CORRECTIONAL MANAGED HEALTH CARE

COMMITTEE

AGENDA

March 8, 2007

9:00 a.m.

Love Field Main Terminal
Conference Room A
8008 Cedar Springs Road
Dallas, Texas

CORRECTIONAL MANAGED HEALTH CARE COMMITTEE

March 8, 2007
9:00 a.m.

Love Field Main Terminal Conference Room A
8008 Cedar Springs Road
Dallas, Texas

I. Call to Order

II. Recognitions and Introductions

III. Approval Excused Absence

IV. Executive Director's Report

V. Consent Items

1. Approval of Minutes, December 5, 2006

2. TDCJ Health Services Monitoring Reports
   - Operational Review Summary Data
   - Grievance and Patient Liaison Statistics
   - Preventive Medicine Statistics
   - Utilization Review Monitoring
   - Capital Assets Monitoring
   - Accreditation Activity Summary
   - Active Biomedical Research Project Listing
   - Administrative Segregation Mental Health Monitoring

3. University Medical Director's Report
   - The University of Texas Medical Branch
   - Texas Tech University Health Sciences Center

4. Summary of CMHCC Joint Committee / Work Group Activities

VI. Performance and Financial Status Dashboard

EACH ITEM ABOVE INCLUDES DISCUSSION AND ACTION AS NECESSARY

VII. Medical Director's Report

1. Texas Department of Criminal Justice
2. Texas Tech University Health Sciences Center
3. The University of Texas Medical Branch

VIII. Texas Correctional Office on Offenders for Medical or Mental Impairments (TCOOMMI) Update

IX. Presentation from Joint Work Group: Policy and Procedures Committee

X. Update on UTMB Staffing: Market Adjustments

XI. Discussion on Hepatitis B Immunization

XII. Financial Reporting

1. Financial Report Highlights
2. Financial Monitoring Updates

XIII. Public Comments

XIV. Date / Location of Next Meeting

XV. Adjourn

EACH ITEM ABOVE INCLUDES DISCUSSION AND ACTION AS NECESSARY

Tab A

CORRECTIONAL MANAGED HEALTH CARE

1300 11th Street, Suite 415♦ Huntsville, Texas 77340
(936) 437-1972

Allen R. Hightower
Executive Director

To: Chairman James D. Griffin, M.D.
Members, CMHCC

Date: February 26, 2007

From: Allen Hightower, Executive Director

Subject: Executive Director's Report

This report summarizes a number of significant activities relating to the correctional health care program since our last meeting:

Sunset Review Process

A decision meeting of the Sunset Commission was held in mid-December and final recommendations from the Commission Staff Report were approved. Those recommendations have been placed into draft legislation and filed (HB 2053, by Madden) that will be considered by the 80th Legislature. A companion filing of the Sunset bill in the Senate is also anticipated.

Legislative Appropriations Requests

CMHCC staff continues to work with the partner agencies and the appropriate legislative offices on supporting the FY 2008-2009 Legislative Appropriations Request (LAR). As of this writing, the correctional managed health care appropriations request has been presented to both the full Senate Finance Committee and the full House Appropriations Committee. Additional presentations have been made to both the House Appropriations Subcommittee on Criminal Justice and the Senate Finance Workgroup on Special Topics.

On February 23rd, the recommendations of the House Appropriations Subcommittee on Criminal Justice were presented to and adopted by the full House Appropriations Committee. Under those recommendations, our first two priority exception items, totaling $58.3M in additional funding, were moved forward (the adjustment to the base in the amount of $36.6M and the request for market salary and shift differential funding in the amount of $21.7M).

Funding recommendations from the Senate Work Group have not been made as of this report.

While no specific actions have yet been taken on the Supplemental Appropriations Request (estimated in November 2006 at $21.1M), both the Senate Finance and House Appropriations Committees have been made aware of and have acknowledged the supplemental request. It is anticipated that the Supplemental Appropriation will be worked through the respective committees later in this session.

80th Legislative Session

The 80th Legislature convened in mid-January. Pre-filing of legislation started on November 13th and to date, more than 3000 bills have been filed. As with past legislative sessions, the CMHCC staff is tracking bills with potential impact on the correctional health care program. At this time, approximately 104 bills are being tracked and a listing of those bills are attached to this report for your reference.

If prior sessions are any indication, we will be tracking the progress of several hundred bills by the end of the session. Should you need information about the status of any bill being considered, please let us know and we will provide that information to you. In many cases, we will be providing written comments to various parties requesting them and will be coordinating those efforts with the respective partner agencies as well as coordinating the provision of resource testimony as may be needed as bills progress through the process .

ARH:ads

Tab B

Consent Item 1

Approval of Minutes, December 5, 2006

MINUTES

CORRECTIONAL MANAGED HEALTH CARE COMMITTEE
December 5, 2006

Chairperson: James D. Griffin, M.D.

CMHCC Members Present: Elmo Cavin, Jeannie Frazier, Cynthia Jumper, M.D., Lannettte Linthicum, M.D., Ben G. Raimer, M.D., Larry Revill, Ed Owens, Desmar Walkes, M.D.

