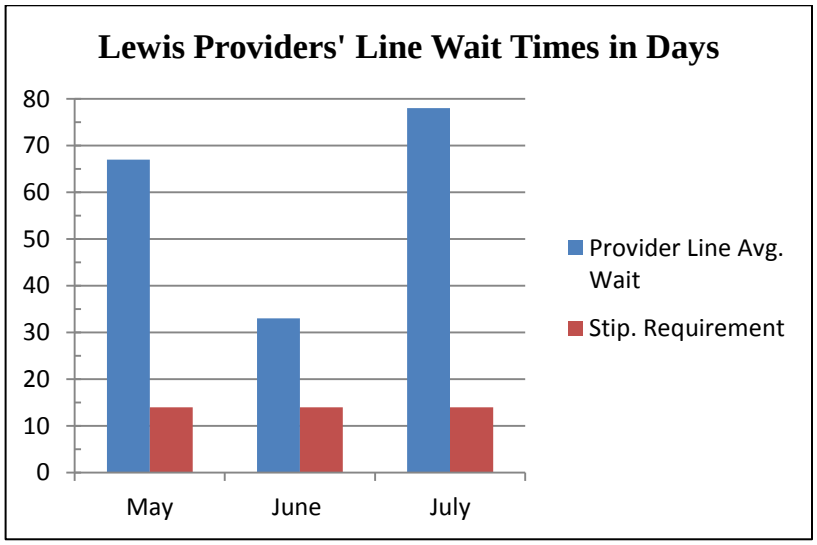


[37] Eyman (56%), Florence (60%), Lewis (60%), Perryville (56%), Tucson (53%).

At Lewis, we spot-checked the June CGAR Access to Care # 4 measure for Bachman, Stiner and Eagle Point/Sunrise units, and found that the monitor overestimated compliance. The monitor found 4 of 10 (40%) at Stiner, and 5 of 10 (50%) at Eagle Point to be compliant. ADCM120824-25. At Bachman, the monitor found 5 out of 10 compliant on his worksheet, ADCM122145, but on the CGAR, Bachman is listed as 1 of 3 compliant. ADCM120824. The total number files listed by institution as compliant on the CGAR adds up to 27 of 53 (51%), not 33 out of 60 listed in the summary. ADCM120824-25. The total number of files listed as compliant on the monitor's worksheets is 43 out of 75 (57%). ADCM122143-58.

With the five Bachman files that were marked as compliant in the worksheets, we found that there were no referrals (and in some cases, no encounters) on the dates listed for four of the five patients. The nine files at Stiner and Eagle Point that were marked as compliant in his worksheets were either not compliant or not applicable to this measure (three not compliant, six not relevant). We found that in fact, assuming that all of the other records were accurate and relevant, the calculation should have been at most that 30 out of 65 files (or 46%) in June were compliant. *See* Appendix A, pages 31-32 for more details.

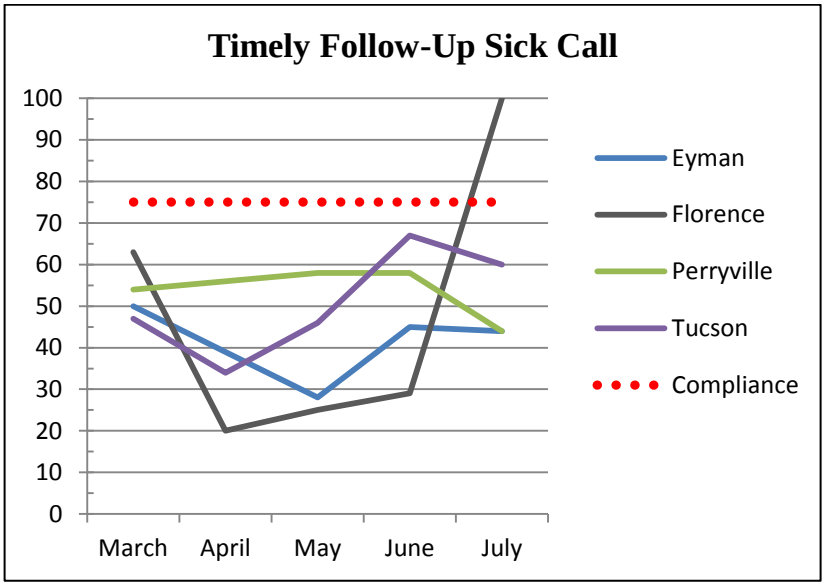
The CQI meeting minutes for Lewis prison quantified the extent of the problem of delays in prisoners being seen by the provider. In May, the average wait time for provider's line was 67 days; in June, 33 days; in July, 78 days. ADCM121073, 121092, 121114-15. The meeting notes explain the May number as being "[d]ue to provider staffing…" When we toured the Rast Unit clinic on September 2, we met Dr. Abraham, the Corizon Associate Regional Medical Director, who was preparing to see patients on a provider line. He reported that he had been running provider lines at Lewis from June 1- July 14 and mid-August to present because of provider vacancies. He said he was focused on chronic care patients and getting the institution caught up on their backlog of provider referrals. Dr. Malachinski told us there are two doctors on staff (him and another person), and five Nurse Practitioners, with the other MD and two of the NPs only recently hired. There is still a 0.5 FTE provider position vacant. Dr. Malachinski reported that in addition to his administrator role as Medical Director, he manages the Hub medical unit, and he is the only provider assigned to Buckley and the infirmary (L-11).



Stipulation Measure # 41 (Access to Care # 7) (follow-up sick call encounter will occur within timeframe specified by the medical/MH provider). Defendants are substantially noncompliant for

this performance measure. For every month but one, the statewide compliance rate was less than 75%.[38] Three facilities were below 75% for five months (Eyman, Perryville, Tucson). Eyman and Florence had five-month average rates of compliance less than 50%.

While at Lewis we reviewed all ten Stiner Unit files marked as compliant for this measure, 6 of the ten Rast files found compliant, and 4 of the ten Bachman files found compliant. We found that none of them were relevant to the performance measure. *See* Appendix A, pages 33-34. This again calls into question the accuracy and relevance of the other 50 medical records the monitor ostensibly reviewed for this performance measure, which we did not review and for which he found 100% compliance institution-wide. ADCM120825.



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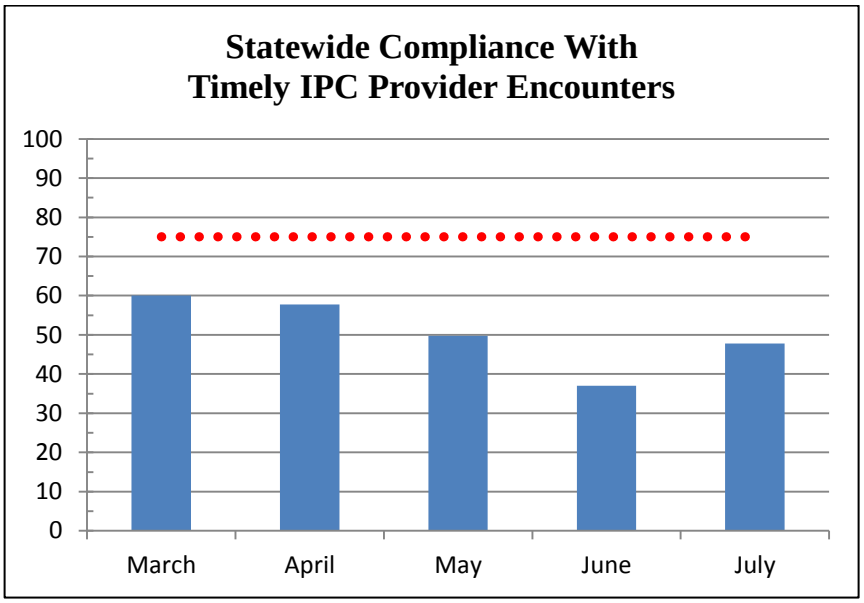
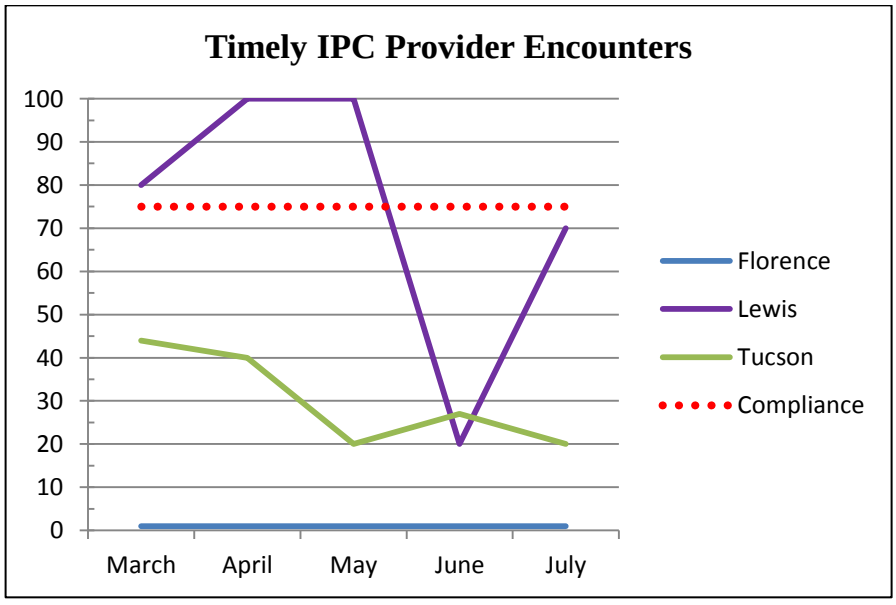
[38] March (72%); April (69%); May (49%); June (72%); July (77%)

Stipulation Measure # 66 (Infirmary Care # 4) (In an IPC, provider encounters will occur at least every 72 hours). Defendants are substantially noncompliant for this measure. Every month the statewide compliance is less than 60%. Three of the four prisons with infirmaries have 5 month average compliance rates below 75%. Florence and Tucson, the two prisons with the largest infirmaries, are woefully out of compliance, with a five-month compliance rate of 30% at Tucson and **a shocking 0% compliance rate at Florence**. *See* Appendix A, page 34 for a detailed summary of each prison's performance for each month.



