No. 13-2346

UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT

RICHARD NUNES, CARL COE, JOHN DOE, PETER POE, and RICHARD ROE,
Plaintiffs-Appellants,

v.

MASSACHUSETTS DEPARTMENT OF CORRECTION, THOMAS GROBLEWSKI, and MARK WAITKEVICH,
Defendants-Appellees.

On Appeal from the United States District Court
for the District of Massachusetts

BRIEF IN SUPPORT OF PLAINTIFFS-APPELLANTS
AND SUPPORTING REVERSAL

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STATEMENT IN SUPPORT OF ORAL ARGUMENT

Pursuant to 1st Cir. R. 34.0(a), Plaintiffs-Appellants request oral argument. In light of the importance of the statutory and constitutional issues in this case, the substantial factual record, and the nature of the District Court's decision granting summary judgment, argument will assist the Court's review.

JURISDICTIONAL STATEMENT

This Court has jurisdiction over this appeal from the final decision of the District Court of the District of Massachusetts pursuant to 28 U.S.C. § 1291. The District Court entered final judgment on all of Plaintiffs' remaining claims on October 3, 2013. Plaintiffs filed a timely notice of appeal on October 24, 2013. The District Court's jurisdiction was based on 28 U.S.C. § 1331 because Plaintiffs brought claims under the Eighth and Fourteenth Amendments to the United States Constitution and under the Americans with Disabilities Act and Rehabilitation Act.

STATEMENT OF THE ISSUE

Whether the District Court improperly granted summary judgment to Defendants by resolving factual disputes and drawing inferences in Defendants' favor, and by disregarding other facts entirely, in determining that there was no genuine issue as to any material fact and that the Defendants' removal of HIV medications from their Keep On Person Program did not violate disability law or the Plaintiffs' civil rights.

STATEMENT OF THE CASE

Five Plaintiffs, all HIV-positive state prisoners, brought this action after they were removed from Defendants' Keep on Person Medication Distribution Program

(“KOP Program”). Add. 7-20.[1] Under the KOP Program, prisoners who are capable of taking their own medications independently are able to keep a supply of their medications in their cells, taking them as prescribed. Add. 7. To participate, prisoners must be approved by medical staff. Add. 8. If a medical provider finds that a patient is not taking his medications responsibly – for example, losing them or forgetting to take them as prescribed – the provider can suspend the patient from the KOP Program. Add. 7-8; App. 259, 844, 1651.

Certain medications are ineligible for the KOP Program. Add. 7, 15-18. They pose security problems, *e.g.* they require a syringe to inject the medicine, or they can potentially be abused. App. 338, 826, 1575-76. These medications are administered to prisoners via directly observed therapy (“DOT”) (Add. 7), requiring prisoners to stand in the medication line (“med line”) at the Health Services Unit, wait for their turn to receive one dose of their medication from a nurse, swallow it, and present their mouth to a correctional officer for inspection. App. 741-42, 1736.

HIV antiretroviral medications had been included in the KOP Program since their arrival in Massachusetts Department of Correction (“DOC”) prisons, in the mid-1990’s. App. 255-56, 827, 1403, 1446, 1451. Defendants removed all HIV antiretroviral medications from the KOP Program in February of 2009. They did

[1] References to the Addendum will be abbreviated as “Add. __.” References to the Appendix will be abbreviated as “App. __.”

not remove any other drugs from the KOP Program at that time. App. 1575-76. In fact, Defendants were in other ways seeking to *expand* the KOP Program. App. 323-24, 737, 812-13, 825-26, 1576-77. The decision to pull HIV medications out of the KOP Program was made over the objections of the Defendants' own infectious disease case managers – specialized nurses who served as primary care providers and coordinators of care for HIV-positive prisoners (App. 256). App. 278-81, 845, 1658-59, 1739-41, 1752, 1917-18, 1932. This change in policy also came over the objections of the infectious disease specialists, physicians hired by Defendants to treat HIV. App. 281, 283, 631-34, 832, 1405, 1452.

Defendants blamed the patients for this change, claiming that it was necessary to remedy patient non-adherence to the medications. App. 646, 1914. This rationale made little sense, since in the KOP Program, non-adherent patients will be suspended from the program and forced to go to med line. Add. 10, 11-12, 19; App. 259, 844, 1651. Pursuant to Defendants' medication policies, nursing staff reviewed patient records to ensure compliance with KOP medications. Nurses checked the records of each patient with KOP medications, to make sure that they were picking up medication refills on time, and they conducted routine audits of these patients. Add. 11; App. 355-60, 1628-29, 1670-71, 1733, 1751.

HIV patients had their medication compliance followed more closely than other prisoners in the KOP Program, to ensure that their treatment was effective

and the virus was under control. The infectious disease case managers reviewed their patients' charts and conducted pill counts (patient appointments at which the prisoner brought his supply of medication, to be counted and checked against the date he received it). App. 257-59, 262, 842, 1588, 1650, 1672-73, 1700, 1733, 1747. They also tested patients for their viral load and CD4 cell count; a viral load that was not at the undetectable level (75 copies/ML), or moving in that direction, would be spotted and could lead to changes in treatment. App. 261, 1700, 1733. Thus, HIV patients were among the most closely monitored patients in the DOC. App. 261-62, 545, 547-48, 620-21.

It was little wonder, then, that the infectious disease case managers and the HIV specialists, who had 15 years of positive experience with KOP antitretroviral medications, decried their blanket removal from the KOP Program. They knew from first-hand experience that the treatment procedure in place produced good results. The HIV specialists found their prisoner patients to be more motivated and to achieve results equal to or better than their patients in the outside community, with the KOP Program; in addition, released prisoners were better prepared to manage their medications if they had KOP medications in prison. App. 282, 335, 631-34, 1404, 1406-08, 1411, 1451. Their supervisor, the Director of Infectious Diseases for the Department of Public Health, pointed out that removing successful patients from the KOP Program would infantilize them and lessen their investment

in their own care, leaving them poorly prepared for their return to society. App. 283, 335, 635.

Patients were upset as well, especially those who were long-term prisoners in the DOC and had proven their ability to take KOP medications responsibly. All five Plaintiffs were adherent to their HIV medications under the KOP Program. They had undetectable viral loads and had not been suspended from the KOP Program. App. 263, 337-38, 773, 853, 984-85, 1023, 1025, 1031, 1057-58, 1111, 1124, 1167, 1171. Being forced to go to the med line for every dose of medicine, every day, was a needless and foreseeably problematic disruption. KOP medications afforded prisoners the ability to time their medications to avoid or limit side effects, to take medications even when the facility's normal operation was disrupted, and to take them even when the prisoner was sick or worn down (not an unusual occurrence for those with HIV). App. 631, 635, 1405, 1451, 1663, 1671-72. Prisoners also controlled their own dosing with KOP medications and would not have to worry about nursing mishaps, except once a month when they needed a renewal.

Mandatory DOT jeopardized all of these benefits. In addition, patients knew that daily appearances in med line would make it far more difficult for them to be private about their HIV-positive status. App. 329-30, 1023-24, 1059. There

remains a significant stigma around HIV, especially in prison. *See* Argument, Sec. IV(A), *infra*.

Defendants followed through with the removal anyway. The results were predictable. Consistency in taking medication is more difficult to maintain under mandatory DOT than it was under the KOP Program. At times Plaintiffs, and patients like them, have been too sick to go to med line, have had schedule conflicts forcing them to choose between medicine and work, or have had poor communication from correctional staff leaving them unaware that their unit was called to med line. App. 320-22, 528, 533, 773-74, 985, 1027, 1074, 1170, 1405, 1420, 1432, 1454, 1683. The length of the med line and the waiting time have deterred med line attendance (and have raised security concerns, to the point where DOC made changes designed to *increase* access to the KOP Program for the non-HIV population). App. 323-24, 529, 532, 536-37, 737, 812, 825-27, 830, 1420, 1576-77, 1635, 1654, 1676, 1745. Patients have received incorrect doses from nursing staff. App. 325-26, 533, 793, 1422, 2249. Such errors are difficult to remedy and difficult even to raise without disclosing one's HIV-positive status to others in the med line. App. 1024, 1171.

In addition, removal from the KOP program has left many HIV patients to suffer unnecessarily from HIV medication side effects. App. 327, 1456. For example, a high number of prisoners take a medication containing Efavirenz,

which is indicated for bedtime administration because of its significant side effects. App. 327, 366, 562. Under the KOP Program, prisoners could take their medications at bedtime if they chose, but this is impossible with mandatory DOT. App. 327-28, 341, 1023, 1055, 1408-09, 1421. Plaintiff Carl Coe ultimately had his medication regimen changed, and side effects have caused others to change regimens too. App. 328, 1029, 1458.

Mandatory DOT has also led to unwanted disclosures of a prisoner's HIV-positive status. Every dose of medicine, every day, is taken after standing in a long med line, in close quarters with other prisoners, some of whom have prying eyes and ears. App. 329, 528, 1023-24, 1059-60. A single thoughtless comment or question from the nurse will "out" the HIV patient to others, as could questions from unit correctional officers about why getting to the med line, every time, is so important. App. 329-32, 525, 528, 1024, 1171. Nursing errors can also lead to disclosures. App. 501-02. For Plaintiffs Coe, Doe, Poe, and Roe, unwanted attention came from suddenly becoming daily regulars at med line, which they previously were not. App. 330, 525, 528, 532, 536. The infectious disease case managers and the HIV specialists reported that fear of disclosure has deterred others from going to med line. App. 332-33, 739, 1422, 1455, 1676-77, 1737.

Many HIV patients stopped taking medication after the removal of their medications from the KOP Program. App. 341-43, 759, 1455, 1457-58. All but

two patients eventually restarted medication. App. 342, 1432, 1457. The HIV specialists reported, however, that several patients previously adherent under the KOP Program now miss their medications intermittently, in some cases affecting their viral loads. App. 343, 1421, 1455. In an audit, the Department of Public Health noted that forty percent of HIV-positive prisoners with an adherence problem attributed it to the DOT policy. App. 343, 2164. For all of these prisoners, the risk of drug resistance is heightened. App. 344, 1414-15, 1430-31, 1456-57.

The HIV specialists have changed medication regimens (the types of HIV medications prescribed) for several patients not for therapeutic reasons, but in order to address the problems posed by mandatory DOT. App 345-46, 763, 1420-21, 1423-24, 1458-60. One specialist learned of two patients who avoided disclosing their HIV to medical staff when entering the DOC and, thus, were not being treated at all until medical staff discovered them. App. 347, 1422-23.

Defendants rely on a so-called "Antiretroviral Quality Adherence Analysis" as justifying the removal of HIV medications from the KOP Program. App. 2059-61. The design of this analysis was skewed to suggest a system-wide problem with adherence to medication, when no such problem existed. *See* App. 303-305. It studied only 19 HIV-positive prisoners out of over 200 prisoners taking antiretroviral medication. App. 2060-61 (table of 19 patients), 556 (total HIV

patients taking medications in October 2008 was 232). This small sample was not randomly selected; Defendants cherry-picked only patients with detectable viral loads at the time, *i.e.* patients more likely to be non-adherent to their medication. App. 924, 927.[2] Accordingly, and as Plaintiffs' expert witness points out, the results of this analysis cannot be generalized to the HIV patient population as a whole. App. 363.

