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UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF CALIFORNIA

DARRYL DUNSMORE, ANDREE ANDRADE, ERNEST ARCHULETA, JAMES CLARK, ANTHONY EDWARDS, REANNA LEVY, JOSUE LOPEZ, CHRISTOPHER NORWOOD, JESSE OLIVARES, GUSTAVO SEPULVEDA, MICHAEL TAYLOR, and LAURA ZOERNER, on behalf of themselves and all others similarly situated,

Plaintiffs,

v.

SAN DIEGO COUNTY SHERIFF'S DEPARTMENT, COUNTY OF SAN DIEGO, SAN DIEGO COUNTY PROBATION DEPARTMENT, and DOES 1 to 20, inclusive,

Defendants.

Case No. 3:20-cv-00406-AJB-DDL

REBUTTAL EXPERT REPORT OF JAY SHULMAN

Judge: Hon. Anthony J. Battaglia
Magistrate: Hon. David D. Leshner

Trial Date: None Set

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I. BACKGROUND

1. I have been asked by Plaintiff's Counsel to prepare this Rebuttal Expert Report. Specifically, I was asked to review and analyze the opinions and conclusions expressed in the August 21, 2024 Expert Report of Dr. Scott Reinecke (hereinafter, "Reinecke Report") to decide if the Reinecke Report caused a change in my opinions and conclusions and to provide a response to the Reinecke Report. A list of all documents that I reviewed and relied on to draft this Rebuttal Expert Report and that are not listed in my initial report is attached hereto as **Exhibit A**.

2. I have reviewed and analyzed the Reinecke Report, and it does not change any of the opinions that I expressed in my initial report dated August 20, 2024 (hereinafter, "Shulman Report"). In the Shulman Report, I opined that the consistently inadequate dental care documented in the records I reviewed is attributable to systemic problems caused by inadequate dentist staffing and inadequate policies and procedures in San Diego County's dental care program as administered by NaphCare. Specifically, San Diego County's and NaphCare's policies and practices show lack of routine care and inadequate diagnosis and treatment of dental conditions, all of which combine into a system that fails to adequately identify, or properly and timely treat, dental issues experienced by incarcerated people, the plaintiff class in this case. San Diego's and NaphCare's policies on these issues are in many cases themselves below the standard of care. These failures place all incarcerated people at risk not only of preventable pain, but also of advanced tooth decay, advanced periodontal disease, and unnecessary loss of teeth. The inadequacies in dental care experienced by the plaintiffs are typical of the risk of inadequate dental care for all incarcerated people. Consequently, all people incarcerated in San Diego are at risk for preventable pain and tooth morbidity.

3. As explained in more detail below, the Reinecke Report does not meaningfully rebut or alter my opinions. In fact, the records reviewed by Dr.

Reinecke, summarized in Appendix C to the Reinecke Report and in Exhibit B to this Rebuttal Report, reinforce my opinions.

4. The opinions expressed in this report are based on information that has been made available to me. Should new information become available to me in the future, I reserve the right to analyze that information and revise my opinions and/or conclusions.

II. METHODOLOGY

5. Dr. Reinecke stated that he selected for review "randomly selected dental records, taken from a pool of all relevant facilities …." Reinecke Report at 3. He described his record selection process as follows:

> A random review of 10 dental patient records from a pool of 27 was performed across all SDSO facilities. This sampling approach is likely to have yielded a reasonable representative sample, according to Dr. Jacques Baillargeon, the Director of Epidemiology and Outcomes Research in the Division of Correctional Managed Care and a Senior Epidemiologist in the Office of Biostatistics at UTMB. Consultation with an epidemiologist regarding sampling methodology is relied upon by experts.

Id. at 4.

6. As a general matter, I agree that a review of randomly selected records of incarcerated people who requested dental care across all jail facilities is an appropriate mechanism for analyzing a jail's dental program. However, the set of records that Dr. Reinecke reviewed does not, in fact, appear to be randomly selected from across all jail facilities.

7. Appendix C of the Reinecke Report lists and summarizes the 30 charts that Dr. Reinecke reviewed: 13 are from George Bailey Detention Facility; 2 are from Rock Mountain Detention Facility; 12 are from Central Jail; 2 are from Vista Detention Facility. One of the charts is marked as being from an "unknown" facility.[1] This chart selection is concerning for at least two reasons, both of which

[1] It is perplexing that he could not identify the facility from which the record was

call into doubt the quality of Dr. Reinecke's analysis.