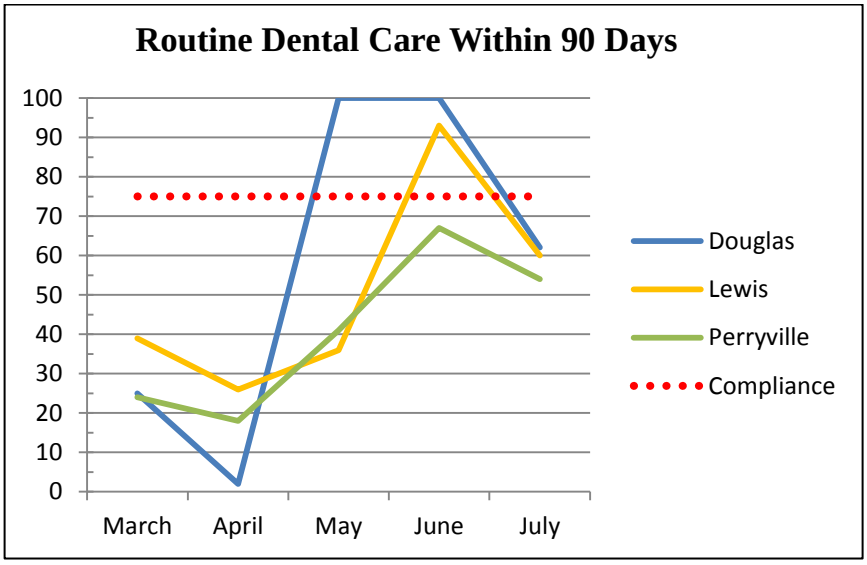


Access to Dental Care

Defendants have consistently been noncompliant on measures related to dental care.

Stipulation Measure # 3 (Staffing # 3) (Dental staffing will be maintained at current contract level). Defendants have been noncompliant four out of five months on this statewide performance measure.[39]

Stipulation Measure # 102 (Dental # 3) (Routine dental wait times no more than 90 days from date HNR was received). Defendants are substantially noncompliant for this performance measure. ADC's statewide average compliance level was below 75% two out of the five months.[40] Three prisons have average compliance levels for the first five months of monitoring that are below 60%.[41] Additionally, Safford prison reported a "N/A" for the month of May, and the monitor reviewed only two records, (ADCM072030) which raises the question as to whether there were only two routine dental appointments the entire month at a prison with 1,770 prisoners.[42] *See* Appendix A, page 35 for a detailed summary of each prison's performance for each month.



Stipulation Measure # 103 (Dental # 4) (Urgent dental care provided within 72 hours). Defendants are substantially noncompliant, and Defendants' performance on this measure is quite erratic. ADC's statewide average compliance level was below 75% two out of the five months.[43] Two prisons

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[39] March (71%); April (72%); May (70%); June (75%); July (74%). The five-month average is 72%. *See* ADCM036997, 56674, 71841, 120818, 135515.

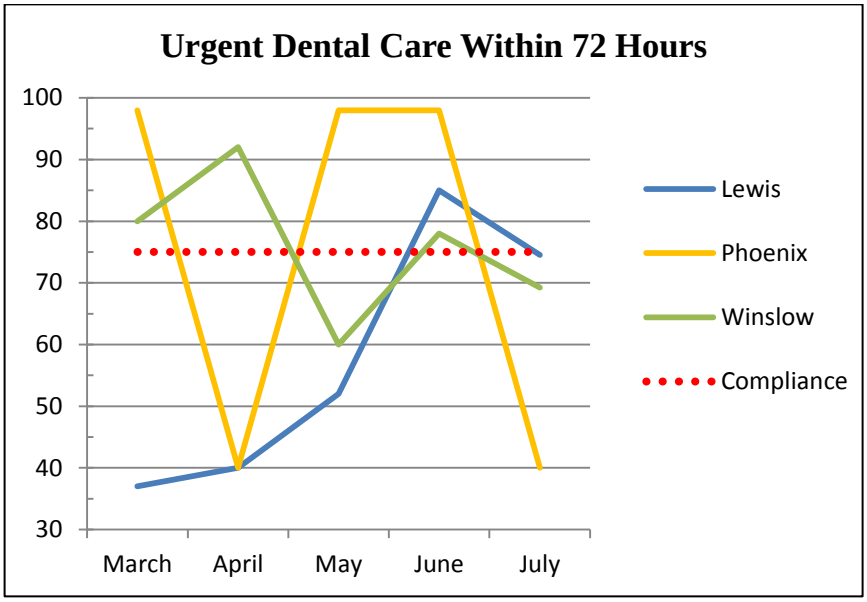
[40] March (70%); April (63%).

[41] Douglas (58%), Lewis (51%), Perryville (41%).

[42] Dr. Chu's CGAR entry was dated 6/15/15. ADCM072030. Safford's population on that day was 1,770. *See* https://corrections.az.gov/sites/default/files/DAILY_COUNT/June2015/june_15th_2015.pdf.

[43] March (74%); April (72%).

were below compliance for three months, and three prisons were out of compliance for two months. *See* Appendix A, 35 for a detailed summary of each prison's performance for each month.



Access to Mental Health Care

As detailed in Plaintiffs' Notice of Non-Compliance dated August 28, 2015, Defendants are not in compliance due to their erroneous position that many mental health measures "do not apply" at certain complexes and units. *See* Section I.A. at page 3; 8/28/15 Fathi letter. This noncompliance with the plain language of the performance measures necessarily invalidates any finding of compliance on these performance measures. In any event, to the extent that Defendants are still monitoring and tracking these performance measures, the data shows sustained noncompliance statewide.

Stipulation Measure # 85 (Mental Health # 13) (MH-3D prisoners seen by provider within 30 days of discontinuing psychotropic medications). Defendants are substantially noncompliant for this performance measure. Five of the six prisons for which Defendants reported data had a five-month average compliance rate of less than 20%.[44] Similarly, for every month but one, average statewide compliance was less than 20%.[45] The statewide five-month average level of compliance was 17%. *See* Appendix A, page 36 for a detailed summary of each prison's performance for each month.

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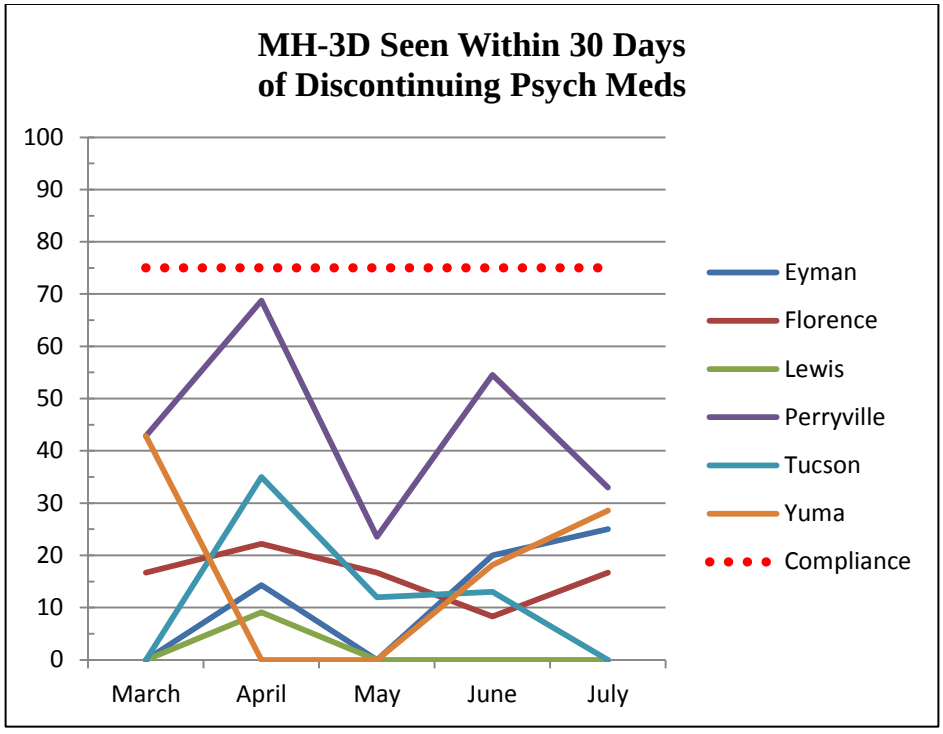
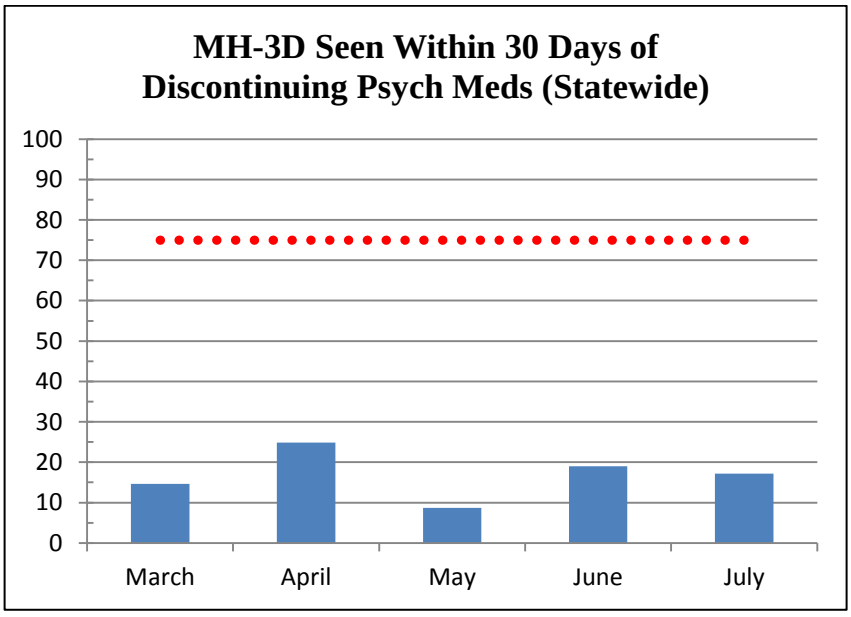
[44] Eyman (12%), Florence (16%), Lewis (2%), Tucson (12%), Yuma (18%). The sixth prison, Perryville, had a five-month average compliance rate of 45%.