Defendants' analysis purported to measure patient adherence to medications by calculating the timing of medication refills, with late refills (*i.e.*, more than thirty days between monthly refills) suggesting that a patient missed one or more days of medicine. App. 2059-61. However, Defendants did not look at when the patient actually received medication refills – instead, they reviewed pharmacy claims, using the date a refill was ordered by nursing staff. App. 284, 363, 1722. Such data have dubious reliability because the day a refill was ordered does not correspond to the day a refill was handed to the patient. App. 284, 1716-17.

Defendants applied this unreliable method to this hand-picked subset of 19 HIV patients, over a limited two-month date range (only one month for some), and they concluded that patient adherence was a problem for all HIV patients. App. 2059-61. Yet, even with its selection bias and unreliable methods, the analysis

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[2] Even among these 19 prisoners, six had their viral load drop to undetectable levels (<75 copies/mL) on their very next blood test, while two more dropped below 150 copies/mL. App. 927. This progression belies any suggestion that there was a significant number of patients with persistent detectable viral loads.

actually showed that seven of the nineteen patients studied had “excellent” adherence, and another seven had “good” adherence. App. 2060. Defendants never compared this adherence analysis to the patients’ actual records to determine whether these prisoners were, in fact, non-adherent, and if so, to discover why they were. App. 364, 2060.[3]

Defendants thus disqualified over 200 HIV patients from the KOP Program, and all future patients, because they suspected (but did not confirm) that five hand-picked patients were non-adherent. Defendants not only ignored the other 98% of the HIV patients, they also ignored the many ways in which compliance with HIV medication was already monitored under the KOP Program. *See* pp. 3-4, *supra*.

Defendants continued to gather refill order data after the policy change, claiming that these data prove that patient adherence is better under mandatory DOT, but the data show *no improvement in patient adherence* since the policy change. App. 305-08. The adherence analyses show that under DOT, a full thirty percent of HIV medication refills are more than two days late. App. 364, 1498, 2043. Half of those gaps extend for over a week. App. 364-65, 2021, 2025, 2030,

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[3] A record review shows how unreliable pharmacy claims can be. What may appear to be late refills may, in fact, be timely. Defendants claimed that four of the five Plaintiffs were non-adherent in July of 2008, using their pharmacy claims data. App. 1997-2011. Review of the patient records, however, showed that these four Plaintiffs were not late, and did not have gaps in medication. App. 287-89, 2605-2621.

2037, 2041. Such lengthy gaps in medication do not represent an improvement; indeed, they seriously jeopardize control of the virus. App. 308, 365.

The evidence suggests that Defendants' interest in removing all HIV medications from the KOP Program, in reality, came not out of concern for patient care, but for money. Defendants were saddled with high drug costs, thanks largely to a state purchasing requirement that forced them to obtain medications through the State Office of Pharmacy Services ("SOPS"). App. 264-65, 591-92. Under this arrangement, Defendants paid higher administrative costs than if they had procured medications on their own, and with respect to HIV medications specifically, it disqualified Defendants from a federal program that produces substantial discounts. App. 265-68, 805, 823-24.

Defendants removed all HIV medications from the KOP Program as a means of capturing all unused HIV medications and returning them for credit. App. 270-71, 1905. Under the state pharmacy's reclaim and reuse policy, unused medications may be repackaged and redistributed, so long as they have not been in the possession of the patient. App. 597-99.

Defendants report "savings" from reclaiming unused HIV medications. App. 308-09, 2049-58. Their calculations ignore the fact that unused medications are largely the result of prisoners being discharged from DOC custody or transferred to another DOC facility. Reclaiming medications from discharged

prisoners (often pretrial or temporary prisoners) violates Defendants' discharge policy, which calls for the discharged prisoner to be given any unfinished medication. App. 276, 311, 589, 612, 819. Reclaiming medications from transferred prisoners violates policy as well, Add. 12, App. 311-12, 612, but it also saves no money at all, since medical staff at the new facility will simply have to order an early refill once the prisoner arrives. App. 625, 1770.[4]

Savings from reclaiming unused medications are inflated, and unused medications are attributable to distinct subgroups of prisoners, not to all of them equally. App. 278-80. The infectious disease case managers studied HIV medication returns in order to identify the cause of returns. App. 621, 1917-18. They found that HIV medication returns were attributable to pretrial or other short-term prisoners being discharged, and to transfers. App. 1743. The case managers and the HIV specialists suggested that long-term, adherent prisoners should be allowed to remain on the KOP Program, and should not be treated the same as pretrial or other temporary prisoners. App. 279, 339-40, 757-58, 845, 1658, 1740, 1752. Defendants rejected this suggestion and enacted the blanket policy, taking all HIV patients out of the KOP Program.

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[4] Returns may also result from duplicate orders – a patient's refill being ordered twice, mistakenly. These extra medications can be returned and reused whether they are part of the KOP Program or DOT, because they have not yet been given to the prisoner. App. 276, 309, 809.

Plaintiffs filed suit on November 22, 2010, seeking the return of HIV medications to the KOP Program. App. 21-57; *id.* p. 56 ¶ g. Under the KOP Program policy, Add. 7-20, Plaintiffs and other HIV-positive prisoners would not be guaranteed KOP medications, but could obtain them so long as they satisfied the program requirements. Plaintiffs claim that the Defendants' actions violated the ADA and Rehabilitation Act, the Eighth Amendment, and their Fourteenth Amendment right to privacy.

On December 14, 2012, Defendants moved for summary judgment. The Medical Defendants[5] and Correctional Defendants[6] submitted their own statements of material fact, totaling 378 and 420 paragraphs, respectively. App. 59-252. They also jointly submitted 121 exhibits. App. 941-2592. Plaintiffs responded to those statements and submitted their own statement of additional material facts, containing 263 paragraphs, App. 253-348, with 66 exhibits. App. 353-870, 2593-2622. Supplemental statements and exhibits were also filed. *See* App. 349- 352, 871-940.

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[5] UMass Correctional Health, Leonard McGuire, Warren Ferguson, Judith Steinberg, and Thomas Groblewski. Plaintiffs did not pursue this appeal as to UMass Correctional Health or its officials, as they no longer serve as the DOC's medical contractor, and therefore cannot afford Plaintiffs the relief they seek. *See* Docketing Statement. Defendant Groblewski remains a party to the appeal because he remains the Medical Director for the DOC's current medical contractor.

[6] Department of Correction and Peter Heffernan. In this appeal, Plaintiffs substituted Mark Waitkevich for Mr. Heffernan, as Mr. Waitkevich succeeded him as Director of Clinical Services for the DOC. *See* Docketing Statement.

On October 3, 2013, the District Court granted the Defendants' motion. Add. 1-6. The opinion referred to the action as a one-Plaintiff case several times. Add. 1-5. To the extent that the District Court referred to the extensive factual record at all, it resolved factual disputes rather than identifying them as issues for trial, and it drew inferences in the light most favorable to Defendants, not to Plaintiffs. *Id.*

SUMMARY OF THE ARGUMENT

Defendants violated the ADA and Rehabilitation Act when they enacted a blanket policy that removed and categorically excluded all HIV-positive patients within the DOC from the KOP Program, solely on the basis of their HIV status, and denied Plaintiffs the individual determinations to which they are entitled. The District Court erred by misinterpreting the nature of Plaintiffs' ADA and Rehabilitation Act claims, by disregarding the Plaintiffs' claim of categorical exclusion and focusing solely on one Plaintiff's separate assertion that Defendants failed to accommodate his specific medical needs. The District Court, in granting summary judgment on the ADA and Rehabilitation Act claims, failed to address the record evidence, failed to view it in the light most favorable to Plaintiffs, and failed to indulge all possible inferences in Plaintiffs' favor. (*Infra*, 18-22)

Defendants were deliberately indifferent to Plaintiffs' serious medical needs, as well as those of other HIV-positive patients, when they enacted a blanket policy that excludes all HIV medications from the KOP Program and requires all HIV-

positive prisoners to go to med line in order to access every dose of their life-sustaining medication, regardless of their individual medical needs or previous success with the KOP Program. Defendants administratively enacted the blanket policy change over the objections of the infectious disease case managers and HIV specialists. By doing so, Defendants interfered with Plaintiffs' prescribed health care and, foreseeably, put them at substantial risk of serious harm. Defendants subjected Plaintiffs and all HIV-positive prisoners to a rigid policy, instead of allowing for individual determinations based on each patient's circumstances. Defendants continue to be deliberately indifferent in the face of evidence that mandatory DOT exacerbates HIV patients' painful medication side effects, causes Plaintiffs and other patients to miss more doses of their HIV medication than they did under the KOP Program, and gives rise to other issues that place Plaintiffs and HIV patients like them at risk of developing drug resistance and compromising the ability of their immune systems to fight the progress of the disease. Defendants' attempt to justify the policy change with claims of improved medication adherence are inaccurate, as are their estimates of cost savings from the policy. The District Court erred by misidentifying which Plaintiffs are advancing the Eighth Amendment claim, by oversimplifying the basis of said claim, and by awarding summary judgment for Defendants in spite of a record replete with factual disputes. The District Court failed to address the evidence pertinent to the Eighth

Amendment claim, failed to view it in the light most favorable to Plaintiffs, and failed to indulge all possible inferences in Plaintiffs' favor. (*Infra*, 22-31)

Defendants violate Plaintiffs' constitutional right to privacy by implementing a blanket policy that removed all HIV patients from the KOP Program and requires them to attend med line for each dose of their HIV medication. Defendants' actions have resulted and will continue to result in unauthorized disclosures of HIV status to prisoners and correctional staff due to wholly foreseeable privacy problems inherent in forcing HIV-positive prisoners to attend med line. There is no valid, rational connection between the policy change and the stated penological interests advanced by Defendants; disclosure of Plaintiffs' HIV status cannot not be undone or further disclosure prevented under the current policy; and accommodating HIV patients by restoring them to the KOP program is a readily available alternative that would have a minimal impact on staff and other prisoners. The District Court erroneously misidentified which Plaintiffs are advancing the Fourteenth Amendment privacy claim, misinterpreted the basis of said claim, and awarded summary judgment for Defendants in spite of a record replete with factual disputes. The District Court failed to address the evidence of Plaintiffs' experiences with privacy breaches since the policy change, failed to view it in the light most favorable to Plaintiffs, and failed to indulge all possible inferences in Plaintiffs' favor. (*Infra*, 31-40)

In the face of material, disputed facts concerning the reasonableness of the accommodation that Defendants offered to Plaintiff Nunes, the District Court erred in granting summary judgment on Plaintiff Nunes' claim for failure to accommodate his particular medical needs, based on a preliminary injunction ruling that weighed the evidence against him, not in the light most favorable to him. (*Infra*, 40-43)

ARGUMENT

I. STANDARD OF REVIEW.

This Court reviews the District Court's grant of summary judgment *de novo*. *Travers v. Flight Services & Systems, Inc.*, 737 F.3d 144, 146 (1st Cir. 2013). Facts are viewed in the light most favorable to the nonmovant. *Kiman v. New Hampshire Dept. of Corrections*, 451 F.3d 274, 282 (1st Cir. 2006) (citation omitted). Summary judgment is appropriate if the record evidence demonstrates that "there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law." *Leavitt v. Corr. Med. Servs., Inc.,* 645 F.3d 484, 496 (1st Cir.2011). "A 'genuine issue' is one which must be referred to a fact finder because it could reasonably be resolved in favor of either party." *Aponte-Santiago v. Lopez-Rivera*, 957 F.2d 40, 41 (1st Cir. 1992) .