8. First, no charts from the Jail's women's facility, Las Colinas Detention and Reentry Facility ("Las Colinas"), were reviewed. Las Colinas comprises 511 (13%) of the 3,957 incarcerated persons in custody as of August 24, 2024.[2] That women were excluded from Dr. Reinecke's "random" sample calls into question the validity of his sampling method and the reliability of any conclusions he makes based on the sample. It is hard to believe a sample that omits the one female institution can be (according to Dr. Reinecke's epidemiology consultant) "a reasonable representative sample." *Id*. at 4. I disagree that such a sample is "representative."

9. Second, Dr. Reinecke's report includes multiple inconsistent descriptions of the sampling process. In particular, the report states that "10 dental patient records from a pool of 27 was performed across all SDSO facilities," *id.* at 4, yet only 30 records are summarized in Appendix C. Given that there are 7 facilities in the Jail, it is not clear how only 30 records can represent 10 records from each facility. And, as noted above, Appendix C contains different numbers of records from each Jail facility; it does not include exactly 10 records from any individual facility. As a further example, the report described the records as having been taken from "a pool of all **relevant** facilities," *id*. at 3 (emphasis added), and, at a later point, as being from "across **all** SDSO facilities," *id*. at 4 (emphasis added). Moreover, the report uses the phrases, "random review" and "review of a random selection of dental records" (*id*. at 4); however, it also states that, "A random selection of IP [incarcerated person] charts was **requested** …." *Id*. at 2 (emphasis added). In other words, it is not clear whether Dr. Reinecke himself specified the selected since he claimed to have selected the records from "pools."

[2] San Diego Sheriff's Office Daily Population Report, Date: Saturday, August 24, 2024. Visited August 24, 2024 at San Diego County Sheriff's Office (sdsheriff.net).

randomization process for selecting charts, or whether he relied on others to do the selection.

10. As described in the Shulman Report (at ¶¶ 52-53), I was denied the charts I selected and was instead forced to accept Defendants' representation that the charts provided to me were in fact randomly selected. In addition, I did not receive access to the charts that Dr. Reinecke reviewed until September 20, 2024. Since receiving them, I have worked diligently to review all these charts to meet the November 1 rebuttal report deadline.

11. In summary, Dr. Reinecke's sample was inadequate because it omitted women and because of inconsistencies in the description of the sampling process. These methodological flaws make me skeptical of Dr. Reinecke's conclusions and undermine the value of his opinions.

III. STAFFING

12. As I stated in my report, the February 2024 NaphCare staffing matrix included 40 dentist hours per week which yields an approximate incarcerated person-to-dentist ratio of 3,936:1. Shulman Report at ¶¶ 182-183. In addition, the staffing matrix included 40 dental assistant hours and 80 dental hygienist hours per week. *Id*. However, other "documents suggest that the Jail is staffed by somewhere between 1.0 FTE and 2.0 FTE dentists, though that number is still well below optimal staffing estimates," which would yield a ratio of 1,968:1—which is approximately half the dentist optimal staffing discussed in my report. *Id*. at ¶ 184. So, even after the implementation of the February 2024 staffing matrix, the number of dentists at the Jail is insufficient.

13. Nothing in the Reinecke Report changes my conclusions regarding the insufficiency of dentist staffing at the Jail.

14. Although Dr. Reinecke opines that the Jail's dental staffing is adequate, that opinion is unsupported because the Reinecke Report fails to address the number of *full-time equivalent* dentists at the Jail. Rather, the Reinecke Report discusses

only the number of individual dentists who work at the Jail. But it is immaterial whether there are four individual dentists working at the Jail if, for example, each of those four people only works one day per week. In that case, those four people would still constitute less than 1.0 FTE dentist.

15. In addition, although Dr. Reinecke opines that "[t]he existing ratio of dentist to patients is not significantly different than what is common in the community at large," he neither states the current Jail ratio nor that of the community at large. Reinecke Report at 5. Further, he fails to explain why comparing these two ratios is relevant to this litigation since the SDSO is not responsible for providing dental care to the community at large.

16. Finally, I have little faith in Dr. Reinecke's opinion about staffing because his tally of the number of dentists at the Jail is confusing and is contradicted by other evidence I reviewed. According to Dr. Reinecke, "[a]t the time of [his] visit" to the Jail on March 27 and 28, 2024, "there were four total dentists." *Id.* at 1. The Reinecke Report also states that, "[c]urrently"—which I assume to mean as of the August 21, 2024 date of the report—"there are four total dentist[s], including two new hires." *Id.* at 3. I assume that these "new hires" must therefore have been added to the roster before Dr. Reinecke's March 2024 visit. However, as of the June 7, 2024 Rule 30(b)(6) deposition of NaphCare, there were only two dentists employed at the Jail. Nix II Tr. at 52:5-17. These contradictions are concerning, and Dr. Reinecke does not identify any document or contract addendum indicating that more dentists have formally been added.