[45] March (15%), April (25%), May (9%), June (19%), July (17%)

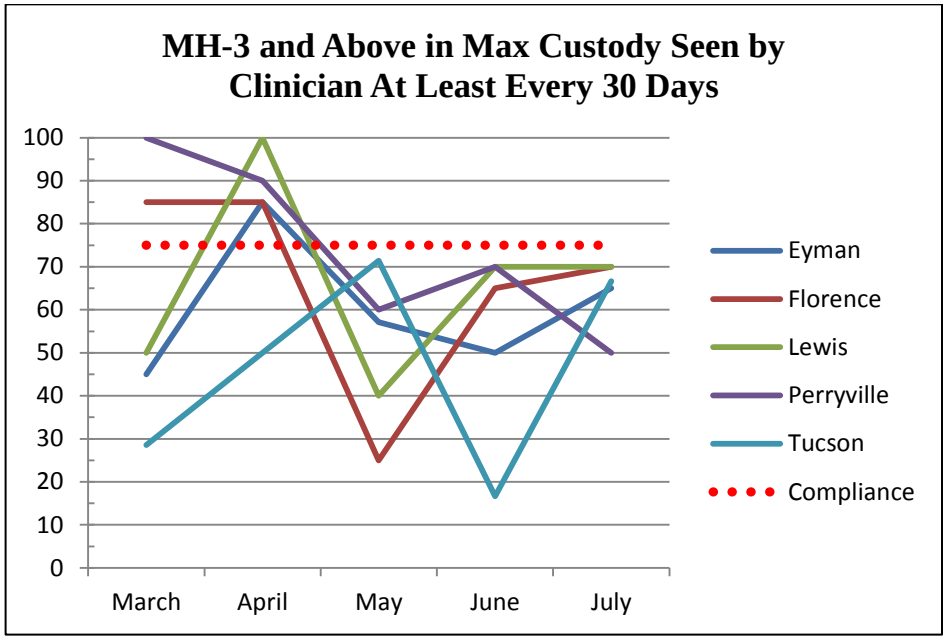




Stipulation Measure # 92 (Mental Health # 20) (MH-3 and above prisoner in max custody seen by clinician for 1:1 or group session at least every 30 days). Defendants are substantially noncompliant for this performance measure, and wildly erratic from month to month. Of the five prisons for which Defendants have data, all had an average five month level below 75%.[46] Statewide, Defendants were in

[46] Eyman (60%), Florence (66%), Lewis (66%), Perryville (74%), Tucson (46%).

compliance only one of five months, April.[47] After April, compliance plummeted at multiple institutions. This may be due to the severe and chronic understaffing of mental health positions. At Florence, Ms. Newman informed us that the Mental Health Director position has been vacant for approximately six months; one psychiatrist and one psych NP position are also vacant. At Lewis, we were told that the Mental Health Director, two psych associate, and one psychologist position were all vacant, the latter for approximately ten months. *See* Appendix A, page 36 for a detailed summary of each prison's performance for each month.



While at Florence, we spot-checked some of the records reviewed for the finding in the June CGAR that 13 out of 20 (65%) files were in compliance. ADCM120802. In fact, while below the 75% threshold, this finding overestimated compliance. At least two of the 13 prisoners listed as compliant had no individual or group sessions on or near the date listed in the CGAR. We did not review all 13 of the allegedly compliant files, but this mistake lowers the rate of compliance for June to be no better than 55%, and lowers Florence's five-month average to 64%.

Stipulation Measure # 93 (Mental Health # 21) (MH-3 and above in max custody seen by mental health staff at least weekly in rounds). Defendants are substantially noncompliant for this performance measure. Again, Defendants' compliance with this performance measure is erratic, as monthly statewide compliance at some priosns has ranged from 7% to 93%. Four of the five prisons for which Defendants have data have a five-month average performance level that is noncompliant. *See* Appendix A, page 37 for a detailed summary of each prison's performance for each month.

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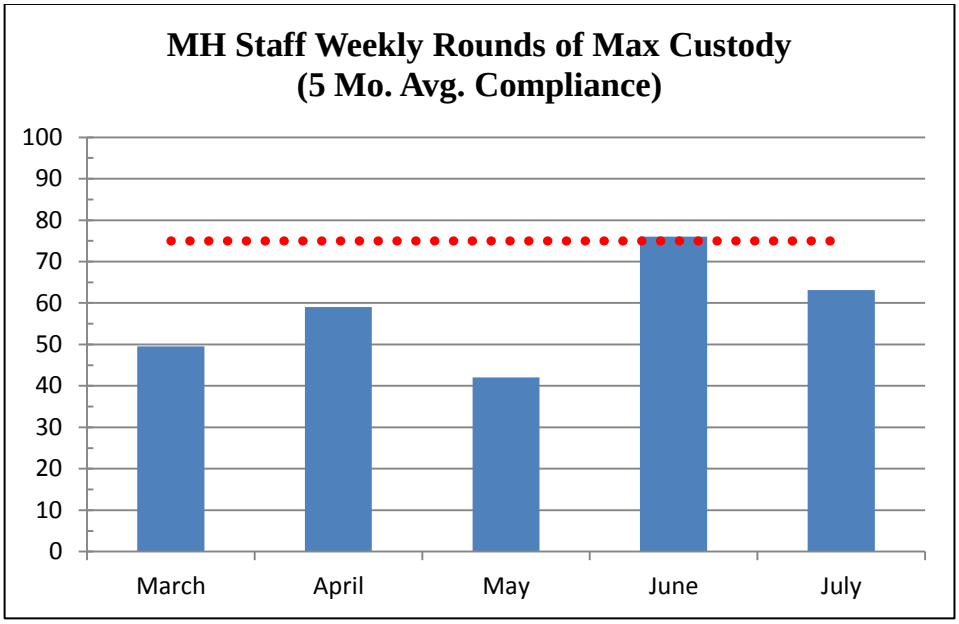
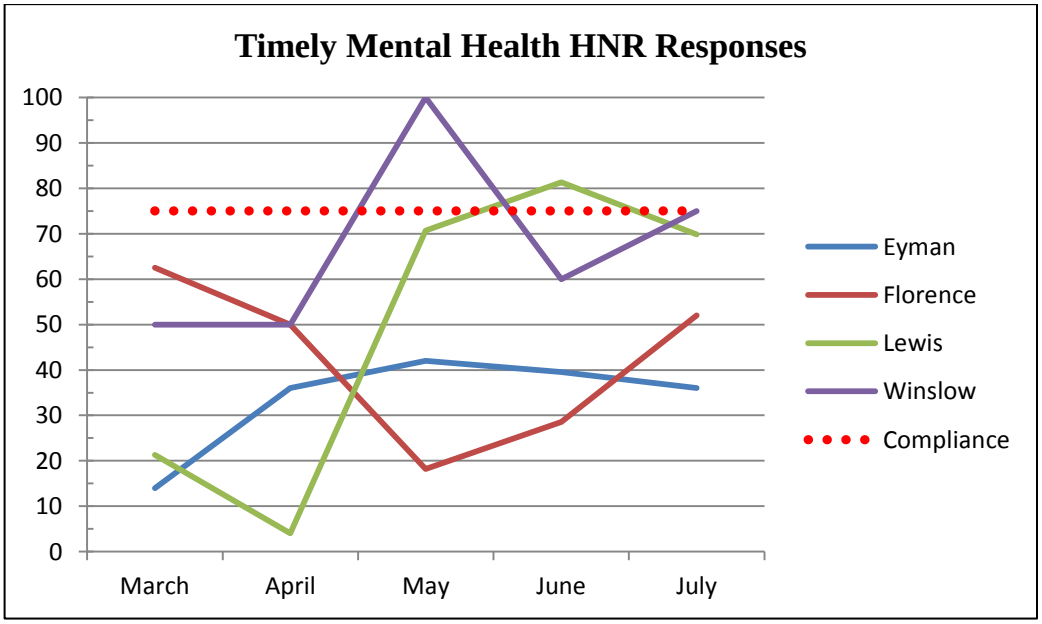
[47] March (62%), April (90%), May (51%), June (54%), July (64%).