II. THE DISTRICT COURT ERRONEOUSLY AWARDED SUMMARY JUDGMENT TO DEFENDANTS ON PLAINTIFFS' ADA AND REHABILITATION ACT CLAIMS.

The District Court erred by misinterpreting Plaintiffs' ADA and Rehabilitation Act claims. Title II of the ADA provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132.

To prevail on a Title II claim, "a plaintiff must establish: (1) that he is a qualified individual with a disability; (2) that he was either excluded from participation in or denied the benefits of some public entity's services, programs, or activities or was otherwise discriminated against; and (3) that such exclusion, denial of benefits, or discrimination was by reason of the plaintiff's disability." *Parker v. Universidad de Puerto Rico*, 225 F.3d 1, 5 (1st Cir. 2000).[7]

Plaintiffs contend that the exclusion of HIV patients from the KOP Program is unlawful discrimination. A blanket policy excluding all HIV-positive prisoners from this program "denies plaintiffs the individualized determinations to which

[7] The liability standards under Title II of the ADA and Section 504 of the Rehabilitation Act, 29 U.S.C. § 794(a), are the same, and this Court relies interchangeably on decisional law applying Section 504 when applying Title II. *Parker*, 225 F.3d at 4.

they are entitled under the ADA." *Henderson v. Thomas*, 913 F.Supp.2d 1267, 1295 (M.D.Ala. 2012).

The KOP Program is clearly a program subject to the ADA. Prison services and programs fall under the ADA's purview. *Pennsylvania Dept. of Corrections v. Yeskey*, 524 U.S. 206, 210 (1998) ("Modern prisons provide inmates with many recreational 'activities,' medical 'services,' and educational and vocational 'programs,'" from which disabled prisoners could be excluded.). Such programs qualify if the prison has them, even though prisoners may not have a freestanding due process right to them. *Kogut v. Ashe*, 592 F.Supp.2d 204, 207-08 (D.Mass. 2008) (finding good-time credit work program subject to ADA even though prisoners lack a constitutional right to prison work program). A recent decision applied the ADA to Alabama's exclusion of HIV-positive prisoners from prison food-service jobs and work release programs (in addition to segregated housing). *Henderson*, 913 F.Supp.2d at 1288, 1309-11. Here, Defendants themselves refer to the KOP Program as a program in the policy that governs it. Add. 7 (Policy No. 27.59, entitled "Keep On Person (KOP) Medication Distribution Program"); *see Yeskey*, 524 U.S. at 210 (finding that prison boot camp amounts to a program where, *inter alia*, enabling statute refers to it as one).

Categorical exclusion of HIV-positive prisoners from the KOP Program violates the ADA. Although Plaintiffs (and other HIV-positive prisoners) are not

entitled to participate in the KOP Program regardless of individual circumstances, they are entitled not to be excluded as a group. *See Henderson*, 913 F.Supp.2d at 1300 n. 30 (with respect to housing segregation claim, "plaintiffs do not request a right to transfer to the facility of their choosing; the plaintiffs ask only not to be segregated on account of their HIV status"). Blanket policies that discriminate are unlawful. *See id.* at 1288, 1309-11 (invalidating policies excluding HIV-positive prisoners from holding kitchen jobs within prison or food service jobs on work release); *McNally v. Prison Health Services*, 46 F.Supp.2d 49, 58-59 (D.Me. 1999) (finding an ADA claim stated where jail excluded HIV-positive detainees from prescription drug service); *Habit Management, Inc. v. City of Lynn*, 235 F.Supp.2d 28 (D.Mass. 2002) (invalidating city's blanket prohibition of methadone clinics).

There is no dispute that all five Plaintiffs, like many other HIV patients, qualified for and participated in the KOP program prior to the February 2009 policy change. They followed the KOP Program's requirements and their treatment was effective. Defendants removed them from the KOP Program because of their HIV. That action violates the ADA. As the district court in *Henderson* held, "[H]ow prisoners should be treated based on their HIV-positive status must depend on an individual-by-individual assessment of these prisoners that honors each prisoner's rights under the ADA." *Henderson*, 913 F.Supp.2d at 1318.

Reversal is warranted where the trial court "fail[s] to address admissible record evidence that may suffice to create genuine issues of material fact as to whether the defendants violated Title II of the ADA." *Kiman*, 451 F.3d at 276. Here, the District Court not only failed to address such evidence, it failed even to acknowledge the theory underlying the five Plaintiffs' ADA claim.

In its decision, the District Court portrayed the ADA claim as belonging to Plaintiff Nunes alone. The court repeatedly refers to the singular "plaintiff,"[8] Add. 3-4, and primarily discusses Plaintiff Nunes' preliminary injunction motion. *Id.* While Plaintiff Nunes did assert in his preliminary injunction motion a distinct ADA theory – alleging failure to accommodate his specific medical needs, including back, leg, and stomach ailments – this was not the theory pressed by the other Plaintiffs. All five Plaintiffs asserted that the exclusion of HIV-positive prisoners from the KOP Program was categorical discrimination prohibited by the ADA. That fact was made clear in Plaintiffs' summary judgment memorandum. *Compare* ECF #98 at 17-23 (discussing categorical discrimination claim) with *id.* at 36-38 (discussing Plaintiff Nunes' failure to accommodate claim).

The District Court also mischaracterized Plaintiffs' claim as one concerning access to "the prison's medical services." Add. 4. This is inaccurate. The "service

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[8] In its discussion of the ADA and Rehabilitation Act claims, the District Court did make one passing reference to an accommodation request by Plaintiff John Doe, but it then returned to Plaintiff Nunes' claim. Add. 4.

[or] program[]" in question under Title II is not prison medical services but the KOP Program. 42 U.S.C. §12132*; see* ECF #98 at 17 ("blanket exclusion of HIV medications from the KOP program"), 18 ("[t]he KOP program is a program or service, subject to Title II").

The District Court did not rule on Plaintiffs' categorical exclusion claim, nor on the validity of any claim by Defendants that an exception to the statute should apply. To the extent that Defendants made any such arguments, the record is replete with factual disputes, and the District Court's role at summary judgment is not to resolve such disputes. Taking the facts in the light as favorable to Plaintiffs as the record will reasonably allow, *Travers*, 737 F.3d at 145 (1st Cir. 2013), summary judgment on the ADA claim must be denied.

III. THE DISTRICT COURT ERRED IN GRANTING SUMMARY JUDGMENT ON PLAINTIFFS' EIGHTH AMENDMENT CLAIM, AS THE BLANKET POLICY REMOVING HIV MEDICATIONS FROM THE KOP PROGRAM AMOUNTS TO DELIBERATE INDIFFERENCE.

The District Court decided, in a two-paragraph analysis, that "[p]laintiff has not shown that prison officials acted with deliberate indifference because the new protocol simply administers the same care in a different manner...Plaintiff does not challenge the quality of the treatment offered and defendants have reasonably addressed his burdens on accessing treatment under the new protocol." Add. 3. As a preliminary matter, the District Court again omits the fact that five Plaintiffs are

advancing this claim. Presumably the District Court focused only on Plaintiff Richard Nunes because it had previously heard and ruled on his Motion for a Preliminary Injunction. The other four Plaintiffs, who did not seek preliminary relief, nevertheless assert a deliberate indifference claim.[9]

The District Court also oversimplified the basis of the Plaintiffs' Eighth Amendment claim. There was more than enough evidence to survive summary judgment, but the District Court did not address that evidence, failed to view it in the light most favorable to Plaintiffs, and failed to indulge all possible inferences in Plaintiffs' favor.

The Eighth Amendment "proscribes medical care that does not rise to the level of 'the evolving standards of decency that mark the progress of a maturing society,'" and acts that "involve the unnecessary and wanton infliction of pain." *Estelle v. Gamble*, 429 U.S. 97, 102-04 (1976) (citations omitted); *Kosilek v. Spencer,* --- F.3d ----, 2014 WL 185512, *26 (1st Cir. 2014), *reh'g en banc granted, op. withdrawn* (Feb. 12, 2014) (citations omitted). Prison officials violate the Eighth Amendment "when they fail to provide an inmate with adequate medical care, such that 'their 'acts or omissions [are] sufficiently harmful to

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[9] Unlike Plaintiff Nunes, the other four Plaintiffs have attended the med line since the policy change. There is a dispute of fact as to whether Defendants have addressed the HIV medication-related concerns of these Plaintiffs and other prisoners since the policy change. App. 198-200, 321-22.

evidence deliberate indifference to serious medical needs.'" *Kosilek*, 2014 WL 185512 at *24 (quoting *Leavitt,* 645 F.3d at 497).

A plaintiff must satisfy two prongs to prevail on such a claim. *Kosilek*, 2014 WL 185512 at *24 (citations omitted). First, "the deprivation alleged must be, objectively, sufficiently serious." *Kosilek*, 2014 WL 185512 at *24 (quoting *Farmer v. Brennan*, 511 U.S. 825, 834 (1994)). Satisfying the objective prong requires a showing that the prisoner has a serious medical need. *See Kosilek*, 2014 WL 185512 at *24. Prisoners are entitled to adequate medical care for serious medical needs, which entails "services at a level reasonably commensurate with modern medical science and of a quality acceptable within prudent professional standards." *Id.* (quoting *United States v. DeCologero,* 821 F.2d 39, 43 (1st Cir. 1987).

The second, subjective prong requires that prison officials were deliberately indifferent to a prisoner's health and safety. *Kosilek*, 2014 WL 185512 at *25. An official is deliberately indifferent if he or she knows of and disregards a substantial risk of serious harm to the prisoner's current or future health. *See Farmer*, 511 U.S. at 842-43; *Helling v. McKinney,* 509 U.S. 25, 33-35 (1993); *Roe v. Elyea*, 631 F.3d 843, 858 (7th Cir. 2011). Conscious disregard can be established by the defendant's response to a known need, or by "denial, delay or interference with prescribed health care." *Battista v. Clarke*, 645 F.3d 449, 453 (1st Cir. 2011)

(quoting *DesRosiers v. Moran,* 949 F.2d 15, 19 (1st Cir.1991)); *see Estelle,* 429 U.S. at 104-05. A "state-of-mind issue such as the existence of deliberate indifference" and the "elusive issues of motive and intent" are usually fact-bound and present questions for the finder of fact. *Kosilek*, 2014 WL 185512 at *26 (quoting *Torraco v. Maloney,* 923 F.2d 231, 234 (1st Cir.1991)).

Plaintiffs in this matter, all of whom are HIV-positive, have a serious medical need. *See, e.g., Leavitt,* 645 F.3d at 500 ("It is obvious that HIV is a serious medical condition, as the condition can be life-threatening if not properly treated.") (citations omitted). In addition, the risk of harm faced by Plaintiffs due to Defendants' actions, which include both painful side effects and missed doses that leave Plaintiffs susceptible to HIV medication resistance and its consequences, plainly constitutes a serious medical need. *See id.* at 500-01; *McNally*, 46 F.Supp.2d at 54-55.

The medical care at issue is Defendants' blanket removal of HIV medications from the KOP Program. The District Court's description of the policy change as "simply administer[ing] the same care in a different manner," Add. 3, ignores the significant effects of this change on Plaintiffs and all other HIV patients who must now go to med line in order to access their life-sustaining medication, regardless of their individual medical needs or previous success with the KOP Program. As Plaintiffs' expert witness stated, the standard of care for

treatment of HIV includes developing an individualized plan to maintain adherence. App. 362; *see also Henderson*, 913 F.Supp.2d at 1305 ("The [Alabama] DOC's own expert ... perhaps expressed the court's impression best: 'HIV is a complex disease, and we have to ... examine it *patient by patient*' (emphasis added.) When determining the medical needs of people with HIV, '[y]ou can't group all patients together.'"). The policy change, enacted by administrators over the objection of the actual medical providers, puts Plaintiffs at substantial risk of serious harm.