Partner Agency Staff Present: Denise DeShields, M.D., Texas Tech University Health Sciences Center; Troy Sybert, M.D., The University of Texas Medical Branch; Nathaniel Quarterman, Dee Wilson, George Crippen, RN, Celeste Byrne, Texas Department of Criminal Justice; Allen Hightower, Allen Sapp, Colleen Shelton, Tati Buentello, CMHCC Staff.

Others Present: Karen Latta, Sunset Advisory Commission; Marthann Dafft, representing herself.

Location: Dallas Love Field Main Terminal Conference Room A, 8008 Cedar Springs Road, Dallas, Texas

Agenda Topic / Presenter	Presentation	Discussion	Action
I. Call to Order - **James D. Griffin, M.D.**	Dr. Griffin called the CMHCC meeting to order at 9:05 a.m. He noted that a quorum was present and the meeting would be conducted in accordance with Chapter 551 of the Texas Government Code.		
II. Recognitions / Introductions - **James D. Griffin, M.D.**	Dr. Griffin thanked everyone for being in attendance then welcomed and recognized Ms. Karen Latta, Sunset Advisory Commission and Mr. Nathaniel Quarterman, Texas Department of Criminal Justice.		
III. Approval of Excused Absence - **James D. Griffin, M.D.**	Dr. Griffin then noted that Dr. Ben Raimer, Dr. Desmar Walkes, Mr. Elmo Cavin and Mr. Larry Revill were absent from the August 29, 2006 meeting due to scheduling conflicts and stated that he would entertain a motion.		Mr. Ed Owens moved that Dr. Ben Raimer, Dr. Desmar Walkes, Mr. Elmo Cavin and Mr. Larry Revill's absence from the August 29, 2006 CMHCC meeting be approved. Ms. Jeannie Frazier seconded the motion. The motion passed by unanimous vote.

Agenda Topic / Presenter	Presentation	Discussion	Action
IV. Approval of Minutes, 08/29/2006 - **James D. Griffin, M.D.**	Dr. Griffin next asked for review of the August 29, 2006 minutes provided at Tab A of the agenda packet and asked if there were any discussions, corrections or changes to the minutes?	.	Dr. Ben Raimer moved that the minutes of the August 29, 2006 CMHCC meeting be approved as presented at Attachment A. Dr. Cynthia Jumper seconded the motion. The motion passed by unanimous vote.
V. Executive Director's Report - **Allen R. Hightower**	Dr. Griffin then called on Mr. Hightower to present the Executive Director's Report.	The Executive Director's Report is included at Tab B of the agenda packet.	No action required.
• Sunset Review Process	Mr. Hightower reported that the Sunset staff completed and published their written report in mid-October. The report recommends continuation of the Committee with some adjustments to its statutory authority and an increased emphasis on making more information about the program readily available to the public and to the offenders.		
• State Audit Review of University Cost Allocations	Mr. Hightower next reported that the State Auditor's Office (SAO) completed its audit of UTMB and TTUHSC's cost allocations for the correctional health care program in late October after completing several weeks of field work onsite at both universities. The report noted overall methodologies used by the universities to allocate costs related to this program were reasonable. In addition, the report contains benchmarking on the costs of the Texas correctional health care program against a number of other state jurisdiction and related data. Those benchmarks confirm that the costs of the Texas correctional health care program continue to be among the lowest in the nation.		No action required.
• State Auditor Follow-up Review	Mr. Hightower then reported that in early November, the SAO initiated another audit of the correctional health care program to follow-up on a number of items to include the examination of the deficit for the FY 2006-07 biennium as reported and projected by CMHCC and a follow-up on the status of any recommendations made in the November 2004 SAO		

Agenda / Topic Presenter	Presentation	Discussion	Action
	Report that were not followed up on in the SAO's October 2006 report.		
• Legislative Appropriations Request Process	Mr. Hightower next reported that CMHC staff continues to work with the partner agencies and the appropriate legislative offices on supporting the FY 2008-09 Legislative Appropriations Request (LAR). A joint public hearing on the budget submission was held by the staff of the Legislative Budget Board and the Governor's Budget Office on September 22nd. He further noted that the Senate Finance Committee met for an overview of the LAR on October 3rd which was the first formal opportunity to present the LAR needs to the Senate.		No action required.
• 80th Legislative Session	Mr. Hightower then noted that the 80th Legislature convenes in mid-January but pre-filing of legislation started on November 13, 2006. As in the past, Mr. Hightower stated that the CMHCC staff will be tracking bills with potential impact on the correctional health care program. He further noted that on occasion it will likely be necessary to provide resource witness testimony about bills that may affect particular aspects of the health care delivery system. Mr. Hightower concluded by stating that the CMHCC staff will be coordinating those efforts with the respective partner agencies.		No action required.
	Dr. Griffin thanked Mr. Hightower and asked if there were any questions.	Mr. Cavin asked if there were any updates on the supplemental appropriation for the current biennium. Mr. Sapp responded that he will be presenting the update on the supplemental appropriations in his report.	