Stipulation Measure # 98 (Mental Health # 26) (Mental health HNRs responded to within the timeframes of the Mental Health Technical Manual). Defendants are substantially noncompliant for this performance measure, and again this is a measure for which there has been no sustained compliance. Four institutions have five month average compliance levels below 75%; three of them are below 50%.[48] Furthermore, as discussed above at pages 8-9, Defendants are not monitoring this measure using the various timeframe requirements in the MHTM. *See* Appendix A, page 37 for a detailed summary of each prison's performance for each month.



[48] Eyman (34%), Florence (42%), Lewis (49%), Winslow (67%).

B. Pharmacy/Medication Administration

The importance of a functional medication administration system in correctional facilities was explained by Dr. Todd Wilcox: "Prescribed medications must be provided to patients in a timely, consistent manner. Medications must be renewed regularly and without interruption, and prisoners must be able to transfer housing locations without medication interruptions. The system must ensure appropriate monitoring of efficacy and side effects." Wilcox 11/8/13 Expert Report [Dkt. 1104-1] at 69.

Defendants have multiple problematic pharmacy practices that interfere with their ability to comply with performance measures. First, the institutions struggle with safely maintaining medications. *See, e.g.*, Lewis July 2015 CQI meeting minutes at ADCM121113-14 (Bachman Unit narcotics cabinet is not locked, so they use a locked file cabinet; Barchey Unit clinic has no air conditioning, they are using a swamp cooler with household extension cord, which puts the temperature of medications at risk; Morey Unit clinic has no hot water in nursing office and no biohazard container in provider office); Lewis June 2015 CQI minutes at ADCM121074 (16 insulin bottles opened and not dated;[49] medication improperly stored (medication requiring a temperature range of 68-77 degrees stored in refrigerator); records of shift counts and narcotic counts are missing or incorrect; incomplete temperature logs; loose tablets in the drawers of medication carts).

Second, the distribution of medication via pill lines or cell-front is extremely erratic, which is problematic when medications need to be taken on a set time frame, i.e. every 12 hours or every 8 hours.[50] We reviewed Medication Administration Records that showed the delivery of the evening medication to Rast close custody could occur any time between 2 pm and midnight from one day to the next. *See, e.g.* ADCM091349-53. The administration of insulin at many yards is not timed to occur at the same time as meals, or the morning and evening shots are only 9 or 10 hours apart, forcing prisoners to go 14 hours through the evening and overnight with no insulin. *See also* Lewis July 2015 CQI meeting minutes at ADCM121116 (prison is struggling with medication watch/swallow being done timely and completely, and "discussion will address the CO's responsibility as it relates to watch/swallow."). It is unclear if the cause of the erratic distribution is rooted in an inadequate number of LPN positions allocated for medication distribution. It may also be caused by the sheer number of medications that have to be distributed: multiple prisoners reported that many medications that have no narcotic, abuse, or other value, and that had always been keep-on-person, have in the past six to 12 months been made watch-swallow. This includes medications such as Coumadin, high blood pressure, dementia and HIV medications. As a result, the waits at pill windows can be inordinately long, which disproportionately affects prisoners with heat sensitivity or mobility impairments, and prisoners have to leave the line and do not receive their medications. At Florence, several prisoners on East Yard told us that the pill line is shut down one hour after it begins, and the prisoners still waiting for their medications are sent away. If they stay because they want their medications, they have to accept a ticket for being late to pill call, in exchange for getting their medication. We asked the Director of Nursing about this and she denied knowing of any such practice.

[49] This failure to properly label and maintain insulin containers is especially disturbing in light of Lewis's history of two separate incidents where medical staff improperly administered insulin, exposing more than a hundred diabetic prisoners to the risk of infectious diseases.

[50] During our tours of Florence and Lewis, the Florence-East unit was the only one where staff reported running a pill line three times a day.

Third, prisoners on multiple yards at Florence and Lewis also reported that if they are being sent off-site for specialty care, they will not be provided their morning medications prior to leaving the institution. This forces prisoners into an untenable double bind, especially when the medications are critical life-sustaining prescriptions for conditions such as cancer, diabetes, and HIV: either they forego their medication and put themselves at risk of harm, so that they can see the specialist, or they decline the specialist appointment so that they can have their medication, and deprive themselves of the right to receive needed specialty treatment, and are labeled as "refusing" the specialty care.

Finally, as detailed below in the discussion of the Pharmacy # 3 performance measure (chronic disease and psychiatric medication refills without interruption), Defendants are out of compliance with this measure, in part because Corizon's system for refilling medication is convoluted and antiquated. During the negotiations of the Stipulation, we sought to include a requirement that the refill (not the renewal) of long-term chronic care and psychotropic medications be done via an auto-refill system similar to that used in many other correctional settings, and that is ubiquitous in community pharmacies. Defendants rejected that proposal, without explanation. During our tours at four different prisons, we spoke to nurses at various yard clinics who reported that anywhere between a third to a half of all HNRs received and triaged are prisoners requesting refills of medication, and that dealing with these HNRs and processing refills occupies a great deal of nurses' time. Numerous prisoners reported, and their medical records show, that every month they experience gaps in receiving a refill of their medication, whether it be KOP or watch-swallow medications. We reiterate our position that an automated refill system should be put in place. It would likely help Defendants come into compliance with that measure, not to mention reduce the workload of nursing staff and ensure that prisoners with chronic medical conditions or mental illness are not put at risk of harm due to gaps in the provision of their medication.

Stipulation Measure # 11 (Pharmacy # 1) (newly prescribed formulary medications will be provided within 2 business days, or the same day if prescribed STAT). Defendants are substantially noncompliant for this performance measure. For every month but July, the statewide average was below 75%. Four prisons were noncompliant every month.[51] Two additional prisons had a five month average compliance rate below 75%.[52] *See* Appendix A, page 38 for a detailed summary of each prison's performance for each month. *See also* Florence July 2015 CQI meeting minutes at ADCM121035 (pharmacy representative at the meeting stated that she had concerns with PRN ("as needed") medications, "[w]hen an RX is written PRN and is the initial RX she is not receiving the full supply. Example: RX written for TID [three times a day] and only receiving 30 pills instead of the 45 pills.").

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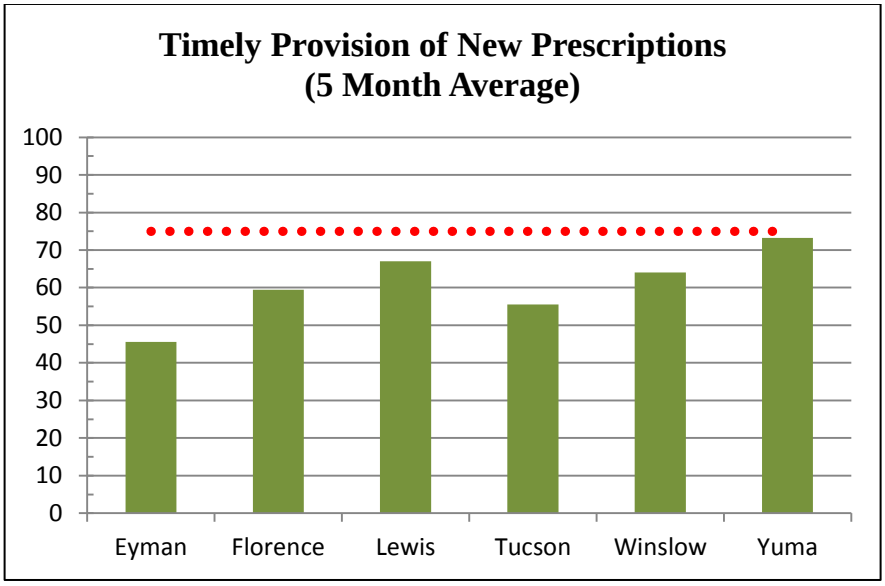
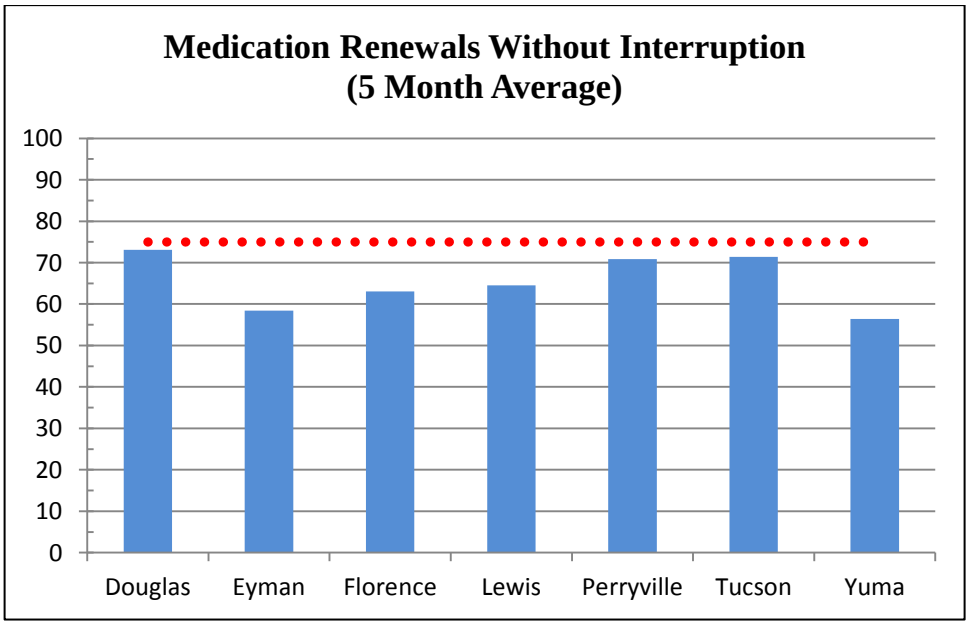
[51] Eyman (46%), Florence (59%), Lewis (67%), Tucson (56%)
[52] Winslow (64%), Yuma (73%)