17. Even taking the Reinecke Report's estimation of the number of dentists at face value (four dentists, two dental assistants, two dental hygienists), I am further concerned by its discussion of dental support staff. Dr. Reinecke reports that "[t]wo more hygienist positions are being added and NaphCare is evaluating the need for two additional assistants, as well." Reinecke Report at 3. If it is correct that there are more dentists than dental assistants working at the Jail, then the two new dentists

will be working without dental assistants. A dentist working without an assistant can accomplish little, as Dr. Reinecke's own chart summaries illustrate. For example, Dr. Reinecke noted:

> [redacted] [Patient 17] was seen on [redacted]/24 by Dr. Polanco via intake ferral with a CC of "My fi ng came out." Tooth #19 was reported have a missing filling on the buccal surface. The dental [redacted] not report to work on this day, so Dr. Polanco s duled for a filling on tooth #19. He was released on [redacted]/24.

Id. at 100. The Shulman Report similarly noted multiple examples of care being delayed because a dentist was working without a dental assistant. *See, e.g.*, Exhibit C to Shulman Report at ¶¶ 30, 94, 189.

18. Regarding dental hygienists: As I stated in my report, having a staffing matrix with one FTE dentist and two FTE dental hygienists is not reasonable because the hygienists will not materially improve incarcerated people's access to urgent care—the most critical deficiency of the Jail's dental program. Shulman Report at ¶ 188. "Simply put, a staffing plan that has twice as many dental hygienists as dentists makes no sense." *Id*. Even with two FTE dentists, the addition of two dental hygienists does not materially improve access to **urgent care**—the most glaring deficiency in the Jail's dental program.

19. Critically, as explained in the Shulman Report, a dental hygienist's role is much more limited than that of a dentist; a hygienist may, *e.g.*, take x-rays or treat patients *only* if a patient has already been examined by a dentist in the practice; that is, if the patient is a "patient of record."[3] Exhibit D to Shulman Report at ¶¶ 33-34. The Shulman Report identified at least one example of a dental hygienist operating outside the scope of practice by ordering an x-ray and making a diagnosis, without apparent supervision by a dentist. *See* Exhibit C to Shulman Report at ¶ 272 (describing care of Freddy Tyson). The Reinecke Report includes many more such

[3] A patient who has been examined, has had a medical and dental history completed and evaluated, and has had oral conditions diagnosed and a written plan developed by the licensed dentist.

examples, leading me to believe that the Jail is using dental hygienists as cheap substitutes for dentists; allowing them to take x-rays, perform examinations, and treat patients **before the patients have been examined or screened by a dentist**. This apparent practice of using dental hygienists in lieu of dentists falls gravely below the standard of care and, in my opinion, would warrant reporting to the California Dental Hygiene Board.

20. Examples from the Reinecke Report of dental hygienists examining and treating patients before they have been seen by a dentist—a practice upon which Dr. Reinecke did not comment—include:

21. [redacted] submitted several requests to have a toothache treated starting on [redacted], 2024 and was seen by a dental hygienist on [redacted] 2024 who performed a gross scaling and took a panograph. Reinecke Report at 97.

22. [redacted] submitted a sick call request ("Broken tooth hurts") [redacted], 2024 and again on [redacted], 2024. *Id*. at 100-101. He was scheduled for a screening by the dental hygienist on [redacted] 2024 which he is documented as having refused. *Id*.

23. [redacted] submitted a sick call request for a painful tooth on [redacted], 2024 and was seen by a dental hygienist (date not provided) who took a panograph x-ray. *Id*. at 101-102.

24. [redacted] submitted a health care request for a "[c]hipped molar" on [redacted] 2023 and was seen by nursing on the next day, was given an analgesic, and had a dental appointment scheduled. *Id*. at 102. He submitted another request on [redacted], 2023 ("Back molar hurts") and was seen again by nursing and was again provided with analgesics. *Id*. He submitted health care requests stating the same problem on [redacted], 2023, [redacted], 2023 and was scheduled to see the dentist. *Id*. He was seen by a dental hygienist on [redacted], 2024 who examined him, took a panograph, and began a debridement. *Id*. at 102.