Agenda / Topic Presenter	Presentation	Discussion	Action
VI. University Provider Financial Status Report **- Allen Sapp**	Dr. Griffin then called on Mr. Sapp for the update of the University Provider Financial Status Report. Mr. Sapp reviewed the financial data along with some of the key demographics and key performance issues being tracked. He reported that the service population has reached the anticipated rate of 150,000 as shown in the graph on page 1 of his presentation. The offender population over 55 is growing at an excess of 10% a year and has continued that trend throughout this fiscal year with a high degree of certainty that this is going to continue to rise based on that trend line. He then noted the psychiatric in-patient census and the outpatient census has been consistent. Mr. Sapp reported that the budgeted level for the outpatient census is around 18,000 but ended the fiscal year with about 21,000 outpatient psychiatric offenders in the program. Mr. Sapp next reported on the access to care indicators that measure whether or not offenders are accessing care in a timely manner as outlined in policy. The three dental indicators being tracked consistently stayed above the 97% range after the first quarter. He noted that this trend is influenced by staff vacancies but both universities have been relatively successful in keeping those vacancies filled. Mr. Sapp next reported that the mental health care indicators being tracked remained close to 98% compliance rate. For the medical access to care, indicators 7 and 8 which Mr. Sapp stated has to do with the initial triage and the initial seeing of the patients have been fairly consistent at the 96% range. Indicator 9 which is for the timely referral to a physician fluctuated to a low of 92%.	University Provider Financial Status Report is provided at Tab C of the agenda packet.	No action required.

Agenda / Topic Presenter	Presentation	Discussion	Action
• University Providers Financial Status Update (Cont.)	Mr. Sapp next reported that the slide on page 5 of his presentation for UTMB & TTUHSC staff vacancies reflect the FY 2005 - 2006 trend broken out by quarter for each fiscal year. The vacancy rate for RN & psychiatrist at UTMB is over the 10% - 13% range. TTUHSC also experienced the RN vacancy rates reaching 20% and LVN vacancy rates above the 10% range. Mr. Sapp again stated that when the rates go above the 10% range, it begins to raise some concerns. Mr. Sapp recalled that Ms. Wilson reported at the last meeting that changes were made in terms of the referral process for the tracking of the MRIS summaries. As a result of those changes, the percent of timely MRIS summaries are closer to the targeted 95% level. For the financial status of the monthly revenue versus expenses, Mr. Sapp reported that TTUHSC continued to struggle throughout the year to bring the expenses down to match the available revenue. At the end of FY 2006, TTUHSC was $2M in the red which cumulatively was on track with the projections made by the TTUHSC financial staff. UTMB experienced more of a swing between their revenue and expenses. UTMB was able to reduce that loss down to $800,000 at the end of the current fiscal year. Mr. Sapp next reported that the universities collectively ended FY 2006 with a shortfall of $2.8M which was an improvement from the estimate made in March of a shortfall of $8M. Because of this change, the CMHCC staff worked with both university financial officers to update the supplemental appropriations needs for the current biennium and provided that data to the Legislative Budget Board (LBB) staff.		

Agenda / Topic Presenter	Presentation	Discussion	Action
• University Providers Financial Status Update (Cont.)	Mr. Sapp concluded by responding to Mr. Cavin's earlier question, that the requested supplemental appropriations amount was decreased approximately a third but is still anticipated to be a $21M dollar supplemental appropriations request.	Ms. Frazier asked what is the likelihood of the supplemental appropriations being approved? Mr. Hightower responded that the legislators in the past have worked with the committee and felt confident in the methods by which the staff was tracking and monitoring those costs. Mr. Sapp added that the committee as well as the university staff has made these needs known to the legislative leadership in advance and the fact that the amount has decreased will show there has been a good faith effort to manage those costs. Ms. Frazier then asked if the $21M include the extra funds needed to recruit and pay up to scale salaries? Mr. Sapp responded that it did not. Dr. Raimer added that this was factored in to the UTMB projections. Ms. Frazier then asked if the revised budget was already provided to the legislators. Mr. Sapp responded that the legislators were informed that amount of $21M was being requested as supplemental appropriations. Mr. Revill pointed out that the supplemental appropriations being requested is based on the costs being managed now but it is always difficult to forecast what that cost trend will be from one quarter to the next quarter.	