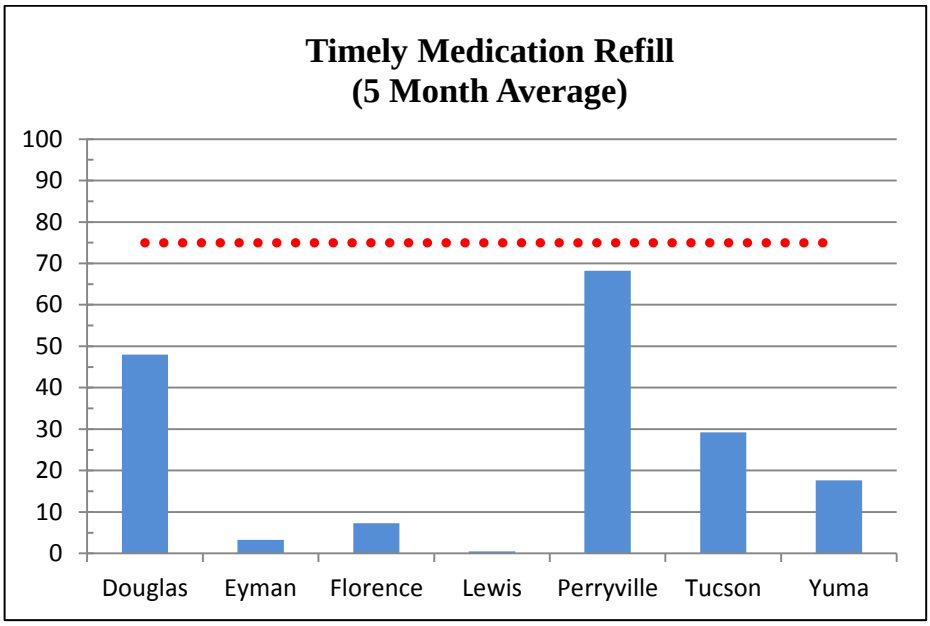
Stipulation Measure # 13 (Pharmacy # 2) (Chronic care and psychotropic medication renewals will be completed in a manner such that there is no interruption or lapse in medication). Defendants are substantially noncompliant for this performance measure. The delays in renewals is not surprising, given the noncompliance identified for timely provider and psychiatrist appointments (See pages ___ above). As shown below, seven out of the 10 prisons had an average rate of compliance over the five months that was less than 75%.[53] *See* Appendix A, page 38 for a detailed summary of each prison's performance for each month.



[53] Douglas (73%); Eyman (58%); Florence (63%); Lewis (65%); Perryville (71%); Tucson (71%); Yuma (56%)

Stipulation Measure # 14 (Pharmacy # 3) (Refills requested between 3 and 7 business days prior to running out will be refilled so there is no interruption or lapse). Defendants are substantially noncompliant for this measure. Defendants' performance across the state has been abysmal every month. Four out of five of the months, the statewide average compliance rate was less than 50%, with the fifth month at 56%.[54] Seven out of 10 prisons are noncompliant.[55] There are three prisons that have an average compliance rate over the past five months that is in the single digits.[56]

Lewis prison has never had a single month above zero percent (0%), in part apparently due to the institution's inability to maintain accurate pharmacy records. *See, e.g.* ADCM120864 (Lewis June CGAR); *see also* ADC056688 (Florence May CGAR). The Florence pharmacy representative reported to the CQI team at the July 2015 CQI meeting that she "has been very diligent in cleaning up 'Past Due Refills' she has gone from 52 pages last month to 7 pages." ADCM121035. Nonetheless, any improvement is marginal, as Florence's June compliance rate was 2%, and in July it was 14%. *See* Appendix A, page 39 for a detailed summary of each prison's performance for each month.



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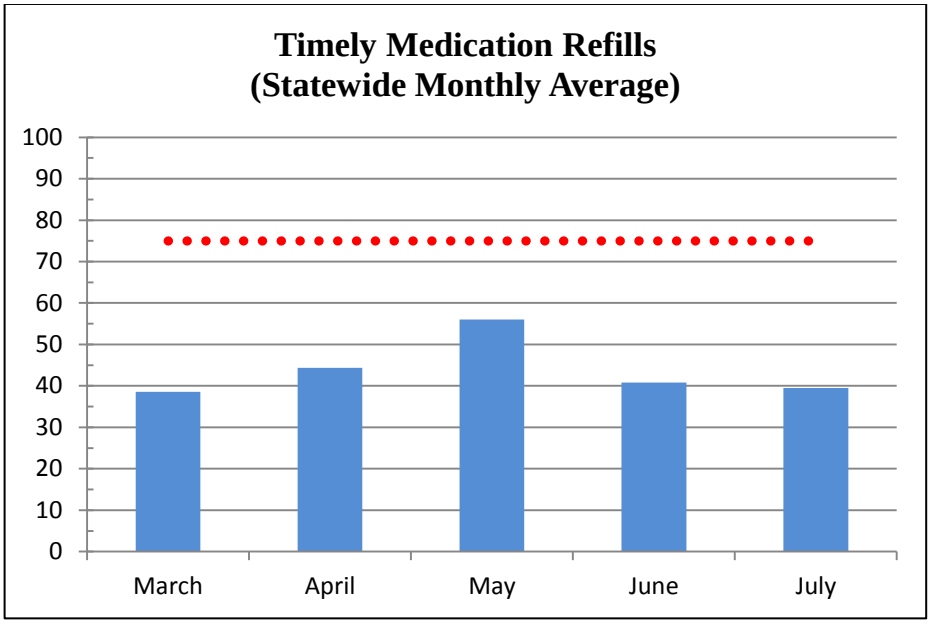
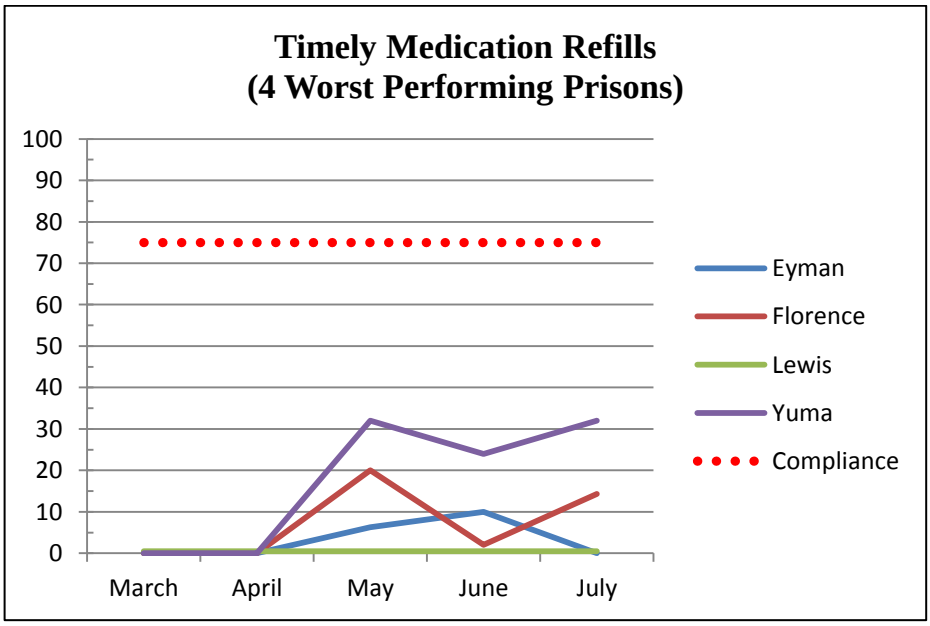
[54] March (39%); April (44%); May (56%); June (41%); July (39%)

[55] Douglas (48%); Eyman (3%), Florence (7%); Lewis (0%); Perryville (68%); Tucson (29%); Yuma (18%).