Mandatory DOT forces HIV patients to endure side effects from their medications unnecessarily, particularly with respect to medications containing Efavirenz. Efavirenz is indicated to be taken at bedtime because of its neurological effects, including dizziness and flulike symptoms. App. 327, 366, 562. Forcing a patient to take this medication hours before bedtime is substandard care. App. 366. The side effects alone are substantial enough to constitute harm under the Eighth Amendment. *See Roe*, 631 F.3d at 864-65; *Gil v. Reed,* 381 F.3d 649, 662 (7th Cir.2004).[10] When Plaintiff Coe experienced significant side effects, the HIV specialist ultimately changed his medications. App. 328, 1029. The HIV specialists, Dr. Stone and Dr. Quirk, testified to changing the medications of other patients as well, sometimes to less optimal regimens, as a result of the policy

[10] The timing of med line relative to meals can also compromise the absorption of HIV medication, which can lead to drug resistance. App. 329, 1409, 1740.

change. App. 345-46, 763, 1420-21, 1423-24, 1458-60. Changing an effective HIV medication regimen for nontherapeutic reasons is not the standard of care, as the available regimens are finite, patients can become resistant, and they may run out of medications that will effectively treat the virus. App. 345, 366, 1415, 1662.

Defendants are aware not only that their policy change exacerbates side effects, but that it causes some patients, including Plaintiffs, to miss *more* doses of their HIV medication than they did under the KOP program. Each Plaintiff was adherent under the KOP program. App. 263, 511, 523, 527, 531, 535. Plaintiffs have recounted occasions of missed, delayed, and partial doses under circumstances that would not have arisen when the medications were KOP. App. 325-26, 533, 793, 1422. The HIV specialists and infectious disease case managers have similarly described problems and complaints from their patients, along with problems apparent from their clinical data. App. 320-26, 345-46. Interruptions in HIV medications risk the development of resistance to the drugs; resistance deteriorates the immune system and renders the virus suppression more difficult. App. 254, 344. Progression of the disease puts patients at risk of developing opportunistic infections, systemic inflammation, AIDS, AIDS-related problems and infections, and death. App. 255, 1416.

Defendants were deliberately indifferent in removing HIV medications from the KOP Program and continue to be indifferent to the harm it causes. Forcing

patients to endure side effects and missed or partial doses, forcing HIV medication regimen changes, and enforcing such a system in pursuit of an administrative, not therapeutic, agenda, amounts to the imposition of "an easier and less efficacious" treatment plan for non-medical reasons. *Chance v. Armstrong*, 143 F.3d 698, 703 (2d Cir. 1998) (citations omitted); *see, e.g., Estelle*, 429 U.S. at 104 n. 10. The deficiencies that repeatedly cause HIV patients' unnecessary suffering and place them at risk of substantial harm are systematic ones – staffing, medication line procedures, and unscheduled interruptions inherent in prison life – that were foreseeable at the time of the policy change and are well known to Defendants. *See Todaro v. Ward*, 565 F.2d 48, 52 (2d Cir.1977). Moreover, Defendants refused to heed the warnings or accept the recommendations of their own infectious disease case managers and HIV specialists, instead choosing to interfere with Plaintiffs' prescribed health care; this is enough to establish Defendants' wanton disregard. *Kosilek,* 2014 WL 185512 at *32 (quoting *Battista,* 645 F.3d at 453); *Johnson v. Wright,* 412 F.3d 398, 404 (2d Cir.2005) (vacating grant of summary judgment on Eighth Amendment claim, where "defendants reflexively applied DOCS [Hepatitis C] policy in the face of the unanimous, express, and repeated-but contrary-recommendations of plaintiff's treating physicians, including prison physicians").

Defendants rationalized the policy change as necessary to improve patient adherence. App. 303-05, 2059-61. Meanwhile, their own adherence figures, based

on pharmacy claims data, reveal just the opposite: that mandatory DOT puts HIV patients in harm's way. After HIV medications were removed from the KOP Program, with staff fully responsible for obtaining refills, thirty percent of the refills have been late, persistently. App. 364, 1498, 2043. Half of those late refills have been a week or more late; such long medication interruptions dramatically increase the risk of viral rebound, which can be disastrous. App. 308, 365. These figures are disturbing and reflect no improvement over the period before the policy change. Likewise, a fair comparison of pre-change and post-change viral loads shows no statistically significant difference. App. 312-13, 365-66. Defendants claim that mandatory DOT has improved viral loads based on fewer detectable viral loads among HIV patients in 2012, but that improvement cannot be linked to the 2009 policy change, as too many other factors that contribute to viral loads cannot be controlled for. App. 366; s*ee Henderson*, 913 F.Supp.2d at 1294 (finding that the link between prison's HIV housing segregation policy and lower HIV transmission rates amounts to "*post hoc ergo propter hoc*"). As Plaintiffs' expert witness submits, newer medications with higher potency are the most likely reason for the improvement in viral loads. App. 366.

Under the KOP Program, prisoners who are not adherent to their medication regimens are accountable and can ultimately end up with DOT medications. The KOP policy, and the testimony of providers, makes that fact clear. Add. 7-8; App.

259, 844, 1651. HIV patients were already very closely monitored. App. 257-62. Like many HIV patients, Plaintiffs did not have adherence problems under the KOP program; they took their medications. Now that they have lost all autonomy regarding their medications, they are definitively worse off.

It is true that an assessment of deliberate indifference must "embrace security and administration and not merely medical judgments." *See Kosilek*, 2014 WL 185512 at *31 (quoting *Battista*, 645 F.3d at 455). That having been said, Defendants' administrative justifications fall flat. "[T]he policy of deference to state officials is less substantial when, as in the present case, matters of prison discipline and security are not at issue." *Todaro*, 565 F.2d at 54 (citing *Newman v. Alabama*, 503 F.2d 1320, 1329-30 (5th Cir. 1974)). No issue of prison discipline or security has ever been raised by Defendants.

Defendants do allege substantial cost savings from mandatory DOT, but cost "is not a legitimate reason for not providing [adequate] care to a prisoner." *Kosilek v. Spencer*, 889 F.Supp.2d 190, 210 (D.Mass. 2012); *see Chance,* 143 F.3d at 704; *Harris v. Thigpen,* 941 F.2d 1495, 1509 (11th Cir.1991); *Ancata v. Prison Health Servs., Inc.,* 769 F.2d 700, 705 (11th Cir.1985). Even if cost were a relevant consideration, Defendants would not be entitled to summary judgment, as their self-serving estimates of savings are disputed and clearly unreliable. Defendants know that returned medications arise from the sudden discharges of pretrial and

other temporary prisoners, and from transfers within the DOC where staff did not transport or forward the medications. Medications should not be taken from discharged prisoners, who by policy are supposed to take those medications with them. App. 276, 311, 589, 612, 819. Returning the medications of a transferred prisoner saves no money, because the returned medications are offset by a new purchase at the new facility. App. 625, 1770. Moreover, pretrial and temporary prisoners could be dealt with separately than Plaintiffs, and others like them, who were at stable sites, were not transferred frequently, and were not going to be discharged without warning. App. 279-80, 294, 339-40, 757-58, 845, 1658, 1740, 1743, 1752.

There are genuine issues of material fact that compel denial of summary judgment on the Eighth Amendment claim.

IV. THE DISTRICT COURT ERRED IN GRANTING SUMMARY JUDGMENT ON PLAINTIFFS' PRIVACY CLAIM, AS THE POLICY CHANGE VIOLATES PRIVACY RIGHTS PRESERVED BY THE FOURTEENTH AMENDMENT.

The District Court granted summary judgment on Plaintiffs' privacy claim stating, "Even if plaintiff has a right to privacy, defendants have not violated it because the new protocol is rationally connected to legitimate penological interests." Add. 5. The District Court described the claim as "[p]laintiff alleg[ing] the new protocol violates his right to privacy because of the likelihood that his HIV status will be disclosed if he participates in the medication line." Add. 4. The

District Court has misinterpreted which Plaintiffs advance this claim. Plaintiffs Coe, Doe, Poe, and Roe assert the privacy claim; they have attended med line since the policy change. Plaintiff Nunes does not advance a privacy claim. In addition, Plaintiffs claim that the policy change *has resulted and will continue to result in* unauthorized disclosures of their HIV status in violation of their right to privacy protected by the Fourteenth Amendment. In support of their claim, Plaintiffs have presented their own experiences with privacy breaches since the policy change. The District Court failed to address the evidence supporting this claim, to view it in the light most favorable to Plaintiffs, and to indulge all possible inferences in Plaintiffs' favor in granting summary judgment.

A. Plaintiffs Have a Constitutional Right to Privacy with Regard to Their HIV Status.

Individuals have a constitutional right to privacy that protects "the individual interest in avoiding disclosure of personal matters." *Whalen v. Roe*, 429 U.S. 589, 599 (1977); *see Houchins v. KQED, Inc.*, 438 U.S. 1, 5 n. 2 (1978) (Prisoners "retain certain fundamental rights of privacy."). A prisoner's HIV-positive status has been deemed to be sufficiently sensitive to trigger the right. *See Moore v. Prevo*, 379 Fed.Appx. 425, 428 (6th Cir. 2010); *Doe v. Delie*, 257 F.3d 309, 317 (3d Cir. 2001); *Powell v. Schriver*, 175 F.3d 107, 112 (2d Cir.1999); *Doe v. Magnusson*, 2005 WL 758454, *10-11 (D.Me. 2005); *Nolley v. County of Erie,* 776 F.Supp. 715, 728-32 (W.D.N. Y.1991); *Rodriguez v. Coughlin,* 1989 WL

59607, * 3 (W.D.N.Y. 1989); *Woods v. White,* 689 F.Supp. 874, 876 (W.D.Wis. 1988), *aff'd*. 899 F.2d 17 (7th Cir.1990); *Doe v. Coughlin*, 697 F.Supp. 1234, 1237-38 (N.D.N.Y. 1988); *see also Alfred v. Corrections Corp. of America*, 437 Fed.Appx. 281, 285-86 (5th Cir. 2011); *Harris,* 941 F.2d at 1513.

HIV-positive status has been distinguished from most other medical conditions suffered by prisoners and individuals living in the community alike, given the intensely personal nature of the infection and the "relentless stigma" accompanying disclosure. *Henderson*, 913 F.Supp.2d at 1278; *see Cortes v. Johnson*, 114 F.Supp. 2d 182, 185-86 (W.D.N.Y. 2000); *cf. Matson v. Board of Educ. of City School Dist. of New York*, 631 F.3d 57, 67 (2d Cir. 2011). "[T]he privacy interest in information regarding one's HIV status is particularly strong because of the stigma, potential for harassment, and 'risk of much harm from non-consensual dissemination of the information.'" *Delie*, 257 F.3d at 315 (quoting *Doe v. Southeastern Pa. Transp. Auth.,* 72 F.3d 1133, 1138 (3d Cir.1995)), *cert. denied* 519 U.S. 808 (1996); *see Matson*, 631 F.3d at 64 n. 6; *Doe v. City of New York*, 15 F.3d 264, 267 (2d Cir.1994); *Henderson*, 913 F.Supp.2d at 1278; *Doe v. Town of Plymouth*, 825 F.Supp. 1102, 1107-08 (D.Mass. 1993) (citing *Woods,* 689 F.Supp. at 876). Privacy of one's HIV status is even more essential for prisoners, because a prisoner identified as HIV-positive "will be severely compromised in his

ability to maintain whatever dignity and individuality a prison environment allows." *Coughlin*, 697 F.Supp. at 1238.