25. These record reviews show that the Jail has a practice of allowing dental hygienists to practice outside their scope of practice as approved by the California Dental Hygiene Board, encouraging them engage in unprofessional conduct. It is surprising that this egregious practice escaped Dr. Reinecke's comment.

26. In sum, nothing in the Reinecke Report changes my opinion that dental staffing at the Jail is inadequate. And, as explained in more detail below, the charts that Dr. Reinecke reviewed reveal extensive wait times for care, which is difficult to reconcile with Dr. Reinecke's opinion that staffing at the Jail is adequate.

IV. CHART REVIEWS AND ACCESS TO CARE

27. While a staffing ratio is one metric to assess the adequacy of a dental program, the most important metric is access to and timeliness of care. As explained in detail in the Shulman Report, the Jail's dental program fails to provide timely urgent care to incarcerated people, subjecting them to avoidable pain and tooth loss and morbidity.

28. As I stated in my report, access to both urgent and routine care is inadequate. Shulman Report at ¶ ¶ 77, 120. Dr. Reinecke disagreed, stating:

> I reviewed the sick call process, timeframe to be seen for all priorities of need, emergency care, referral process and services, and patient education offered. Dental needs identified that required referral to an off-site specialty provider were documented and scheduled in a timely manner.

Reinecke Report at 3.

29. This opinion is unsupported and unpersuasive for multiple reasons. First, the Reinecke Report does not provide any definition of timely care as I do in the Shulman Report.[4]

30. Second, the Reinecke Report does not explicitly compute wait times for urgent care of any of the charts reviewed, although it notes that, "[there were]

[4] *See* Shulman Report ¶¶ 79, 108-111.

inherent time gaps of approximately 5 to 65 days between triage/screening and definitive diagnosis and/or treatment." Reinecke Report at 4. This statement, on its own, highlights the scope of the urgent care problem at the Jail. A 65-day "time gap[]" in providing treatment should be concerning to any dentist, not merely written off as an "inherent" delay.

31. Third, with respect to off-site specialty providers, the Reinecke Report focuses only on whether referrals are "scheduled in a timely manner," not whether treatment is actually provided in a timely manner. Indeed, the charts Dr. Reinecke reviewed include multiple examples in which treatment was not given for an extended period of time after the referral was placed. As just one example, [redacted] did not receive extractions for 69 days after Dr. Patel initiated a request for an offsite referral. *See* Exhibit B at ¶¶ 21-39.

32. Finally, in determining timeliness, the Reinecke Report does not appear to distinguish between evaluations by a nurse as opposed to a dentist. As explained in the Shulman Report

> Incarcerated people experiencing painful dental conditions should be examined by a nurse practitioner ("NP"), physician assistant ("PA"), or physician ("MD" or "DO") within 24 hours of the complaint being received by the facility staff. The NP, PA, or physician may prescribe antibiotics for dental abscesses at that preliminary examination, as appropriate. **However, all incarcerated people complaining of dental pain must be scheduled to see a dentist, since only a dentist is qualified to make a definitive diagnosis on dental issues and determine the clinically appropriate sequence of care.**

Shulman Report at ¶ 84 (emphasis added).

33. In contrast to Dr. Reinecke's apparent conclusion that the Jail provides timely dental care, the records Dr. Reinecke reviewed also support my conclusion that dental care at the Jail is untimely and therefore inadequate. A complete summary of my reviews of the 30 records summarized in the Reinecke Report is attached as **Exhibit B**. Notably, Dr. Reinecke's own summaries of these records do not reach a specific conclusion regarding whether timely care was provided in each case. However, the records reviewed by Dr. Reinecke reflect a median wait time of

35.5 days for urgent care. By way of example only, [redacted] waited 140 days before he is documented as having refused a dentist appointment on [redacted] 2024. Exhibit B at ¶¶ 16-20. [redacted] waited 154 days before being seen by a dentist on [redacted], 2024. *Id.* at ¶¶ 71-78. These, and the many other examples documented in Exhibit B, are clearly untimely.

V. DENTAL SERVICES PROVIDED

34. Dr. Reinecke states that the Jail provides:

> General dentistry is provided to all IPs, to include oral healthcare instruction, preventive services (gross scales and prophies), restorative services (fillings and crowns), endodontics (root canals, referred to off-site provider), prosthodontics (dentures), and oral surgery (completed both on site and via off-site referral).

Reinecke Report at 3.