[56] Eyman (3%), Florence (7%); Lewis (0%)



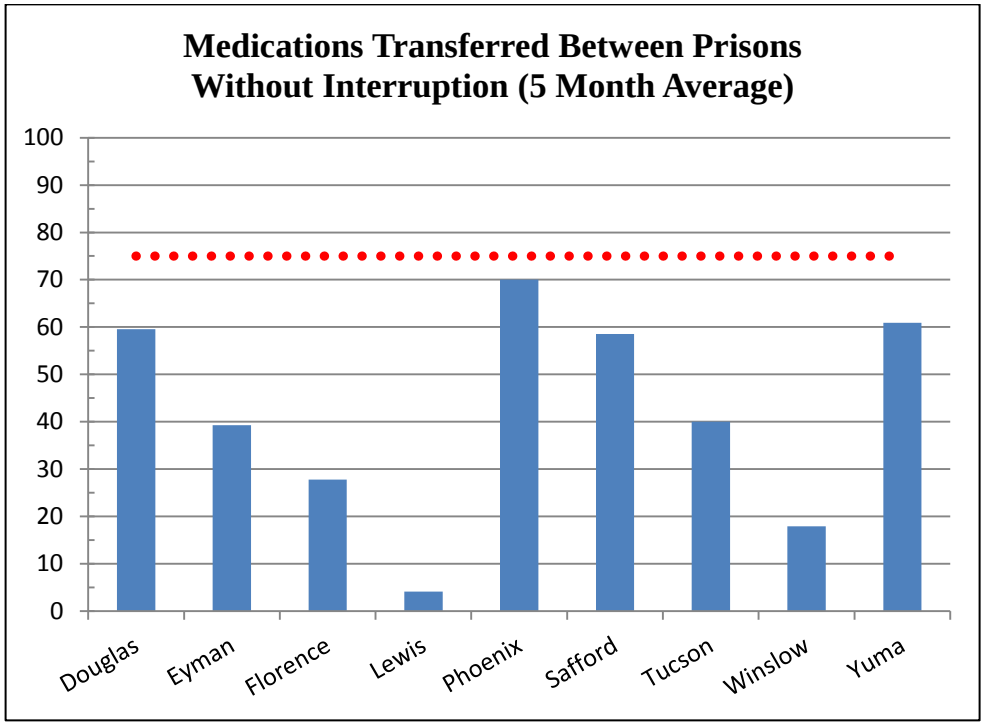


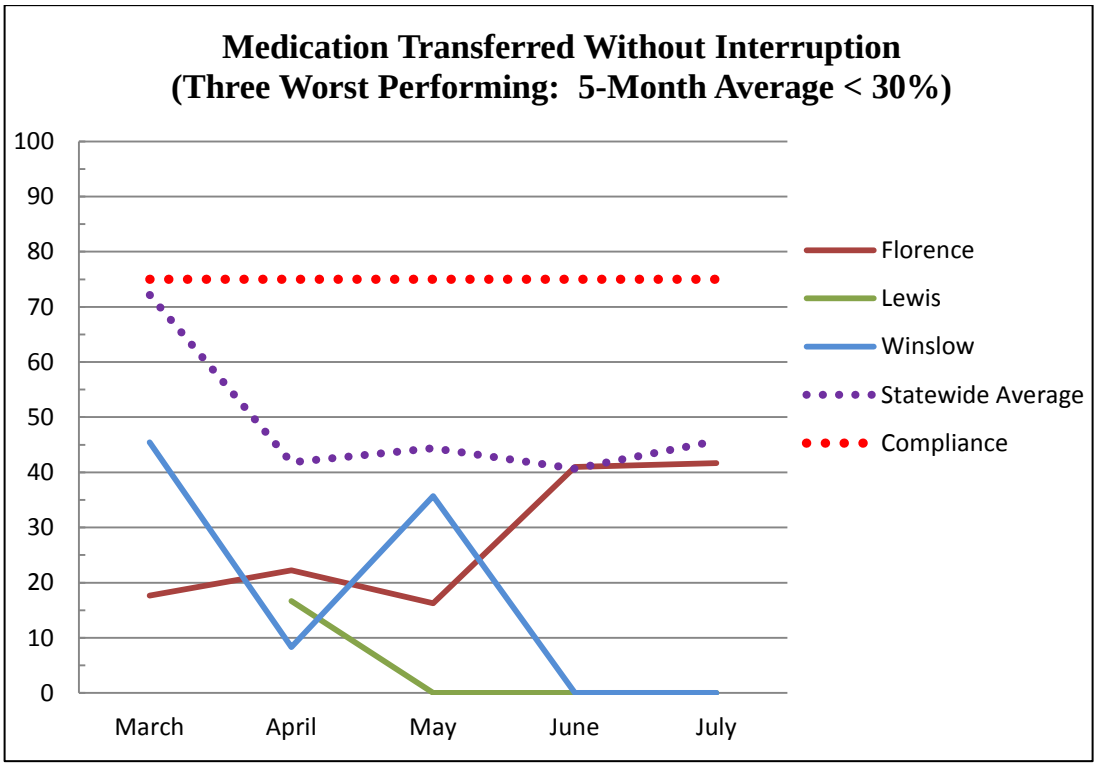
Stipulation Measure # 35 (Access to Care # 10) (All medications will be transferred with inmate and provided at receiving prison without interruption). Defendants are substantially noncompliant for this performance measure. Defendants' performance was abysmal. Nine of the 10 prisons were below the compliance level for the five months;[57] and five prisons averaged less than 40% for the five months (three prisons had a five-month average of less than 30%).[58] Two prisons (Lewis and Winslow) had multiple

[57] This measure is not applicable to Perryville except when women are moved to or from Phoenix for inpatient mental health care.

[58] Eyman (39%); Florence (28%); Lewis (4%); Tucson (40%); Winslow (18%).

months with a compliance level of zero. For four months, the statewide average compliance was less than 50%. *See* Appendix A, page 39 for a detailed summary of each prison's performance for each month.



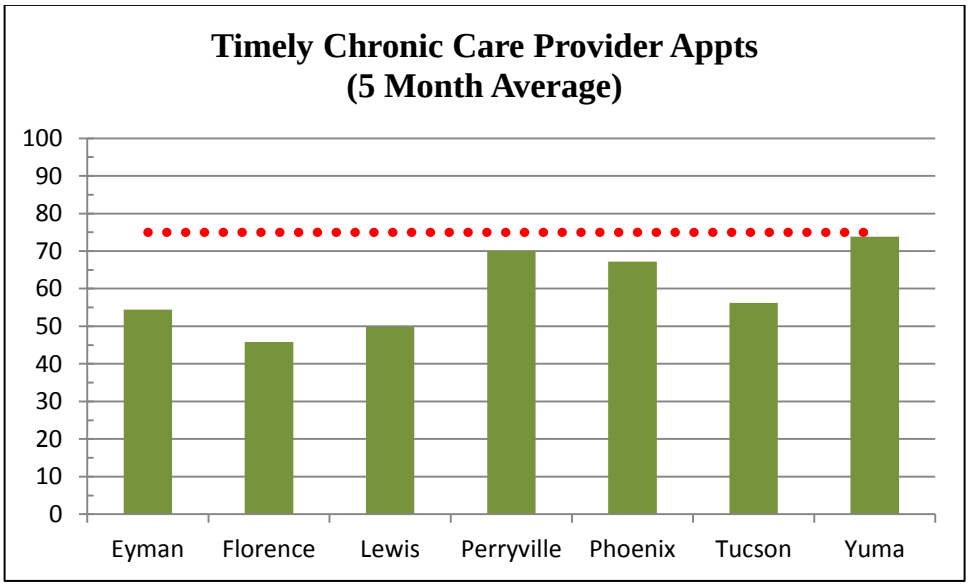


C. Chronic Disease Management

Dr. Wilcox explained the importance of a functional chronic disease management system in his expert report. "Chronic care clinics are a major focus of healthcare in any correctional setting. Preventive care is essential with chronic care patients; it is impossible to provide community standard of care without regularly scheduled appointments that allow providers to track the progress of these patients and ensure appropriate treatment modification are made." *See* Wilcox 11/8/13 report at 32.

Stipulation Measure # 54 (Chronic Care # 2) (chronic disease inmates seen by provider as specified, no less than every 180 days). Defendants are substantially noncompliant for this performance measure. Seven of the ten prisons' average compliance level for the five months was less than 75%, and four prisons averaged below 60% and did not have a single month where it reached the compliance level.[59] Each month, the statewide average compliance level was at 70% or lower. *See* Appendix A, page 40 for a detailed summary of each prison's performance for each month.

Additionally, the Mortality Review for a Lewis prisoner who died [redacted] notes that he had co-existing conditions of uncontrolled diabetes, hyperlipidemia, and HCV. ADC Medical Program Administrator Dr. Rowe wrote in his 7/28/15 review that "Chronic care for patients with diabetes should be more timely and frequent especially when not controlled." ADCM120633-36.