Agenda / Topic Presenter	Presentation	Discussion	Action
• University Providers Financial Status Update (Cont.)		Mr. Cavin stated that the previous State Auditor's report just released on the overhead cost and the benchmarking on the comparison of the health care costs in Texas with other states is a good source to have to support the numbers that are being provided to the legislative leadership. Dr. Griffin agreed that third party resource is always good.	
VIII. Medical Director's Report TDCJ **Lannette Linthicum, M.D.**	Dr. Griffin thanked Mr. Sapp then called on Dr. Linthicum to provide the TDCJ Medical Director's Report. For the fourth quarter of FY 2006, ten facilities were audited and special audits were also conducted on two facilities. The facilities that were audited and the compliance rate for each operational categories are listed at Attachment 1 of the TDCJ Medical Director's Report.	TDCJ Medical Director's Report is the separate booklet provided with the agenda packet.	No action required.
- Operational Review Audit	Dr. Linthicum noted that the indicators relating to therapeutic diets were below the 80% compliance rate. She further explained that the budgetary cuts in 2003 – 2004 eliminated all the dieticians in the UTMB sector except one. She commented that having only one dietician serving the 120,000 offender population is problematic and that most physicians and nurses are not trained in nutrition. Dr. Linthicum further noted that this may be something that needs to go through the SLC as an indicator for future tracking. Dr. Linthicum stated that because of the shortages of staff on the units, some of the compliance rates for administrative and documentation requirements are also slipping.	Dr. Griffin asked if there were other ways to get nutritional information out or whether there were any other innovative programs that are being considered? Dr. Raimer responded that his staff prioritizes diets and are looking at steps that include watching a diabetic education program internally for the most fragile diabetic patients; focused efforts on dietary counseling; cross-training of staff on dietary or nutritional programs and having a nurse clinician to implement the program. He further stated that he would work with Dr. Linthicum to achieve the established compliance level.	

Agenda / Topic Presenter	Presentation	Discussion	Action
• Operational Review Audit (Cont.)		Dr. DeShields added that dietary counseling is performed onsite at the chronic care facilities by nurses and not by a licensed dietician.	No action required.
	Dr. Linthicum next reported on a special audit conducted at the Dawson State Jail. This was based on correspondence from the unit warden expressing serious concerns in the areas of medications, sharps and employee training. Corrective action plans were requested and received back from the facility and most of the deficiencies have been corrected. Dr. Linthicum then reported on a special audit conducted at the Eastham Facility. This was again based on correspondence from the unit warden expressing serious concerns in the areas of medication and health care delivery. Corrective action plans were requested and received but another follow-up audit will be conducted as there are still outstanding corrective actions related to personnel actions.		
• Office of Professional Standards Update	During the fourth quarter of FY 2006, Dr. Linthicum reported that the Patient Liaison Program received 1,647 correspondences and the Step II Grievance received 1,749 correspondences. Of the total number of 3,396 correspondences received, 216 or 6.63% action requests were generated for the Patient Liaison Program and the Step II Grievance Program.		No action required.
• Quality Improvement Program	During this quarter, the Clinical Services staff performed 42 access to care audits. The facilities and the indicator scores are summarized in a table found on page 4 of the TDJC Medical Director's Report. Those facilities scoring below the established threshold were placed on weekly access to care monitoring. Dr. Linthicum noted that education and training was also being provided by the TDCJ Clinical Services staff.		No action required.

Agenda / Topic Presenter	Presentation	Discussion	Action
• Preventive Medicine Program	Attachment 4 in the TDCJ Medical Director's Report shows the data reported by the facilities on the incidence of eleven infectious diseases that are being monitored. Dr. Linthicum noted there were 163 reports of suspected syphilis this quarter compared with 223 in the previous quarter. These figures represent a slight overestimation of actual number of cases as some of the suspected cases will later turn out to be serofast meaning there were no changes in blood level rather than new cases. The corrected number of confirmed cases are reconciled in the year to date column. Dr. Linthicum next reported there were 18,740 routine HIV screens conducted which represent the continuation of routine testing TDCJ has been doing for the past several years. An additional 9,020 pre-release HIV tests were reported in compliance with HB 43 which requires mandatory testing of all offenders before release for a total of 27,760 HIV tests. She further noted that 45 offenders have been found HIV positive in the pre-release testing through August 31, 2006 for a yield of 0.16%. Based on the intake seroprevalence study completed in 1999, about 2.4% of offenders were though to be HIV positive at the time of entry into TDCJ. Routine testing identifies 1.7% of offenders as positive and the difference of 0.7% would be the expected yield on pre-release testing. Dr. Linthicum again stated that while pre-release testing is mandatory, the legislative intent was for the tests not to be obtained by use of force. Offenders who refuse pre-release testing are given disciplinary cases but very few releases would actually be affected by a disciplinary case given just prior to release. Dr. Linthicum next reported there were 964 Methillin-Resistant Staph Aureaus (MRSA) cases identified compared to 826 during the same quarter of FY 2005. The increase in MRSA most likely represents an increase in obtaining cultures as a result of emphasis being placed by the SLC as there were similar percentage increase in Methicillin-Sensitive Staph Aureus (MSSA) cases reported.	Dr. Griffin asked how far in advance from the offender's release dates are the offenders being required to do the pre-release HIV testing and what level of information are being provided? Dr. Linthicum responded that offenders are tested 60 days prior to the offender's release and they are provided both pre-counseling and post-testing counseling. Dr. Griffin then asked if the intent was for generalized public safety how does the information of the test results get to those concerned? Mr. Sapp responded that the Department of State Health Services is notified of the positive test results and it is their responsibility to notify the partners as required by law in the same manner they would any other cases.	No action required.