Both Massachusetts law and Defendants' own policies recognize the special importance of maintaining privacy regarding one's HIV status. *See, e.g.,* M.G.L. c.111, § 70F ("A facility, [] physician or health care provider shall not...(2) disclose the results of [a] test [for the presence of the HIV antibody or antigen] to any person other than the subject of the test without first obtaining the subject's written informed consent; or (3) identify the subject of such tests to any person without first obtaining the subject's written informed consent. A written consent form shall state the purpose for which the information is being requested and shall be distinguished from written consent for the release of any other medical information."); 105 CMR 180.300(B)(1) ("[B]oth the identity of the subject of HIV tests and the test results are confidential and may not be released to anyone except the subject of the test without first receiving the subject's written consent."); App. 2075-77 (UMCH Policy 62.02, *Release of HIV Information and Test Results*).

In *Borucki*, this Court declined to decide whether a constitutional right to privacy regarding medical records existed. *Borucki v. Ryan*, 827 F.2d 836, 841-44 (1st Cir. 1987). Instead, the Court conducted a qualified immunity analysis and held that no clearly established right of privacy protected a defendant's court-ordered psychiatric report from disclosure after dismissal of the criminal case. *Id.*

Since *Borucki*, several District Court decisions in this Circuit have recognized the existence of a right to privacy in one's medical information. See *Flood v. Maine Dept. of Corrections*, 2012 WL 5389533, *26 (2012); *Klein v. MHM Correctional Services, Inc.*, 2010 WL 3245291, *4 (D.Mass. 2010); *Hodgdon v. Downeast Correctional Facility*, 2010 WL 53504, *4 (2010); *Marchand v. Town of Hamilton,* 2009 WL 3246607, *7 (D.Mass. 2009); *Magnusson*, 2005 WL 758454 at *10-11*;* *Pouliot v. Town of Fairfield*, 184 F.Supp.2d 38, 50 (D.Me. 2002); *Town of Plymouth*, 825 F.Supp. at 1107. Plaintiffs have a right to avoid unwanted disclosures of their HIV-positive status.

B. Defendants Violate Plaintiffs' Right to Privacy, and the Unwanted Disclosures Are Not Reasonably Related to a Legitimate Penological Interest.

Plaintiffs have provided evidence that the removal of all HIV medications from the KOP Program has resulted and will continue to result in unauthorized disclosures of HIV status to prisoners and correctional staff. Defendants knew that the policy change would result in privacy violations, due to privacy problems inherent in forcing HIV-positive prisoners to attend med line. Indeed, problems manifested immediately after the change, as Plaintiffs (and others) suddenly went from not attending med line to attending it every day. App. 330, 525, 528, 532, 536. Since the policy change, unwanted disclosures have arisen in different contexts, including: a poster showing HIV medications for all to see and compare

to the medications being given to HIV patients; prying eyes of many prisoners at med line keen to identify medications that others take; med line nurses announcing that HIV medication was being administered; med line nurses using different cups for HIV medications and giving a signal to the med line CO; med line nurses giving Plaintiff's HIV medication to another prisoner; med line nurses compelling Plaintiffs to answer questions that force them to disclose their HIV status; and correctional staff compelling Plaintiffs to disclose their HIV status in order to explain why it is vital that they access med line. App. 329-32, 501-02, 525, 528, 1023-24, 1059-60, 1171. Plaintiffs have had prisoners accost them and ask about their status. App. 525, 528, 532, 536.

Though Defendants suggest that Plaintiffs suffered from an equal number of unwanted disclosures under the KOP Program, the evidence suggests otherwise. If unit officers had access to information about Plaintiffs' status, they either did not review it or were discreet. App. 203, 1060. Plaintiffs were able to keep their medications hidden in transit between the KOP line and their cells. They were able to maintain privacy from their cellmates, if they chose. App. 203-04, 524-25, 528, 532, 536, 1033, 1060; *see Henderson*, 913 F.Supp.2d at 1312 (finding that voluntary disclosure differs from forced disclosure).

A prisoner's constitutional right may be curtailed by a policy or regulation that is shown to be "reasonably related to legitimate penological interests." *Turner*

v. Safley, 482 U.S. 78, 89 (1987). The District Court decided that the removal of HIV medications from the KOP Program was rationally related to safeguarding prisoner health and to conserving financial resources. Add. 5. In doing so, the District Court improperly ignored disputed facts and resolved contested issues in Defendants' favor.

The Supreme Court has set forth several factors relevant in determining the reasonableness of a prisoner regulation or policy: (1) "there must be a 'valid, rational connection' between the [policy] and the legitimate governmental interest put forward to justify it"; (2) "whether there are alternative means of exercising the right that remains open to prison inmates"; (3) "the impact accommodation of the asserted constitutional right will have on guards and other inmates, and on the allocation of prison resources generally"; and (4) the absence or existence of a ready alternative "that fully accommodates the prisoner's rights at *de minimis* cost to valid penological interests." *Turner,* 482 U.S. at 89-90. The existence of obvious, easy alternatives may be evidence that the regulation is not reasonable, but rather an "exaggerated response" to prison concerns. *Id.* at 91. Even assuming that the penological purposes of medication adherence and medication waste reduction are genuine, Defendants' actions were and are not reasonable.

First, there is no valid, rational connection between the policy change and the stated penological interests advanced. Defendants' expressed desire to improve

adherence is contradicted by their own adherence analyses, depicting significant late refills and lengthy medication interruptions. Under the KOP Program, medical staff were already evaluating adherence on an individual basis using multiple measures, including the patient Medication Administration Record and chart. Removing *all* HIV patients from the KOP Program does not further the interest of adherence, especially for Plaintiffs and patients like them whose adherence is worse with DOT. Moreover, waste from returned medications is well overstated by Defendants. Returning unfinished medications of a transferred prisoner, instead of forwarding them to the new facility, is not waste-reduction at all. Returning unfinished medications of a discharged prisoner, instead of giving them to him, is not waste-reduction, but a violation of policy and a dangerous practice for public health. Whatever meager benefits the policy change offers "are insufficient standing alone to warrant permitting infringement of the prisoner's right to privacy." *Coughlin*, 697 F.Supp. at 1241 (holding that prisoners are entitled to protection against non-consensual disclosure of HIV status through involuntary placement in a separate dormitory, after balancing against penological interests of improved health care for HIV-positive prisoners and reduced costs of transportation to medical appointments).

Second, HIV-positive prisoners have no alternative means to exercise their right to privacy. It is entirely unclear from the evidence what accommodations the

District Court believes are available to Plaintiffs to allay their privacy concerns. Add. 6. All HIV patients are required to attend the med line and, once their status has been disclosed, the right "is lost forever." *Nolley*, 776 F.Supp. at 733, 736.

Third, accommodating HIV-positive prisoners' right to privacy will have a minimal impact on staff and other prisoners, given that the KOP Program was available for HIV patients for years. *See id.* at 733, 736. The District Court's inference that the policy change is likely to increase prison resources by reducing medical waste, Add. 6, is not supported by the evidence. The evidence shows that long-term prisoners are not causing waste. The evidence does, however, show that forcing all HIV-positive prisoners to attend the med line for each dose actually increased the volume of work for medication line nurses and officers, creating a greater burden on facility staffing of the medication line.

Fourth, restoring KOP Program eligibility to HIV patients is an obvious, ready alternative with *de minimis* cost to valid penological interests. Defendants would be able to ensure adherence and reduce waste by enforcing the KOP policy to suspend HIV patients' privileges when warranted and ensuring that medications actually go with discharged or transferred prisoners.[11] Removing all HIV

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[11] Defendants could also remove KOP eligibility from only pretrial and short-term HIV-positive prisoners, as the infectious disease case managers and the HIV specialists recommended previously. App. 279, 339-40, 757-58, 845, 1658, 1740, 1752.

medications from KOP eligibility for all prisoners was an exaggerated response to an exaggerated issue.

The privacy violations established are inextricably related to the policy change requiring HIV-positive prisoners to obtain their HIV medications at med line. The med line procedure, foreseeably, gives rise to repeated gratuitous disclosures. Such violations of HIV-positive prisoners' right to privacy are not reasonably related to a legitimate penological purpose. *See Powell,* 175 F.3d at 109, 112 ("[T]he gratuitous disclosure of an inmate's confidential medical information as humor or gossip-the apparent circumstance of the disclosure in this case-is *not* reasonably related to a legitimate penological interest, and it therefore violates the inmate's constitutional right to privacy."); *Magnusson,* 2005 WL 758454 at *11.

V. THE DISTRICT COURT ERRED IN GRANTING SUMMARY JUDGMENT ON PLAINTIFF NUNES' CLAIM FOR FAILURE TO ACCOMMODATE, BASED ON A PRELIMINARY INJUNCTION RULING THAT WEIGHED THE EVIDENCE AGAINST HIM, NOT IN THE LIGHT MOST FAVORABLE TO HIM.

Plaintiff Nunes sought a trial on his failure to accommodate claim under the ADA, so that the District Court could assess the credibility of each side with regard to the accommodations proposed by Defendants to address Plaintiff Nunes' specific needs. Accommodations are necessary to ensure that Plaintiff Nunes will have access to HIV medications, even when he has difficulty ambulating, and

when he is too ill or pain-ridden to attend the med line. Otherwise, the interruptions in his treatment will heighten the risk of resistance.

Defendants proposed accommodations that they contended were reasonable, including the use of a rolling walker to and from the med line, use of a bench (to sit) and a bathroom (as needed) while waiting in line, App. 2219, and a special procedure for days when Plaintiff Nunes could not get to the med line. Under that procedure, a nurse would go to his cell to assess his condition and determine whether he needed to be admitted to the prison's infirmary; the nurse would not administer his medication at the cell. App. 2226, 2232. Plaintiff Nunes contends that these proposed accommodations are not aimed at ensuring his access to medications, but at erecting enough barriers to ensure that he does not invoke them. App. 2231-36.

There is record support for Plaintiff Nunes' contention that the proposed accommodation is unreasonable. Illnesses of the kind that Plaintiff Nunes chronically suffers do not generally cause a prisoner to be admitted to the Health Services Unit. To the contrary, on one occasion when Mr. Nunes missed medical appointments because of illness, he was admitted not to the Health Services Unit, but to the segregation unit for refusing the appointment. App. 2253-55.

Admission to the Health Services Unit has a punitive effect, as it means Plaintiff Nunes would be held in the Health Services Unit without access to his

property and denied other privileges until Defendants chose to discharge him; he would also lose his cell placement with bottom-bunk arrangements and be returned to an orientation unit to wait until a new placement permanent became available. App. 2234-35, 2239-40. His constant motion in and out of the Health Services Unit and into different cells with different cellmates would be challenging, and it is common for items from prisoners' property to be lost or damaged in the shuffle. *Id.* In addition, there is no guarantee that simply reporting his illness to an officer will result in a call to nursing staff and a visit from a nurse in the first place. Plaintiff Nunes attempted once to get a nurse to evaluate him when he felt too ill to attend a medical appointment and was, instead, taken to the segregation unit. App. 2253-55. If a nurse did come, but disputed his claim of illness, he would miss med line and, thus, his HIV medication anyway. Defendants have no reasonable explanation for why a nurse could not simply bring Plaintiff Nunes' HIV medications to the cell, in case he or she concurred that he was ill.