35. Absent among the services listed by Dr. Reinecke is the treatment of moderate periodontal disease which is a standard component of general dentistry. In fact, as I point out in my report, scaling and root planing can be performed by dental hygienists when ordered by a dentist.[5] Failure to include treatment of mild to moderate periodontal disease within the scope care is inadequate and below accepted professional standards.

VI. PHYSICAL SPACE

36. Dr. Reinecke assessed the physical space of each facility he visited to determine if there was adequate space and equipment to deliver dental care. *Id*. at 3.[6] As I understand his report, the Jail now has four dentists.[7] Is the space sufficient to accommodate four dentists, two dental hygienists, and the two additional hygienists that may be added to the staffing matrix?

[5] *See* discussion of periodontal diagnosis and treatment in Shulman Report Exhibit D at ¶¶ 17.

[6] No notes from this inspection were produced.

[7] He did not specify how many full-time equivalent dentists are on staff.

37. As I mention in my report

> While all the treatment rooms were adequate from a dental perspective for current staffing, any clinic with only one treatment room (such as George Bailey) is limited because a dentist and dental hygienist cannot work at the same time. When dentist staffing is increased substantially (as I believe it must be), it is likely that clinics will have to be expanded or an additional shift added.

Shulman Report at ¶ 48.

38. While Dr. Reinecke stated that the equipment was adequate to provide dental care (Reinecke Report at 3), an issue that bears mentioning that I noticed in the 85 charts I reviewed (the 55 described in the Shulman Report and the 30 selected by Dr. Reinecke) was equipment downtime. For example, on [redacted], 2023, Dr. Borquez rescheduled a filling appointment for [redacted] because no suction was available. Reinecke Report at 95. Similarly, inoperative suction caused Dr. Polanco to reschedule the extraction of [redacted] painful tooth—a 21-day delay. *Id*. at 95-96.

39. My record review also found examples of treatment delays resulting from equipment malfunction. As I noted in my report

> On the day I visited Las Colinas on February 8, 2024, a handwritten sig[redacted]at the x-ray machine was broken. The medical records of [redacted] ind[redacted]the x-ray machine at Las Colinas was sim[redacted]on [redacted], 2024. SD 837496-501. Other records indicate equipment f[redacted]r Jail fa[redacted]*e.g.*, suction equipment broken on [redacted] 2023, [redacted] Medical Records, SD 841562; [redacted]oken o[redacted]3, preventing completion of prophy, [redacted] Medical [redacted]ds, SD 825095-101. Each of these equipme[redacted]ontributed to delays in care for incarcerated people. While I did not review enough charts to determine the extent to which equipment downtime contributes materially to untimely care, these examples are troubling. This should be studied by the Sheriffs' Department and NaphCare and eventually be followed during monitoring.

Shulman Report at ¶ 105.

VII. QUALITY MONITORING

40. According to Dr. Reinecke:

> Quality assurance monitoring is a necessary process for every

> healthcare system to ensure consistent and adequate delivery of care. The quality monitoring for all providers who serve at the seven SDSO facilities is appropriate. Dr. Pandit performs monthly chart reviews and an annual quality review on each dental provider.

Reinecke Report at 3.

41. Dr. Reinecke opined that the Jail's Quality Assurance Monitoring with respect to dental care is "appropriate." However, he provides no evidence on which to base this opinion. In my report I reviewed the Sheriff's Department internal medical Quality Assurance Meeting and concluded that the Sheriff's Department has essentially outsourced its continuous quality improvement ("CQI") of the dental program to NaphCare, yet—to the extent that NaphCare does any auditing of dental care—those audits are inadequate. Shulman Report at ¶ 221. Furthermore, my review of the minutes indicates that dental care is not substantively discussed as part of the Sheriff's Department's own CQI process. In some of the Committee's minutes, the word "dental" does not appear at all. *Id*. at ¶ 222.

42. Although NaphCare has purportedly conducted some auditing of the Jail's dental care, that oversight program is deficient. For one thing, the quarterly presentations regarding quality assurance and quality improvement run by NaphCare do not appear to contain any information or analysis about the *quality* of dental care provided, or even about the type of issues being diagnosed and treated. *Id*. at ¶ 225.

43. There is, again, no discussion of inadequate periodontal diagnosis and treatment and inadequate initial examinations and treatment plans I found in my chart reviews. Most damningly, there are no statistics regarding average wait times for dental care. *Id*. at ¶¶ 225-226.