Agenda / Topic Presenter	Presentation	Discussion	Action
• Peer Education	The Peer education statistics are provided at Attachment 4. There are now 74 units with peer education programs with 454 peer educators.	Ms. Frazier asked how many units did TDCJ have? Dr. Linthicum responded 106 units and that she is working with Mr. Quarterman on getting 100% participation.	No action required.
• Utilization Review	During this quarter, 10% of combined TTUHSC and UTMB hospital discharges and infirmary discharges were audited. Dr. Linthicum noted there was a slight slippage from prior reports, with 11% of the patients lacking the appropriate discharge documentation from the free-world hospitals and Hospital Galveston and 10% lacking proper discharge documentation from infirmaries.		No action required.
• Capital Assets	Capital Assets Contract Monitoring Office audited 10 units and these audits are conducted to determine compliance with the Health services Policy and State Property Policy. The compliance range is provided at Attachment 6 of the TDCJ Medical Director's Report.		No action required.
• American Correctional Association Accreditation	During this quarter, the American Correctional Association accreditation were received for three facilities with health care provided by UTMB facilities and TTUHSC provided health care for one facility. This brings the total accredited TDCJ facilities to 47.		No action required.
• Morbidity & Mortality Committee	The Mortality & Morbidity Committee during this quarter reviewed 91 deaths and of those, 10 were referred to peer review committees. Dr. Linthicum noted that a referral to peer review committee does not necessarily indicate substandard care was provided. It is a request for the CMHC provider to review the case through their respective quality assurance process. Referrals may also be made to address systemic issues to improve the delivery of health care.		No action required.
• Biomedical Research Projects	The external research projects as well as those pending approvals are provided at Attachment 8 of the TDCJ Medical Director's Report.		No action required.

Agenda / Topic Presenter	Presentation	Discussion	Action
• Administrative Segregation Mental Health Audit	Dr. Linthicum then reported that Administrative Segregation Mental Health Audits were conducted on 12 facilities during this quarter.	The results of the audits are provided at Attachment 9 of the TDCJ Medical Director's Report.	No action required.
• Access to Care Concerns	Dr. Linthicum stated in relation to the special audits conducted at the Eastham and Dawson units, she wanted to note that the Office of Professional Standards have also been receiving complaints from advocacy groups relating to access to care. After looking at the list of complaints it was found that most of them primarily centered around the 2250 prototype units, such as the Allred, Robertson and Connally. The Office of the Professional Standards will be conducting a pilot study of these units and report back to the committee with the findings. Dr. Linthicum further stated that the Joint Medical Director's Committee and the various leadership council have agreed to audit access to care at TDCJ facilities for an entire fiscal year. The Patient Liaison investigators will go to every TDCJ unit on a quarterly basis and the units will be required to record all sick call requests to be sure that these requests have been forwarded to EMR and that a clinical visit or nursing visits were made that correlates to that particular sick call request. Once the unit successfully meet the established 80% compliance threshold , these sick call requests will be forwarded to the Huntsville Medical Archives for proper disposal. Dr. Linthicum clarified that the audit team consists of both her staff and university team members.	Dr. DeShields added that staffing vacancies particularly nursing vacancies contribute to this problem as these staff serve as the conduit to access to care. Mr. Sapp also added that one of the later agenda items is a discussion of some of the sick call changes that resulted from the process that Dr. Linthicum just outlined. He further noted that this is a good example of how the interaction between the security and administrative staff on the unit noticing a problem, and using the appropriate mechanism in place to work with the university providers in resolving the problem.	No action required.

Agenda / Topic Presenter	Presentation	Discussion	Action
		Dr. Walkes asked which personnel would be interviewed on these audits at the unit? Dr. Linthicum responded that the senior warden, the major, usually the lieutenant and the chief classification officer. On the medical side, the unit medical director, the director of nurses, the responsible dentist and psychologist, CID nurses and anyone else who may be involved.	
	Dr. Linthicum further stated that the patient liaison investigators interview 10% of the offenders from all custody levels to be sure that the entire population is represented.	Dr. Walkes then asked if there were any concerns as to whether the offender felt comfortable enough to respond openly with security staff present during the interview? Dr. Linthicum responded that she did not see a problem as the offenders are brought in one at a time and are interviewed in a private area. Mr. Quarterman agreed by stating that the offender usually bring a problem to the attention of the security staff who in turn relays the information on to the unit warden.	
	Dr. Linthicum also noted that Step 1 Grievances are responded to by the unit medical staff who fall under the Administrative Review and Investigative Management Office but she is provided with a quarterly report of the breakdown of the type of grievances at that level.	Dr. Griffin stated that is would be helpful to have the data from the Step I Grievances for the committee members. Dr. Linthicum responded that she would have this included in the agenda for the next meeting.	
VIII. Medical Director's Report **TTUHSC, D. DeShields, M.D.**	Dr. Griffin asked if there were any other comments, hearing none thanked Dr. Linthicum for her report, then called on Dr. DeShields to provide the TTUHSC Medical Director's Report.	TTUHSC Medical Director's Report is provided at Tab D of the agenda packet.	