Defendants try to portray Plaintiff Nunes as unreasonable, suggesting among other things that he will refuse all accommodations except KOP medication. The record demonstrates otherwise. While Plaintiff Nunes would prefer KOP medications, and a KOP order would be more efficient and less labor-intensive for staff than other accommodations, Plaintiff Nunes has proposed other accommodations to Defendants. He requested, for instance, that he be allowed to

go to med line either first or last to minimize his waiting time. App. 112. He also requested to have his medication brought to him by a nurse who was already coming to his housing unit, to administer medications to prisoners locked in their cells. *Id.*

The reasonableness of the Defendants' proposed accommodation is an issue that warrants a trial. The material facts are disputed, and the court at trial could better measure the parties' credibility and the reasonableness of their positions. The District Court awarded summary judgment to Defendants, stating that the undisputed facts showed that the proposed accommodation was reasonable. Add. 2. The District Court made this finding by referring to its ruling on Plaintiff Nunes' motion for a preliminary injunction. *Id.* However, the District Court's ruling on the preliminary injunction motion stated that the record was not clear. App. 2288. The record is not clear, because Defendants' proposed facts are contested. The award of summary judgment on this claim should therefore be reversed.

CONCLUSION

For the foregoing reasons, Plaintiffs Richard Nunes, Carl Coe, John Doe, Peter Poe, and Richard Roe respectfully request that this Court reverse the entry of summary judgment in this case and remand the case to the District Court.

Dated: February 14, 2014

Respectfully submitted,

/s/ Joel H. Thompson

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CERTIFICATE OF COMPLIANCE WITH RULE 32(a)

1. This brief complies with the type-volume requirements of Federal Rules of Appellate Procedure 32(a)(7)(B) because this brief contains 9,649 words, as determined by the word-count function of Microsoft Word, excluding the parts of the brief exempted by Federal Rule of Appellate Procedure 32(a)(7)(B)(iii); and

2. This brief complies with the typeface requirements of Federal Rule of Appellate Procedure 32(a)(5) and the type style requirements of Federal Rule of Appellate Procedure 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using Microsoft Word in 14 point Times New Roman font.

Dated: February 14, 2014

/s/ Joel H. Thompson
Joel H. Thompson (No. 1082850)
Attorney for Plaintiffs-Appellants

CERTIFICATE OF SERVICE

I, Joel H. Thompson, hereby certify pursuant to Fed. R. App. P. 25(d) that on February 14, 2014, the foregoing Brief of Prisoners' Legal Services as Amicus Curiae in Support of Plaintiff-Appellant and Supporting Reversal was filed through the CM/ECF system and served electronically on the individuals listed below:

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No. 13-2346

UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT

RICHARD NUNES, CARL COE, JOHN DOE, PETER POE, and RICHARD ROE,
Plaintiffs-Appellants,

v.

MASSACHUSETTS DEPARTMENT OF CORRECTION, THOMAS GROBLEWSKI, and MARK WAITKEVICH,
Defendants-Appellees

On Appeal from the United States District Court
for the District of Massachusetts

ADDENDUM TO PLAINTIFFS-APPELLANTS' PRINCIPAL BRIEF

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UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

CIVIL ACTION NO. 10-12013-RWZ

RICHARD NUNES, *et al.*

v.

UMASS CORRECTIONAL HEALTH, *et al.*

MEMORANDUM OF DECISION
October 3, 2013

ZOBEL, D.J.

Plaintiff Richard Nunes, a state prisoner, brings suit on behalf of himself and similarly situated inmates, against UMass Correctional Health, the Massachusetts Department of Correction, and several individual employees of both entities ("defendants"). He claims a newly enacted policy prohibiting him from self-administering his HIV medication violates the Eighth Amendment (Count I), the Equal Protection Clause of the Fourteenth Amendment (Count II),[1] Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §§ 794-794a et seq. ("RA") (Count III), Title II of the Americans with Disabilities Act, 42 U.S.C. §§ 12131 et seq. ("ADA") (Count IV), and his right to privacy under the Fourteenth Amendment (Count V). Defendants move for summary judgment.

I. Background

[1]Plaintiff has since stated he does not oppose defendants' motion for summary judgment on Count II. See Pls.' Consol. Mem. in Opp. to Defs.' Mot. for Summ. J., Docket # 98, at 7.

Plaintiff earlier moved for a preliminary injunction against enforcement of the new protocol requiring HIV-positive inmates to stand in line at the Health Services Unit to receive their medications, as well as an order allowing him to resume self-administering his medication. I denied the motion after defendants permitted plaintiff to travel to and from the medication line more comfortably and follow a different procedure when he is too ill to do so.

II. Legal Standard

Summary judgment will be granted if there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(a). The court must view the record in the light most favorable to the nonmovant and draw all justifiable inferences in that party's favor. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 255 (1986).

III. Analysis[2]

A. Count I: Eighth Amendment

Plaintiff must meet two requirements to demonstrate he suffered cruel and unusual punishment that violates the Eighth Amendment. First, he must show that he suffered an objectively serious harm or deprivation. Second, he must prove that the prison officials responsible for that deprivation acted with deliberate indifference to his serious medical need. Farmer v. Brennan, 511 U.S. 825, 834 (1994). Deliberate indifference is defined as the "unnecessary and wanton infliction of pain." Estelle v.

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[2]Because plaintiffs' claims fail on their merits, I do not analyze defendants' arguments regarding failure to exhaust administrative remedies under the Prison Litigation Reform Act of 1995, 42 U.S.C. § 1997e, et seq.

Gamble, 429 U.S. 97, 104 (1976) (quotation and citation omitted).

Plaintiff has not shown that prison officials acted with deliberate indifference because the new protocol simply administers the same care in a different manner. "Where the dispute concerns not the absence of help, but the choice of a certain course of treatment, deliberate indifference may be found where the attention received is so clearly inadequate as to amount to a refusal to provide essential care." Torraco v. Maloney, 923 F.2d 231, 234 (1st Cir. 1991) (internal quotations and citations omitted). Plaintiff does not challenge the quality of the treatment offered and defendants have reasonably addressed his burdens on accessing that treatment under the new protocol. The facts do not establish any Eighth Amendment violations.

B. Counts III and IV: RA and ADA[3]

To demonstrate an ADA violation, plaintiff must establish that (1) he has a disability; (2) he was excluded from participating in, or denied the benefits of a public entity's[4] services, programs, or activities, or was otherwise discriminated against; and (3) the exclusion, denial of benefits, or discrimination was because of his disability. Kiman v. N.H. Dep't of Corrs., 451 F.3d 274, 283 (1st Cir. 2006) (quotation and citation omitted). A public entity must "'make reasonable modifications[5] in policies, practices,

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[3]The liability standards under § 504 of the RA and Title II of the ADA are the same, and courts "rely interchangeably on decisional law applying § 504" when applying Title II. Parker v. Universidad de Puerto Rico, 225 F.3d 1, 4 (1st Cir. 2000); see 29 U.S.C. § 794(d); 42 U.S.C. §§ 12134(b), 12201(a).

[4]A state prison is a "public entity" for ADA purposes. Pa. Dep't of Corrs. v. Yeskey, 524 U.S. 206, 210 (1998).

[5]Although the Department of Justice regulations implementing Title II use the phrase "reasonable modifications" instead of Title I's "reasonable accommodations," the terms create identical standards, and I use them interchangeably. See McGary v. City of Portland, 386 F.3d 1259, 1266 n.3 (9th Cir. 2004); Parker, 225 F.3d at 5 n.5.

or procedures when the modifications are necessary to avoid discrimination on the basis of disability . . . .'" Id. (quoting 28 C.F.R. § 35.130(b)(7)). A "reasonable modification" gives "meaningful access" to the program or services sought. Alexander v. Choate, 469 U.S. 287, 301 (1985); see Bibbo v. Mass. Dep't of Corr., No. 08-10746-RWZ, 2010 WL 2991668, at *1 (D. Mass. July 26, 2010) ("A reasonable accommodation does not require the public entity to employ any and all means to make services available to persons with disabilities."); cf. Bell v. Wolfish, 441 U.S. 520, 540 n.23 (1979) (stating courts should defer to the better-informed views of prison administrators regarding the reasonableness of a given accommodation).

The undisputed facts show defendants provided plaintiff reasonable accommodations. Indeed, the inmates who have sought accommodations have received them. The preliminary injunction ruling addressed plaintiff's request, see Docket ## 57, 66, and defendants honored co-plaintiff John Doe's request to attend an early evening medication line. Docket # 99, SOF ¶ 191. No other similarly situated inmates have requested accommodation. Id. ¶¶ 186, 196-97. Plaintiff has not cited any evidence that defendants have denied him or others "meaningful access" to the prison's medical services. Choate, 469 U.S. at 301. Summary judgment is therefore appropriate.

C. Count V: Right to Privacy

Plaintiff alleges the new protocol violates his right to privacy because of the likelihood that his HIV status will be disclosed if he participates in the medication line. It is not clear that the right plaintiff claims defendants violated exists. The Supreme

Court has not decided whether the Fourteenth Amendment includes a right against public disclosure of private medical information, see Nat'l Aeronautics & Space Admin. v. Nelson, 131 S. Ct. 746, 756-57 (2011), and the question remains open in the First Circuit. Coughlin v. Town of Arlington, No. 10-10203-MLW, 2011 WL 6370932, at *13 (D. Mass. Dec. 19, 2011).

Even if plaintiff has a right to privacy, defendants have not violated it because the new protocol is rationally connected to legitimate penological interests. See Turner v. Safley, 482 U.S. 78, 89 (1987).[6] Safeguarding the health of inmates is a legitimate penological interest, Cryer v. Mass. Dep't of Corr., 763 F. Supp. 2d 237, 250 (D. Mass. 2011), as is conserving financial resources. Klein v. Tocci, No. 09-11248-GAO, 2010 WL 2643414, at *2 (D. Mass. July 1, 2010). Attending the medication line safeguards inmate health because it allows prison medical staff to watch inmates take their medications and thereby ensure they comply with their drug regimens. Furthermore, HIV medication represents a significant cost for defendants. See Docket # 99, SOF ¶ 53 (noting that in fiscal years 2008-2011, HIV medications cost approximately $5 million per year and constituted forty-two percent of pharmacy expenditures, spent on two percent of the inmate population). Because defendants can only receive a monetary credit for returned, unused medications which have not previously been distributed to inmates, id. ¶¶ 54-56, retaining possession of HIV medications enables

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[6]Turner lists four factors to consider when evaluating the constitutionality of a prison regulation: (1) whether there is a valid, rational connection between the regulation and the legitimate government interest put forward to justify it; (2) whether alternative means to exercise the right exist; (3) the impact that accommodating the right will have on prison resources; and (4) the absence of alternatives to the prison regulation. 482 U.S. at 89-90.

potentially substantial cost savings. The new protocol is therefore rationally connected to the interest in financial prudence.