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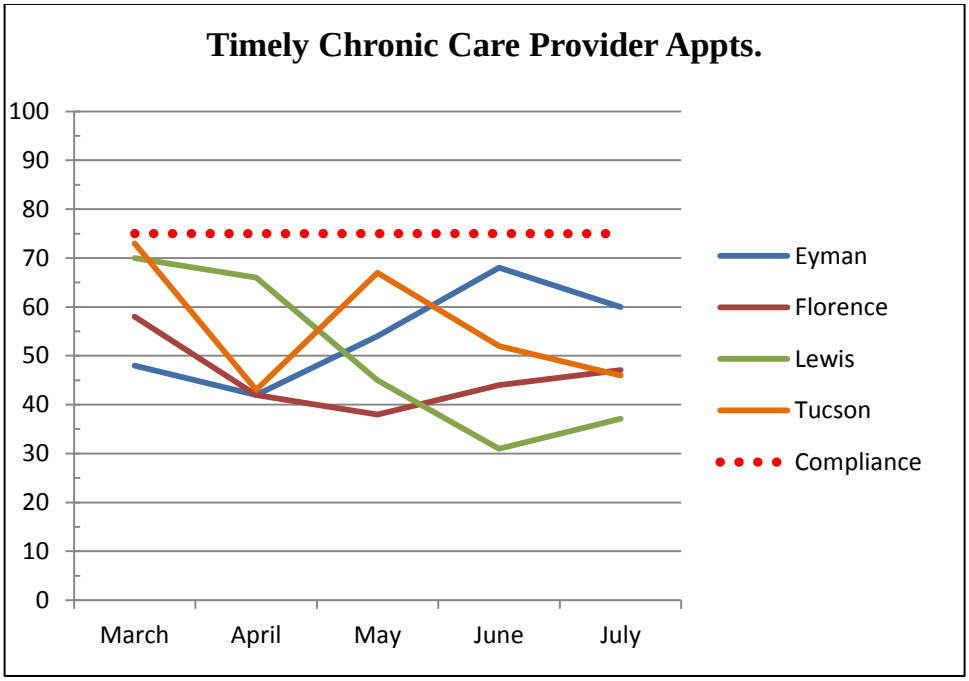
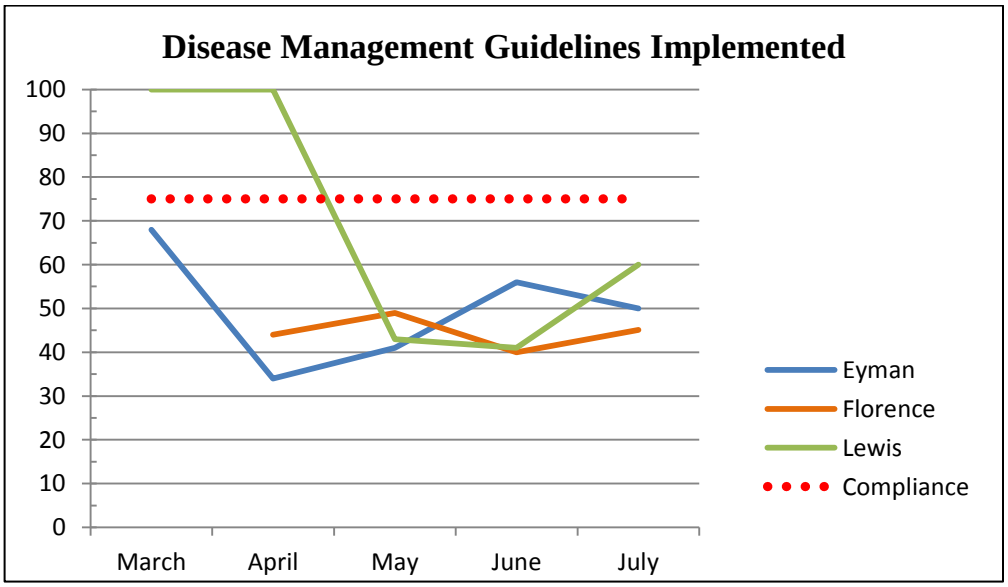
[59] Eyman (54%); Florence (46%); Lewis (50%); Perryville (70%); Phoenix (67%); Tucson (56%); Yuma (74%).



Stipulation Measure # 55 (Chronic Care # 3) (Disease management guidelines implemented for chronic diseases). Defendants are substantially noncompliant for this measure. Four prisons (Eyman, Florence, Lewis, Winslow) had multiple months of noncompliance, with Florence in particular never getting above 50% compliance in a single month. (Florence reported no data in March). See Appendix A, page 40 for a detailed summary of each prison's performance for each month.



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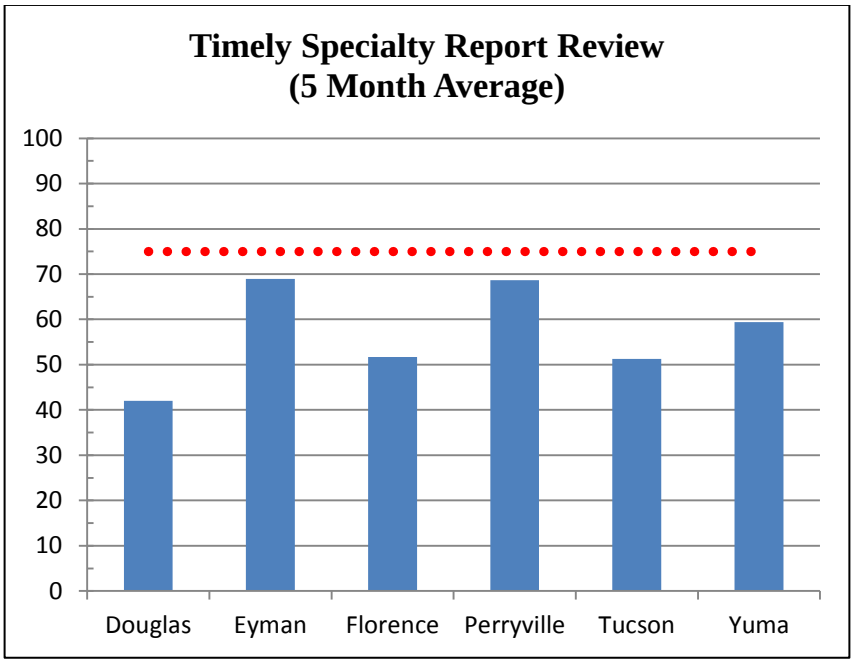
D. Specialty Care

Dr. Wilcox explained the importance of a functional system to refer patients to specialists when the person's needs are outside the primary care provider's expertise. "The exercise of professional judgment sometimes requires more in-depth knowledge than primary care providers possess. In these cases, the provider must be able to refer patients for specialty consultations." Wilcox report at 55. And when the prisoner has finally been able to see the specialist,[60] the provider must review the results of any tests performed by the specialist, and implement the specialist's recommendations in a timely manner.

Stipulation Measure # 52 (Specialty Care # 5) (specialty consultation reports reviewed and acted upon by provider within 7 days of receipt of the report). Defendants are substantially noncompliant for this performance measure. Six prisons have a five-month average performance rate below 75%; four are below 60%.[61] For four out of the five months, statewide compliance was below 75%.[62] *See* Appendix A, page 41 for a detailed summary of each prison's performance for each month.



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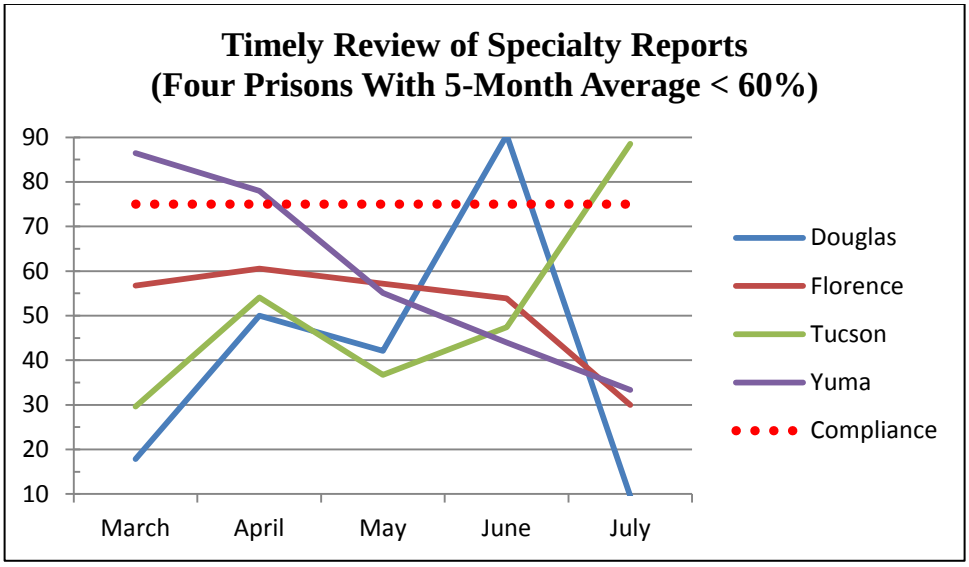
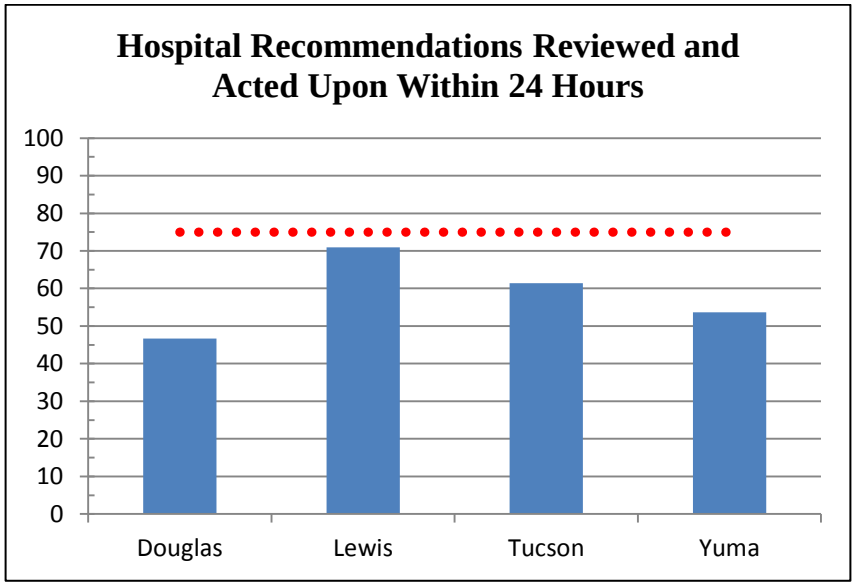
[60] See pages 9-10 above regarding the inaccuracy of performance measures dealing with the denial of a provider's request for specialty care. (Specialty Care # 1 and # 2).