Agenda / Topic Presenter	Presentation	Discussion	Action
• Statistical Summary	Dr. DeShields reported that the average population and encounters for the fourth quarter of FY 2006 remained stable. She did note that the medical inpatient facilities did see the average daily census and the number of admission steadily increase over the course of the quarter, however there was a slight decrease from the last quarter for the average length of stay. Dr. DeShields then reported that towards the latter part of August, two patients had over 55 admission days which will show a dramatic increase for the next quarter.		No action required.
• Staffing	There was a slight improvement in the dental vacancy rate but for the most part Dr. DeShields reported that all the disciplines noted increased vacancy rates over the quarter. She further reported that these vacancies are being covered by local temporary staff but they are not as affective since they are not familiar with the policy and procedures.		No action required.
• Montford RMF	Dr. DeShields then reported that the long term care facility at the Montford RMF has been in operation now for almost two months. The ten beds at the RMF were all filled up to two days ago, but only nine are filled as of this date. She further reported that approximately 35-40% of the needed staff to fully operate the facility has been hired.		No action required.
• Highland Hospital Initiative	Dr. DeShields next noted that TTUHSC established a contractual agreement with the Highland Hospital which is a 123-bed facility in Lubbock primarily for specialty evaluation procedures and admissions. This contract was effective on September 15, 2006 and the initiatives provide additional outpatient, ambulatory and some in-patient hospitalization resources for the Lubbock area. This is particularly important as TTUHSC was only able to send patients to UMC who have a threat of loss of life or limb, or are emergent patients. Dr. Griffin hearing no further comments thanked Dr. DeShields for the report and called on Dr. Sybert, UTMB Hospitalist, who will be presenting the UTMB Medical Director's Report on behalf of Dr. Murray.		No action required.

Agenda / Topic Presenter	Presentation	Discussion	Action
VII. Medical Director's Report **UTMB, Troy Sybert M.D.**	Dr. Sybert stated that he would be reporting on the UTMB Medical Director's Report which is provided at Tab E of the agenda packet on behalf of Dr. Murray who was unable to attend the meeting due to scheduling conflicts. Dr. Sybert reported that the quarterly average population has slightly risen from 119,700 in the previous month to 120,093 for this quarter. The average physician medical encounter was 28,474 and the average nursing medical encounter was 187,206 for this quarter. He further reported that the average medical inpatient census was 126 with a monthly average number of admissions at 501. In addition the average clinical visits during this quarter was 1,906. Dr. Sybert at this point stated that he would like to briefly go over the changes taking place at Hospital Galveston. He clarified that a hospitalist is defined as a doctor who stays in the hospital, is committed to the care of the patients in that hospital as well as the quality of care delivered within the hospital. There are currently three hospitalist at Hospital Galveston committed to CMC and the prison population. An additional hospitalist will come on board in January. Dr. Sybert further noted that the hospitalists are committed to improving the communications process between the hospital and the units. Dr. Sybert next reported on the implementation of an internal infirmary or skilled nursing facility where the patient goes after they get out of the hospital as they still need physical therapy or some other ancillary services. The tentative plan is to have this set up in January for an 18 bed capacity within the hospital. Dr. Sybert added that this would improve the efficiency for hospital bed usage.	Dr. Walkes asked what type of training a hospitalist has. Dr. Sybert responded that hospitalists typically are internal medicine trained and approximately 25% are family practice trained. Ms. Frazier asked if these were new beds or re-categorizing existing beds. Dr. Sybert responded that they are partially taking a wing in the hospital to free up 6 rooms with a capacity of 3 patients beds each for a total of 18 beds.	No action required.

Agenda / Topic Presenter	Presentation	Discussion	Action
- UTMB Medical Director's Report (Cont.)	Hearing no further comments, Dr. Griffin thanked Dr. Sybert for the UTMB Medical Director's Report and the briefing on the hospitalist program. Dr. Griffin then stated that he would like to invite Dr. Sybert back in a year to update the committee on the progress of the hospitalist program. Dr. Griffin then called on Dr. DeShield to provide the SLC Update.	Dr. Raimer added that the hospitalist program was created after putting together a physician advisory council made up of university and unit based doctors to improve communication methods and reorganize outpatient services. Dr. Linthicum agreed and noted that now that an infirmary is located within Hospital Galveston the offender patient does not have to get on a chain bus and travel to the appropriate unit which may take a week or two and felt that this was a win-win situation for all involved. Mr. Owens also added that he was involved with the design of the infirmary and agreed that this would help with the way the system operated.	
VIII. System Leadership Council **- Denise DeShields, M.D.**	Dr, DeShields noted that at the last meeting, Chairman Griffen requested that she provide a report for the record on the SLC activities. Historically, the SLC's function is to monitor access to care indicators, quality of care indicators as wel as any other operational issues identified by the CMHCC. The SLC committee is comprised of representatives from UTMB & TTUHSC medical, mental health, dental and nursing directors as well as the TDCJ Health Services Director, QI nursing staff and the CMHCC Assistant Director. The committee met last on November 9, 2006.	System Leadership Council Report is provided at Tab F of the agenda packet.	No action required.