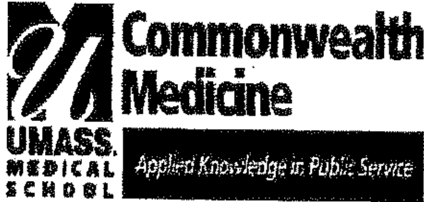
The other Turner factors also support the constitutional validity of the new protocol. The second factor is satisfied because inmates may still seek accommodations to allay their privacy concerns. See id. ¶ 177 (citing 103 DOC 207.04). As for the third, the medication line policy is likely to increase available prison resources by reducing medical waste. Finally, plaintiff presents no policy alternatives that "fully accommodate[] the prisoner's rights at *de minimis* cost to valid penological interests." Thornburgh v. Abbott, 490 U.S. 401, 418 (1989). Therefore, the new protocol bears a rational relation to legitimate penological interests and the right plaintiff asserts may be curtailed.

IV. Conclusion

Defendants' motion for summary judgment (Docket ## 87, 89) is ALLOWED. Plaintiffs' motion to supplement its statement of additional material facts (Docket # 113) is DENIED AS MOOT. Judgment will be entered accordingly.

October 3, 2013	/s/Rya W. Zobel
DATE	RYA W. ZOBEL UNITED STATES DISTRICT JUDGE

UMass Correctional Health Program
Massachusetts Department of Correction
Policy & Procedure Manual



NO:	27.59
Approved:	
Lawrence Weiner Assistant Deputy Commissioner of Clinical Services, DOC	6/13/12 Date
Lenny McGuire Reviewing Authority, UMass Correctional Health	5-30-12 Date
Lynn Davis Chief Nursing Officer, UMass Correctional Health	5/29/12 Date

27.59 KEEP ON PERSON (KOP) MEDICATION DISTRIBUTION PROGRAM

Subject: Keep-On-Person Medication Distribution Program (Essential)

Purpose and Policy Statement: Under the direct supervision of the Health Services Unit Authority, selected prescribed medications may be given to eligible inmates to keep on person and self medicate according to established rules and procedures.

Procedure:

1. The UMass Correctional Health (UMCH) Executive Director and the Department of Correction (DOC) Assistant Deputy Commissioner of Clinical Services with the input of the Pharmacy and Therapeutics (P&T) Committee will approve which medications inmates may keep on person according to guidelines set forth in this policy. Medications which are excluded from Keep-on-Person (KOP) program are listed in Attachment A. These medications must be administered to the inmate on a directly observed therapy (DOT) basis. Medications (prescriptions and over-the-counter) will only be added to this list with the approval of the Pharmacy and Therapeutics Committee. Any exception requires prior written approval by the Assistant Deputy Commissioner of Clinical Services and the UMCH Statewide Medical Director.

2. Each institution will establish and post specific times and days for KOP medication to be reordered and/or picked up by inmates.

3. Inmates are excluded from the KOP program for the following reasons:

   a. Failure to comply with the rules and regulations of the program.

   b. Determined to be at-risk for abuse of the program or inability to comprehend the rules and regulations as determined by medical or

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mental health staff members. (Criteria include known health status, behavioral or clinical concerns, and institution drug history).

c. Temporary or permanent housing arrangements do not have an individual, lockable storage location within the inmate's living area to secure his/her medication.

- If an inmate is excluded from participating in the KOP program for reason (a) and (b), this will be documented on the problem list, and in the comment section of the MAR then dated and signed by the medical or mental health staff.
- The site Superintendent and Clinical Administrator of a facility may submit a written request for the waiving of the requirement that medication be stored in an individual, locked area. The reason for the waiver request must be provided as well as a reasonable equivalency for such storage. All requests for waivers shall be submitted to the Assistant Deputy Commissioner who shall approve or deny it.

4. Termination from the KOP program is under the authority of the Superintendent for rules and regulation infraction or under the authority of the Clinical Administrator for non-compliance with the KOP program or other health care related issues.

5. The following life-saving medications must remain on the inmate's person or within the inmate's reach at all times. A lock or signed KOP agreement is not required for inmate's prescribed life-saving medication alone. When an inmate who is on life-saving medications requires a mental health watch a consultation must be secured by medical staff with mental health staff on the advisability on maintaining these medications on their person.

   - Nitroglycerin sublingual tablets
   - Oral asthma inhalers
   - Oral glucose tablets.

6. Epi-pens ordered for specific inmates at minimum security and pre-release sites will be managed on a case-by-case basis according to site-specific policy to assure immediate 24-hour day availability to the inmate in event of an emergency. This includes any off-site work detail.

7. Site-specific policies regarding availability of lockable locations for KOP medications will be determined by the superintendent on a site-by-site basis.

8. For an inmate to be in possession of a prescription medication, the prescribing practitioner, after careful review of the medical and mental health record to ensure the inmate's ability to comprehend and comply with the program, writes the original order for the medication and indicates Keep-On-Person (or KOP) on the order sheet. The prescriber will instruct the inmate on how to take the medication.

9. The Keep-On-Person medication program will be explained to the inmate. The "KOP Medication Distribution Program Contract" (UMCH 8046) will be documented by the nurse above the label along with the nurse's initials.

The "KOP Medication Distribution Program Contract" (UMCH 8046) is signed by the inmate at this time. The contract becomes part of the medical record. The nurse transcribing KOP medication orders will verify the presence of the signed contract in the medical record.

10. All KOP medication orders will be designated as KOP by the Provider on the MD order sheet.

11. The medication order will be transcribed on an inmate-specific MAR, including the start and stop dates in the left column, and nursing will order the medication from the pharmacy.

    a. The nurse transcribing the order will assure that a current KOP contract has been signed by the inmate, and placed in the record, indicating understanding of the program.

    b. If the signed contract is not present a notation will be placed on the medical record and the Medication Administration Record (MAR), and the contract will be obtained by the medication nurse prior to dispensing the medication.

    c. When the inmate presents to pick up the medication, the medication nurse will review the instructions for taking the medication and how to obtain refills if applicable with the inmate. The nurse will document on the MAR the number of doses given, date and will initial it. The inmate will acknowledge receipt of the medication by signing the MAR.

    d. The nurse will clearly indicate on the MAR the date on which the supply will run out, either by drawing a box in the "date" column, to indicate the date the supply will end, or by indicating in the right column the date of the following month on which the supply will end.

12. When the prescription requires more than one (1) blister pack to fill a thirty (30) day order, only one (1) pack will be given to the inmate at a time, and subsequent packs given from the HSU medication room when the inmate turns in his previous empty pack.

13. By agreement between DOC Health Services and UMass Program Administration, particular sites may elect to expand KOP. In those instances, inmates will be given **thirty (30) days** of their prescribed medications.

14. All prescription medications issued to inmates will be clearly labeled with Name, Date, Medication, Method of Administration, Start Date, Stop Date, and Expiration Date. When the inmate picks up his/her medications, the nurse will adjust the stop date, if necessary, to coincide with the actual stop date.

15. Upon expiration of the stop date, the blister pack will be returned by the inmate to the medication line to establish a current stop date when indicated. The new stop date will be written by the nursing staff above the medication label along with the nurse's initials.

16. All oral tablets and capsules will be issued in blister cards, except certain medications such as nitroglycerin sublingual tablets and Glucose tablets.

17. Disposition of blister cards by the inmate:
    a. Once a prescription expires, the blister card or container is considered contraband.
    b. Empty blister packs for medications, which cannot be refilled, must be returned to the Health Service Unit.
    c. Empty blister packs for medications, which may be refilled, must be returned to the HSU in exchange for a filled blister pack.
    d. Medication cards/containers will be brought to the HSU to arrange for authorized refills within the time frame directed by the doctor or nurse, but no later than 3 days prior to its running out.
    e. The inmate assumes responsibility for returning all unused medication to nursing staff when the prescription order expires.
18. An inmate is allowed to possess only one (1) prescription container of each ordered medication at any given time (e.g., one (1) blister pack, one (1) tube or container of a topical preparation, one (1) container [not glass] of ophthalmic or otic drops, one (1) of each prescribed asthma inhaler). The Assistant Deputy Commissioner of Clinical Services, the Regional Medical Director, and the site Superintendent must approve any exceptions to this policy.
19. At KOP 'expansion' sites, inmates will be allowed to possess thirty (30) days of medication (blister packs), topical treatment, ophthalmic or otic drops, or inhalers.
20. Under the following circumstances, medical staff may impose consequences for non-compliance including counseling, revocation of KOP privileges and confiscation of medications.
    a. An inmate who is found with more than one (1) prescription container of any ordered medication in his possession, except at KOP expansion sites where no more than thirty (30) day prescription container.
    b. An inmate who is found with prescription medication in his possession which is not labeled according to standard with his name on the prescription label, or any OTC medication provided through the HSU, and, verified by medical staff, for which there is no valid physician order.
    c. An inmate who fails to secure KOP medications in the designated locked location.
    d. Inmate who maintains medication past the expiration of the prescription order.
21. Selected over-the-counter medications approved by the UMCH Executive Director and the Assistant Deputy Commissioner of Clinical Services may be possessed by inmates in accordance with established dispensing protocols.

a. Bulk over-the-counter medications, such as creams, ointments, artificial tears, and Metamucil are issued in original packaging, with manufacturer's label attached.

b. Each facility will establish a site-specific list of the institutionally approved OTC medications.

22. Most medications are issued in "blister packs". All medications must be maintained by the inmate in the container as dispensed and stored according to established protocols for the Keep-On-Person program.

23. All documentation of KOP medication administration and distribution will be maintained on inmate-specific Medication Administration Records.

24. Daily Medication Compliance Verification

a. Nursing will review MAR's daily to identify inmates who have not ordered refills, or have not returned to pick up KOP medications, and inmates who have had KOP medications discontinued, who may have unused medication in their possession.

b. These inmates will be listed on the Medication Non-Compliance Log for follow-up action the following day.

c. Inmates who have not picked up medication will be followed according to Policy 27.51 "Compliance Monitoring - Medications"

d. Inmates who have discontinued medication will be asked to return to the medication line at which time the inmate will return the unused medication. Failure to return unused doses of discontinued medication will be reported to the Clinical Administrator for follow-up with institutional security.

25. Monthly KOP Compliance Verification

a. Nursing will make a monthly check of dosing compliance of at least ten percent of inmate population on KOP medications.

b. Nursing staff will randomly select the required number of inmates, visit the housing units escorted by security staff, and check for compliance.

c. A report will be completed by Nursing which will include:

- Name of nurse completing compliance check
- Name of security staff
- Name of inmates checked
- Designation of "Compliant" or "Non-Compliant" for each inmate named (names of medication should not be listed).
- Date and time of compliance check
- Action taken for non-compliance, if applicable.
- The report will be forwarded to the Clinical Administrator with a copy sent to the Superintendent or a designee.

- Inmates who are found to be non-compliant with the KOP program will be counseled. Any further incidents of non-compliance will result in the inmate's suspension or removal from the KOP program.

26. When an inmate loses the privilege to participate in the program for any reason this information will be documented on the Problem List, in the Progress Notes and on the Medication Administration Record. When the program privileges are revoked, the minimum duration of time for revocation will be a three (3) month period.

27. The Clinical Administrator at each site will provide to the Superintendent or a designee a monthly updated list of all inmates on the KOP program, along with the number of medications the inmate is currently receiving by KOP.