[61] Douglas (42%); Eyman (69%); Florence (52%); Perryville (69%); Tucson (51%); Yuma (59%).

[62] March (67%); April (78%); May (71%); June (72%); July (56%).



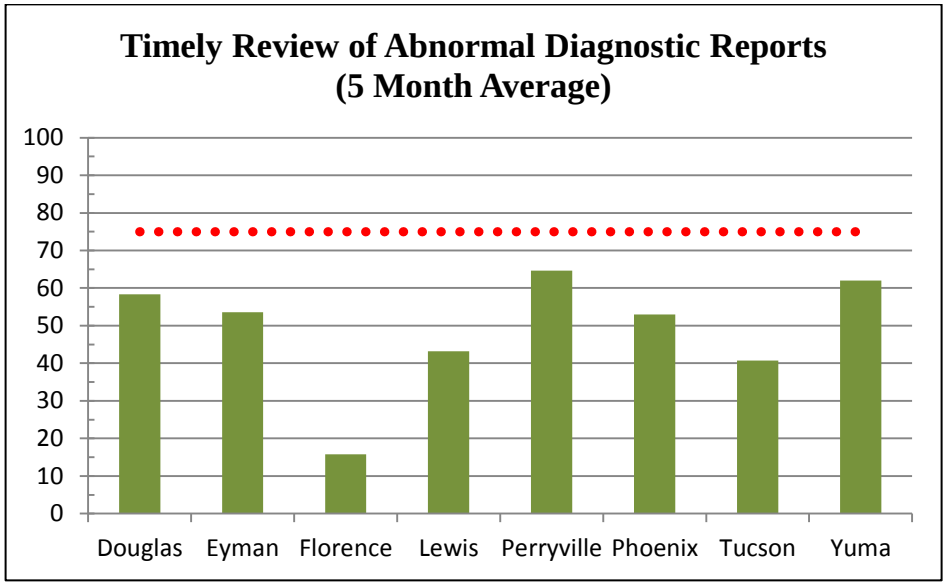
Stipulation Measure #44 (Access to Care # 9) (Hospital discharge instructions are reviewed and acted upon by provider within 24 hours). Defendants are substantially noncompliant for this performance measure. Four prisons have a five-month average performance rate below the compliance level.[63] *See* Appendix A, page 41 for a detailed summary of each prison's performance for each month.



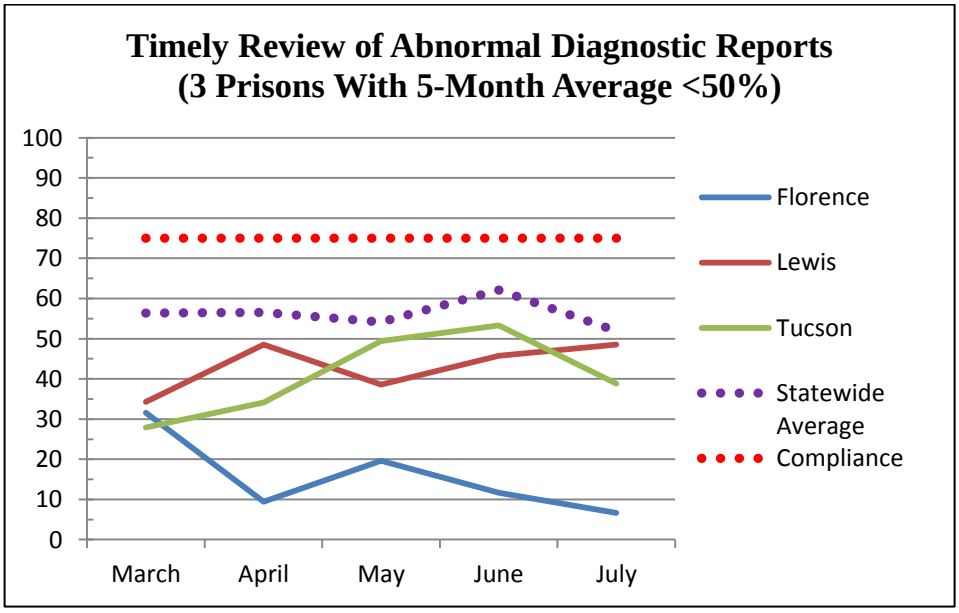
Stipulation Measure # 46 (Specialty Care # 7) (provider will review and act on abnormal values in diagnostic or pathology reports within 5 days of receipt). Defendants are substantially noncompliant for this measure. Eight of the 10 prisons have five-month average performance levels that are less than 75%,

[63] Douglas (47%); Lewis (71%); Tucson (61%); Yuma (54%)

six of them are below 60% and three are less than 50%.[64] For every month but one, the statewide average was below 60%.[65] *See* Appendix A, page 42 for a detailed summary.



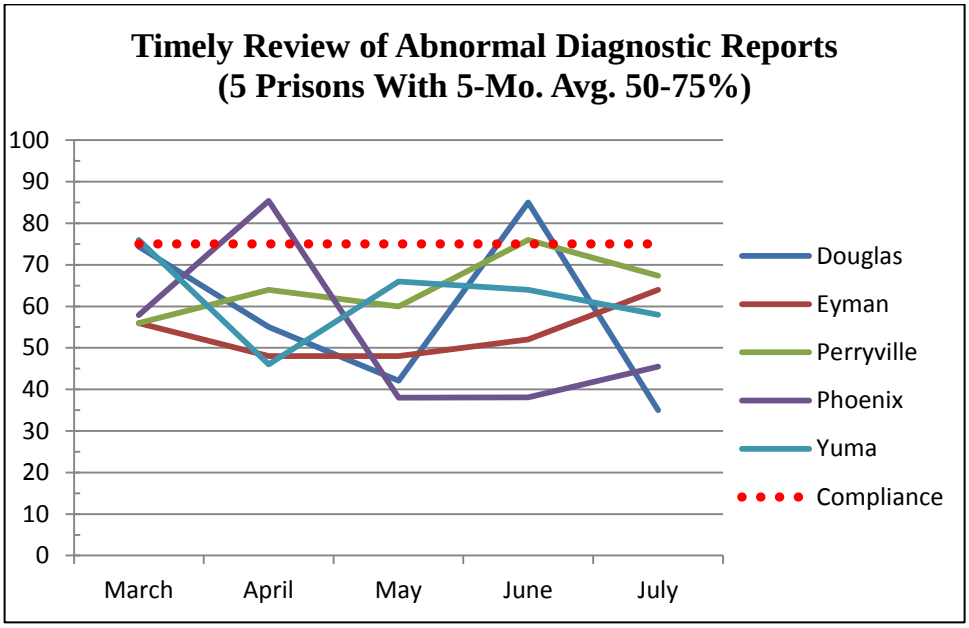
The monthly performance of the three prisons with a five-month average compliance level of less than 50% is shown below:



[64] Douglas (58%); Eyman (54%); Florence (16%); Lewis (43%); Perryville (65%); Phoenix (53%); Tucson (41%); Yuma (62%).

[65] March (56%); April (57%); May (54%); June (62%); July (52%). The five month average statewide level of compliance was 56%.

The monthly performance of the five prisons with a five-month average compliance level between 50 and 75% is shown below:



Thank you for your attention to this matter. We look forward to the opportunity to work productively with ADC to find a way to resolve these problems. We ask that you advise us of your availability the week of November 9, 2015 to discuss this Notice.

Sincerely yours,

/s/ Corene Kendrick

Corene Kendrick, Staff Attorney

cc: Counsel of Record
Mr. Brad Keogh, ADC General Counsel