Agenda / Topic Presenter	Presentation	Discussion	Action
• SLC Report (Cont.)	Dr. DeShields then reported that the access to care monitoring indicators are listed in the table on page 1 of her report. The SLC reviewed with those facilities with less than the established 80% compliance rates; corrective actions were put forth and will continue to monitor those below the 80% compliance rate. Units at less than required compliance were related to provider shortages and lockdowns. Dr. DeShields further reported on the four other SLC indicators that are being monitored. The first indicator is for no show due to security and 95% of the units were compliant with this indicator. The second indicator monitors MRSA for all patients with draining wound will have culture obtained and 97% of the units were in compliance. The third indicator is for patients with medication orders will receive meds from pharmacy within 72 hours. Dr. DeShields noted that only 76% of the units were in compliance but this was due to some confusion regarding the indicator parameters and methodology so this indicator has been suspended pending a review and updating of the indicator by the Joint Nursing Group. The last indicator is for the mental health assessment and 97% of the units were in compliance. Dr. DeShields concluded her report by noting that other business discussed at the meeting included a review of sick call request policies; scanning and copying of all sick call request to assure access to care; corrective actions from prior monitoring efforts; an update on the status of the safe prisons initiatives; and monthly grievance exception reports for the quarter. Dr. Grifin asked if there were any questions or comments and hearing none, thanked Dr. DeShields for the report.		

Agenda / Topic Presenter	Presentation	Discussion	Action
IX. Joint Work Group Summaries **- James Griffin, M.D.**	Dr. Griffin noted that SLC is only one of several joint work groups established under the correctional managed health care contracts and policies. As part of the Sunset Report it was recommended that the CMHCC make it more easily accessible for the public to get information about the committee as to how it operates and what we do. The other method of getting the information out would be to set up a webpage with links to get more specific data. Dr. Griffin suggested that each of the joint work group committee provide a brief summary as part of the future CMHC agenda items and asked for any comments or discussions from the committee members.	Dr. Linthicum suggested that the joint work groups provide copies of the agenda or minutes to the CMHCC committee staff for review and put it into a specific format for inclusion in the CMHCC agenda packet. Ms. Frazier agreed that agendas from the joint work groups would inform the public as to what is being discussed at these meetings. Dr. Walkes added that information like the hospitalist program would also be a good resource item to show some of what is being done. Dr. Walkes then asked if it was necessary to get legal advise on what is or what is not posted on the website? Dr. Linthicum responded that most of this information can be obtained through the Open Records Request. She clarified that she was not referring to information on peer reviews or mortality reviews. After some discussion, Mr. Sapp suggested collectively taking in the comments and input being made and have the committee staff work with the Medical Directors to decide on the format and the type of data that will be made available then bring it back to the CMHCC with some recommendations for consideration.	No action required.
X. TCOOMMI Update **- Dee Wilson**	Dr. Griffin then called on Ms. Wilson to provide the TCOOMI Update. Ms Wilson noted that the Medically Recommended Intensive Supervision (MRIS) program provides for the early parole review and release of certain categories of offenders such as those who are mentally ill or retarded, elderly, terminally ill, long term care or physically handicapped.		No action required.

Agenda / Topic Presenter	Presentation	Discussion	Action
- TCOOMMI Update (Cont.)	The purpose of MRIS is to release offenders from incarceration who pose minimal public safety risk in to a more cost effective alternative setting. She reported that she has been working with Dr. Linthicum and the Medical Director's Committee to see if there was anything that could have been done for those offenders who died in the system prior to or shortly before they were released on MRIS. Ms. Wilson further reported that she is working with both UTMB and TTUHSC on the Article V Rider relating to TCOOMMI and TDCJ to develop an automated report to assist in identifying offenders eligible for MRIS by developing a uniform diagnosis codes to flag offenders eligible for early release. Ms. Wilson concluded her report by stating that she will be updating the committee in the future on the continuity of care issues as she has done in the past. Hearing no further discussion, Dr. Griffin thanked Ms. Wilson for the update.	Dr. Griffin asked how many of those MRIS offenders are presented to the Board of Pardons and Paroles (BPP) that are actually approved for early release under MRIS? Ms. Wilson responded of the 401 presented 161 offenders were approved by the BPP. She further noted that on page 5 of her report provided at Tab G shows the number by diagnosis presented and page 4 shows how many were approved by diagnosis from FY 2001 – FY 2006. Dr. Griffin then asked for clarification on when an offender is released are they placed in another controlled facility? Ms. Wilson responded that these offenders are placed with Medicaid to a more cost effective alternative facility. Mr. Sapp added that those offenders are still under parole supervision.	