28. When an inmate is transferred, (i.e. intersystem transfers):

    a. Their medication blister packs must be returned by security to the Health Services Unit (HSU) for transfer to the new institution.

    b. Blister packs will be placed inside the Medical Record with the MAR, Health Status Report, and Documentation Log for transfer. Schedule II-V medications in the narcotic book are co-signed by 2 nurses (zeroing out the page), a copy of the page is made and the medications are placed in the sealed "Confidential Medical Record" envelope. All documentation will be placed in a sealed "Confidential Medical Record" envelope labeled appropriately for transfer to the receiving institution.

    c. Inmates must carry asthma inhalers, oral glucose tablets, and nitroglycerin sublingual tablets on person during transfers. The HSU staff at the receiving institution will verify that the inmate has one or all of these medications on his/her person.

    d. When an inmate is transferred to another DOC facility, the intake nurse at the receiving facility will review the existing KOP agreement with the inmate. The nurse will document the name of the facility. The nurse and the inmate will sign and date the document to indicate that the review has taken place. If a KOP agreement is not in place, a new agreement must be created with the inmate.

29. If an inmate is temporarily removed from general population to a restricted area (e.g., segregation, infirmary, etc.), security will return KOP medications to the Health Services Unit for watch-take administration. The nurse will note the revocation of KOP on the MAR, and indicate the amount of medication received on the MAR. The inmate may return to KOP when returned to general population if not contraindicated.

30. For inmates on work release or who go off-site on trips, every effort will be made to provide a dosing schedule while at the site. If this cannot be accomplished, the situation will be managed in a case by case basis in <u>one</u> of the following ways:

    - The inmate may be allowed to carry necessary doses of the medication on their person while away from the site to cover the period of time away.

- The medication may be delivered via self-administration.
- Work release may be temporarily discontinued.

Attachments:

1. "Keep On Person" (Attachment A)
2. "KOP Medication Distribution Program Contract"-English/Spanish(UMCH 8046)

References:
National Commission on Correctional Health Care: Standards for Health Services in Prisons, 2008, P-D-02.
American Correctional Association: Standards for Adult Correctional Institutions, 4th Edition, 2003, 4-4378.
Massachusetts Department of Correction Health Services Division: 661.07

KEEP ON PERSON

DRUGS ON THIS FORMULARY ARE NOT INCLUDED IN THE KEEP ON PERSON PROGRAM

Controlled Substances (Narcotics, Morphine and other Opiates) Any Schedule II-Schedule V Drug EXAMPLES	
GENERIC NAME	BRAND NAME
Oxycodone w/ APAP	Percocet, Roxicet
Morphine	MS-Contin, MS-IR
Acetaminophen w/ Codeine	Tylenol #3
Propoxyphene	Darvon, Darvocet-N 100
Oxycodone	Oxycontin, OxyIR, Roxicodone
Clonazepam	Klonopin
Lorazepam	Ativan
Diazepam	Valium
Methadone	Dolophin
Methylphenidate	Ritalin
Pemoline	Cylert
Diphenoxylate	Lomotil
Hydrocodone w/ APAP	Vicodin, Lorcet, Lortab

Injectables Medications EXAMPLES	
GENERIC NAME	BRAND NAME
Ceftriaxone	Rocephin
Penicillin G Benzathine	Bicillin-LA Tubex
Penicillin G Procaine	Wycillin
Insulin	Novolin
Epinephrine	Epi-Pen
Vaccines	Fluogen, Pneomovax

ALL Anticonvulsants	
GENERIC NAME	BRAND NAME
Carbamazepine	Tegretol
Phenobarbital	
Phenytoin	Dilantin
Valproic Acid	Depakene
Divalproex Sodium	Depakote

KEEP ON PERSON

DRUGS ON THIS FORMULARY ARE NOT INCLUDED IN THE KEEP ON PERSON PROGRAM

ALL Antidepressants	
GENERIC NAME	BRAND NAME
Amitriptyline HCL	Elavil
Desipramine	Norpramin
Doxepin	Sinequan
Imipramine HCL	Tofranil
Clomipramine	Anafranil
Trazodone HCL	Desyrel
Fluoxetine	Prozac
Paroxetine	Paxil
Sertraline	Zoloft
Bupropion	Wellbutrin
Venlafaxine	Effexor
Nafazadone	Serzone
Fluvoxamine	Luvox
Mirtazapine	Remeron

Antigout Agents	
GENERIC NAME	BRAND NAME
Colchicine	

Blood Related Drugs	
GENERIC NAME	BRAND NAME
Warfarin Sodium	Coumadin

Antiretrovirals	
GENERIC NAME	BRAND NAME
NNRTI	
Didanosine	Videx
Emtricitabine	Emtriva
Lamivudine	Epivir
Stavudine	Zerit
Zidovudine	Retrovir
Abacavir	Ziagen
Tenofovir	Viread
NNRTI	
Delavirdine	Rescriptor
Nevirapine	Viramune

Efavirenz	Sustiva
Etravirne	Intelence
PI	
Indinavir	Crixivan
Nelfinavir	Viracept
Lopinavir/ritonavir	Kaletra
Amprenavir	Agenerase
Atazanavir	Reyataz
Saquinavir	Invirase
Fosamprenavir	Lexiva
Darunavir	Prezista
Tipranavir	Aptivus
Ritonavir	Norvir
Integrase Inhibitors	
Raltegravir	Isentress
CCR5 Antagonists	
Maraviroc	Selzentry
Combination Agents	
Lamivudine+ Zidovudine	Combivir
Abacavir + Lamivudine	Epzicom
Emtricirtabine + Tenofovir	Truvada
Lamivudine+ Zidovudine + Abacavir	Trizivir
Emtricirtabine + Tenofovir + Efavirenz	Atripla

KEEP ON PERSON

DRUGS ON THIS FORMULARY ARE NOT INCLUDED IN THE KEEP ON PERSON PROGRAM

All Tranquilizers and Psychotherapeutics	
GENERIC NAME	BRAND NAME
Alprazolam	Xanax
Chlordiazepoxide HCL	Librium
Chlorpromazine	Thorazine
Clonazepam	Klonopin
Clozapine	Clozaril
Diazepam	Valium
Diphenhydramine	Benadryl
Fluphenazine	Prolixin
Haloperidol	Haldol
Lithium Carbonate	Lithonate
Lithium Citrate	Lithonate-S
Lorazepam	Ativan
Loxapine Succinate	Loxitane
Olanzapine	Zyprexa
Risperidone	Risperdal

Hydroxyzine hydrochloride	Atarax
Thioridazine HCL	Mellaril
Thiothixene	Navane
Trifluperazine	Stelazine

Antituberculin drugs	
GENERIC NAME	BRAND NAME
Isoniazid	Rimifon, INH
Ethambutol	Myambutol
Pyrazinamide	
Rifampin	Rifadin

Oral Corticosteroid Anti-Inflammatory Drugs	
GENERIC NAME	BRAND NAME
Dexamethasone	Decadrom
Prednisone	Orasone, Deltasone

All Muscle Relaxers EXAMPLES	
GENERIC NAME	BRAND NAME
Baclofen	Lioresol
Methocarbamol	Robaxin

KEEP ON PERSON

DRUGS ON THIS FORMULARY ARE AUTHORIZED FOR CLINICIAN CONSIDERATION IN THE KEEP OF PERSON PROGRAM AT THE FOLLOWING FACILITIES:

Boston Pre-release
Massachusetts Alcohol and Substance Abuse Center
Northeastern Correctional Center
Pondville Correctional Center
MCI-Shirley Minimum
Old Colony Correctional Center - Minimum
MCI-Plymouth

Psychotherapeutics	
GENERIC NAME	BRAND NAME
Fluoxetine	Prozac
Paroxetine	Paxil
Sertraline	Zoloft
Mirtazapine	Remeron
Buspirone	Buspar

Massachusetts Department of Correction
Health Services

KEEP-ON-PERSON MEDICATION DISTRIBUTION PROGRAM

____
Institution

NAME: ______________________ ID#: ______________ D.O.B. ____________

You have been selected to participate in the keep on person (KOP) self-medication program. You will receive up to one-month supply of some of you medication if approved.

In order to continue participating in the KOP program is it is expected that you will abide by the following KOP rules. **You must:**

1. Secure the medication in an approved locked location except at times when you are taking it or transporting it to or from the HSU unless the doctor has written a prescription for Nitroglycerine, Asthma inhalers or glucose tablets. These three medications may be carried on your person at all time.
2. Take the medications exactly as directed on the label, or as you have been directed by medical staff.
3. Keep all medications in the card or container in which the medication was issued to you.
4. Keep in your possession only one card/container of each medication you have been issued unless you have special authorization for additional cards.
5. Return all empty medication containers to the HSU.
6. Bring the medication container to the HSU to arrange for authorization refills within the time frame directed by the doctor or nurse, but no later than 3 days prior to its running out.
7. Bring all medication to the HSU on the day of the stop date printed on the label, or, on the date indicated by the doctor or the nurse regardless of the amount of the medication remaining in the package.

If you fail to abide by the rules listed above, you will lose the privilege to continue on the program for 3 months or more. In some cases, you may lose the privilege permanently.

Any medications found outside the card/container without specific medical authorization, any witnessed selling, any reported stolen medication or any loss of a medication car/container will result in losing your KOP privilege.

I understand and will adhere to the procedures.

____
Inmates' Signature

____
Date

____
Witness Signature

____
Date

8046 Eng Rev. 8/08

Massachusetts Department of Correction
Health Services

PROGRAMA DE LA DISTRIBUCIÓN DE LA MEDICACIÓN DE KEEP-ON-PERSON

NOMBRE: ______________________ ID#: _______________ D.O.B. ___________ ____________ Institución

Le han seleccionado participar en la subsistencia en programa de la uno mismo-medicación de la persona (KOP). Usted recibirá hasta la fuente de un mes de él medicación si está aprobado.

En orden continuar participando en el programa de KOP es él espera que usted seguirá las reglas siguientes de KOP. **Usted debe:**

1. Asegure la medicación en una localización bloqueada aprobada excepto ocasionalmente cuando usted la está tomando o transporte de ella a o desde el HSU a menos que el doctor haya escrito una prescripción para Nitroglicerina, Asma inhaladores o tabletas de la glucosa. Estas tres medicaciones se pueden continuar su persona en toda la hora.

2. Tome las medicaciones exactamente según lo dirigido en la etiqueta, o como al personal médico le ha dirigido.

3. Mantenga todas las medicaciones la tarjeta o el envase en los cuales la medicación fue publicada a usted.

4. Mantener su posesión solamente un tarjeta/envase de cada medicación le han publicado a menos que usted tiene autorización especial para las tarjetas adicionales.

5. Vuelva todos los envases vacíos de la medicación al HSU.

6. Traiga el envase de la medicación al HSU para arreglar para los repuesios de la autorización dentro del marco de tiempo dirigido por el doctor o la enfermera, pero no más adelante de 3 días antes de su funcionamiento hacia fuera.

7. Traiga toda la medicación al HSU en el día de la fecha de la parada impresa en la etiqueta, o, la fecha indicada por el doctor o la enfermera sin importar la cantidad de la medicación restante en el paquete.

Si usted no puede seguir las reglas enumeradas arriba, usted perderá el privilegio de continuar en el programa por 3 meses o más. En algunos casos, usted puede perder el privilegio permanentemente.

Cualquier medicación encontró fuera de la tarjeta/del envase sin la autorización médica específica, venta atestiguada, cualquier medicación robada divulgada o cualquier pérdida de un coche/de un envase de la medicación dará lugar a perder su privilegio de KOP.

Entiendo y adheriré a los procedimientos.

____
Firma de los internos '

____
Fecha

____
Firma del testigo

____
Fecha

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