44. Dr. Reinecke cites the fact that "Dr. Pandit performs monthly chart reviews and an annual quality review on each provider." Reinecke Report at 3. However, as I point out in my report, this audit again appears to focus only on documentation. Shulman Report at ¶ 228. In fact, at least Dr. Pandit's

December 2023 audit—the only one I have seen—is mute on the Jail's inadequate periodontal diagnosis and initial examinations that I document in my report. *See id.*

45. In summary, quality monitoring by both the SDSO and NaphCare are inadequate. First, there is no regular monitoring of the timeliness of care, which, based on Dr. Reinecke's and my record reviews is grossly deficient. Second, there is no focus on the diagnosis and treatment of periodontal disease—a critical component of general dentistry. Third, the use of bitewing x-rays to diagnose caries is not monitored. Finally, hygienists are allowed to examine and treat patients who have not been previously examined by a dentist—which, as explained above, is an inappropriate practice.

VIII. RECORDS MANAGEMENT

46. Dr. Reinecke opines that "the current TechCare electronic health record in use at SDSO is a suitable vehicle to record and track dental healthcare encounters." Reinecke Report at 3. However, he later suggests that inadequate documentation might be "the result of a charting system that is not full spectrum, relies too much on "check the box" format or is not user friendly. *Id*. at 4. I make this point *inter alia* in my report.

> The charts I reviewed suggest that a dentist can color-code individual teeth to indicate, *e.g.*, whether the tooth is impacted or designated for extraction. However, I have not seen any indication that a dentist can color-code only *part* of a tooth, *e.g.*, to indicate where on a tooth the decay is or where an existing restoration was placed; a standard electronic dental chart would have this partial color-coding feature. Because it lacks the ability to mark locations on an individual tooth, the Jail's chart is insufficient for routine care.

Shulman Report at ¶ 200.

47. While the chart allows for text entry of information about specific teeth, this information should be visible on the chart to facilitate a dentist's following the status of specific teeth. Similarly, while the chart allows the entry of periodontal pocket depth on the buccal and lingual surfaces (*id*. at ¶ 201), it does not

facilitate[8] the entry of PSR or CPITN scores[9]—a *sine qua non* for dental and dental hygiene practice.

48. I noticed that minor changes were made to the dental treatment note form that were not present in the charts I reviewed. I presume that these changes were made after the charts I reviewed were pulled for production. First, the types of dental appointments a dentist (or hygienist) can select have been updated. *Compare* Figure 1 (appointment types from February 13, 2024 chart) *with* Figure 2 ("Dental Type" from May 29, 2024 chart).

Figure 1:

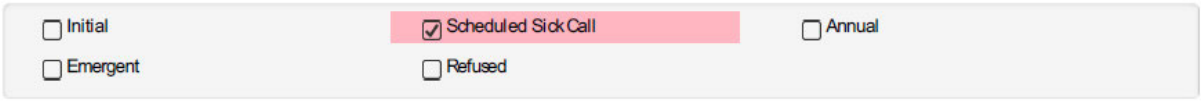
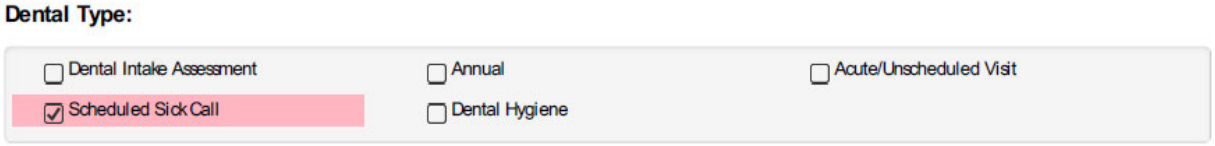


Figure 2:



49. As is clear in comparing Figures 1 and 2 above, the "Initial" box has been changed to "Dental Intake Assessment"; a "Dental Hygiene" box has been added; and the "Emergent" box has been removed and replaced by "Acute Unscheduled Visit." These changes seemingly make clear that there is no "initial exam" equivalent to the ADA procedure code D0150 ("Comprehensive Oral Examination"), but rather an assessment, which I take to be less rigorous.

50. Second, the revised form includes what appears to be a field that links to the "most recent completed health assessment." I was not able to evaluate its functionality in my review.

[8] While the scores can be entered as free text, there is no separate block for the scores to be entered.

[9] *See* discussion of periodontal diagnosis in ¶¶ 156-159.

51. Third, changes were made in the X-ray section to add fields for "Panoramic X-ray (PANO)," "Periapical X-ray (PA)," and "Bitewing X-ray." *Compare* Figure 3 (February 13, 2024 chart) *with* Figure 4 (May 29, 2024 chart).

Figure 3:

Figure 4:

52. Fourth, changes were made in the "Exam/X-Ray Reveal section, again adding more boxes that a dentist may (or may not) check. *Compare* Figure 5 (February 13, 2024 chart) *with* Figure 6 (May 29, 2024 chart).

Figure 5:

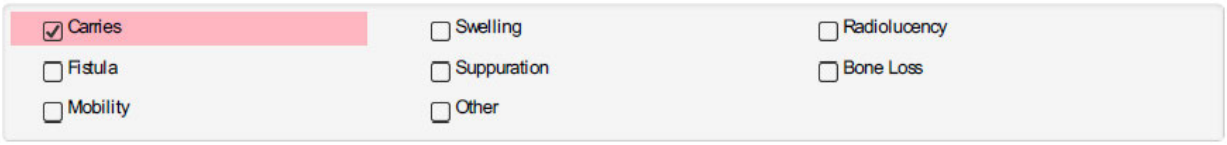
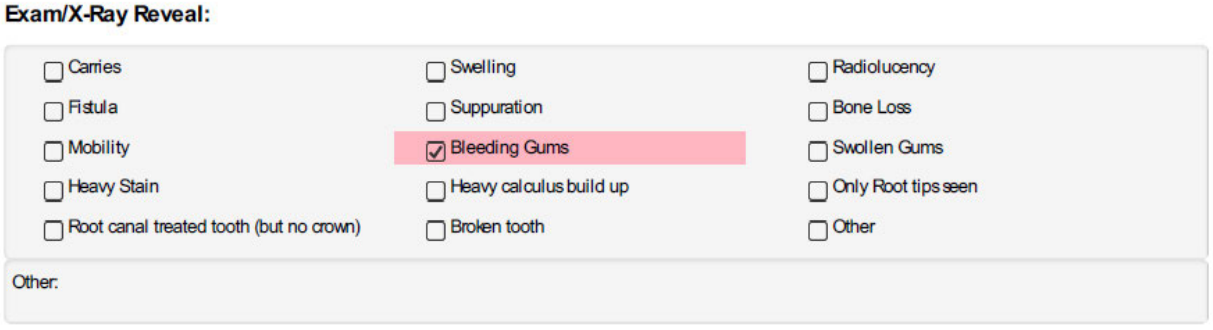


Figure 6:



53. Fifth, under "Diagnosis," the "Non-Restorable" option was updated to: "Non-Restorable – Needs extraction." The addition of "– Needs extraction" does not change my opinion, as stated in the Shulman Report (pp. 63-64), that there is a lack of clarity about the difference between a "restorable" and "non-restorable" tooth. The critical question is whether a tooth is not restorable under any circumstances, even with advanced treatment offered by an endodontist, for example. That a dentist at the Jail diagnoses a tooth as "needing extraction" may—absent any explicit definition—mean that the Jail's policy is such that extraction is the only available treatment. Further definition is still required.

54. Sixth, the "Treatment Options" have been updated to include several additional choices. *Compare* Figure 7 (February 13, 2024 chart) *with* Figure 8 (May 29, 2024 chart).

Figure 7:

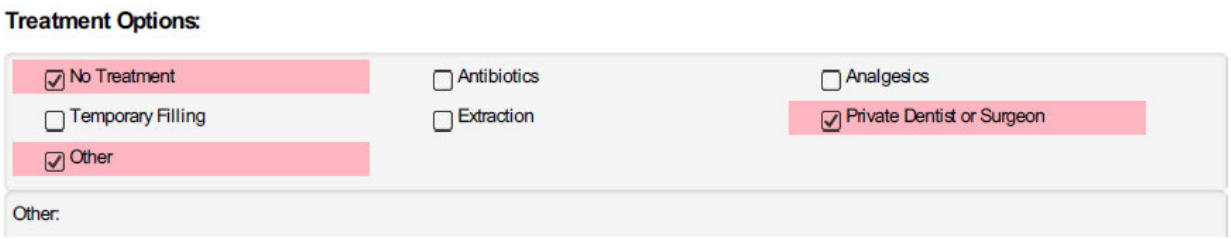
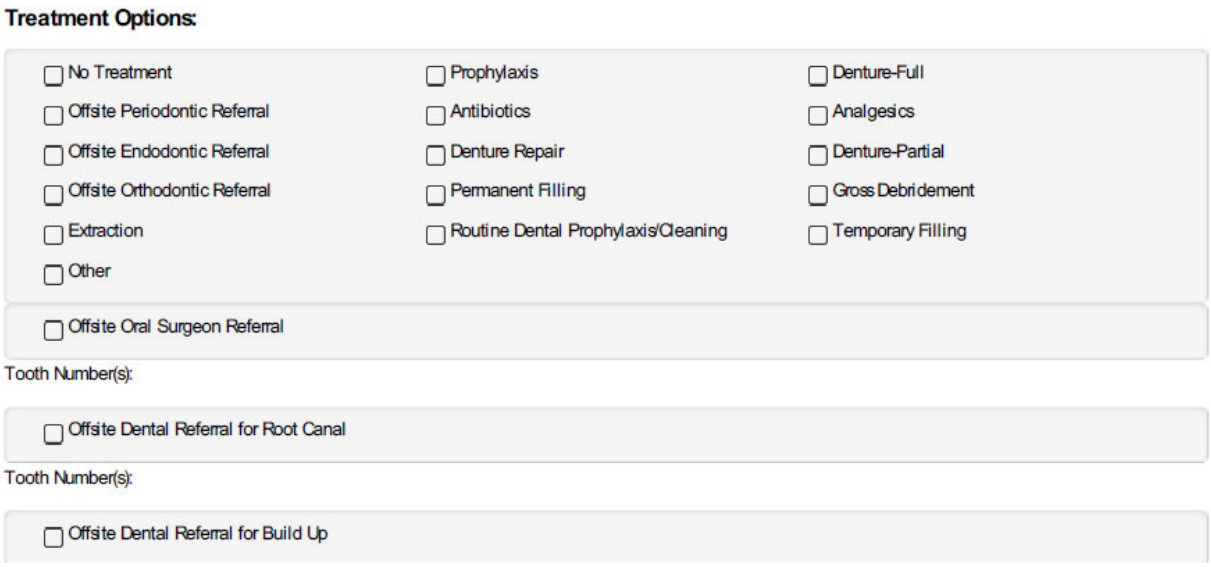


Figure 8:



55. These minor revisions and the handful of other minor changes in the dental treatment form do not change any of my opinions. Although the new categories have the potential to provide useful information, they do not produce a narrative flow that makes it easy for a dentist to grasp the clinical history quickly. In fact, these cumbersome additions magnify Dr. Reinecke's critique of the Jail's dental chart:

> Chart audits revealed that while documentation was present, it was typically not comprehensive in nature, nor did it represent a fluid sequence of assessment, diagnosis, and treatment. This may be a result of a charting system that is not full-spectrum, **relies too much on a "check the box" format, or is not user-friendly.**

Reinecke Report at 4 (emphasis added). I agree with Dr. Reinecke that this "check the box" format of a chart is not user-friendly.

56. Finally, while minor changes were made, it remains difficult to follow a patient's clinical progress over time. Unlike, for example, the "Progress Notes" section of a patient's medical record where clinical progress can be followed easily, a dentist wanting to understand a patient's history must look at separate records of examinations and treatments. For example, following [redacted] clinical history requires reviewing at least 12 separate clinical encounters—each of which comprises four or five pages.[10] Looking at only the most recent clinical encounter

[10] Dr. P[redacted]co: [redacted]22, [redacted]/22, [redacted]23, [redacted]/24, [redacted]/24; [redacted]Patel [redacted]/23, [redacted]/24, [redacted]/24, [redacted]/24; [redacted]a de[redacted]l hy[redacted]nist: [redacted]/24, [redacted]/24, [redacted] sumi[redacted]hat th[redacted]ocumentation for each encou[redacted]is fo[redacted]r five[redacted]ages long, a dentist would have to review between 48 and 60 pages to piece together a treatment chronology.

does not capture all the detail from every prior appointment.

57. To summarize, the Jail's dental chart as currently configured is inadequate to enable a dentist to follow a patient's dental health. While the chart tool might be useful for patients that receive only urgent care on a single tooth at a time, it is below the accepted professional standard for providing routine care. It is also difficult to use for patients who require urgent care on multiple teeth at the same time. I have reviewed dental records in the military, academics, and corrections and found the Jail's charts among the most difficult I have reviewed to determine a patient's clinical history over time.

58. The information and opinions contained in this report are based on evidence, documentation, and/or observations available to me. I reserve the right to modify or expand these opinions should additional information become available to me. The information contained in this report and the accompanying exhibits are a fair and accurate representation of the subject of my anticipated testimony in this case.

DATED: October 31, 2024

Jay Shulman