Agenda / Topic Presenter	Presentation	Discussion	Action
XI. Improvements to Sick Call Processing Procedures **- Allen Sapp**	Dr. Griffin next called Mr. Sapp to provide the report on the Improvements to Sick Call Processing Procedures. Mr. Sapp stated that this topic was touched on earlier by Dr. Linthicum during her report on the special audits which raised concerns relating to the adequacy of internal controls at the facility level to insure that the required access to care standards were met. Mr. Sapp then stated that sick call request (SCR) collection practices were revised to require segregation of duties for counting and loggings of these requests; policies clarified to specify only licensed personnel triage SCR's; facility level processes reviewed to ensure timely scanning of SCR's into the EMR; a process established for storage and retention of SCR's at the facility level pending return to central records; all SCR's and other documentations with PHI requiring destructions be returned to TDCJ Health Services Archives to maintain confidentiality required by HIPAA standards; and adopted a standard schedule for shipping records to archives. Follow-up monitoring will be conducted to ensure changes are implemented. Hearing no questions or further discussions, Mr. Sapp stated that he would next provide an update on the Sunset Advisory Commission.		No action required.
XII. Update: Sunset Advisory Commission **- Allen Sapp**	Mr. Sapp reported on the Sunset report issued on October 13th. There were two issue discussions related to CMHCC. The key findings in Issue 9 were to remove the separate Sunset date, to continue the CMHCC and that the Committee's statutory responsibilities need updating to better reflect its actual purpose. Mr. Sapp further stated that the recommendations would remove limitations on TDCJ's ability to monitor		No action required.

Agenda / Topic Presenter	Presentation	Discussion	Action
	the quality of health care provided to offenders and require that the Chair of the Committee be a public physician member. Mr. Sapp further reported that Issue 10 had to do with increasing the amount of information available about the correctional health care program to promote a better understanding of the system and its operations. This recommendation was a 3 fold requirement. The first having to do with the committee's information being readily accessible to the public and Mr. Sapp reported that the CMHC staff is currently working on a website; second, TDCJ is to make information about health services more readily available to offenders and Dr. Linthicum is working on improving the information being accessible through the law libraries; and three, the health services and university providers should provide more useful information in response to offender grievances. Mr. Sapp concluded by noting that the full text of the report is provided at Tab H of the agenda packet. Dr. Griffin thanked Mr. Sapp for the update on the Sunset Advisory Commission Report and hearing no further discussions asked Mr. Sapp to next to summarize the State Auditor's Report.		
XIII. State Auditor's Office Report - **Allen Sapp**	Mr. Sapp stated that Tab I of the agenda packet includes a copy of the audit report on the cost of the state's correctional managed health care program published in late October 2006 which audited the methodology used to account for and report the costs of providing health care to state offenders. The overall conclusions were that the financial reports that that two universities submitted to the Committee are supported by the institutions accounting system; that the methodology used to allocate those costs are reasonable; and that both universities had reasonable		No action required.

Agenda Topic / Presenter	Presentation	Discussion	Action
• SAO Report (Cont.)	support for the supplemental appropriations requested and received from the legislatures during the last legislative session. Mr. Sapp then noted that both providers compute their indirect cost allocation rates as a percent of revenue instead of as a percent of expenses and then apply these rates to the revenue they received from the CMHCC. While the report notes that this is not the standard methodology for allocating indirect costs, cost accounting guidance indicates that any reasonable methods may be used. Mr. Sapp further noted that UTMB had some errors on the methodology that resulted in minor inaccuracy in reporting costs, but these were identified and corrective actions submitted. The SAO report also noted that the Committee in partnership with UTMB, TTUHSC and TDCJ had made changes to address many of the recommendations from the November 2004 SAO report including improving the financial reporting process; adding the listing of allowable expenditures; obtaining commitments from the university internal audit offices; and hiring a financial officer to monitor those expenditures. Mr. Sapp further reported on the benchmarking chapter added to the report, due to in large part, to Mr. Cavin's specific request to the auditors that some background information on inmate health care that compares Texas' costs to other states be included in the audit. Although costs are not entirely comparable across states, the analysis indicates that the cost of offender health care in Texas is generally lower than costs in other states.		

Agenda Topic / Presenter	Presentation	Discussion	Action
	Hearing no further discussions, Dr. Griffin thanked Mr. Sapp for the updates and called next on Ms. Shelton.		
XIV. Financial Reports - **Colleen Shelton** - **FY 2006 Fourth Quarter Report**	Ms. Shelton stated that the financial summary will cover data for the 4th Quarter ending August 31, 2006 and the end of year summary. She further noted that due to the changes in the methodology of allocating costs at UTMB and not receiving the finalized UTMB financials, the September monthly report will be forwarded to the committee members and the state leadership once this information has been received. Overall health costs through August of FY 2006 totaled $420.4M. On a combined basis, this amount exceeded overall revenue earned by the university providers by $2.8M. UTMB's total revenue through August was $336.1M; expenditures totaled $336.9M, resulting in a shortfall of 0.8M. TTUHSC's total revenue through August was $81.4M; expenditures totaled $83.5M, resulting in a shortfall of $2.0M. Of the $420.4M in expenses reported through August, onsite services comprised of $196.8M or 46.8% of the expenses; pharmacy services totaled $38.6 or 9.2% of total expenses; offsite services accounted for $130.2M or 31.05 of the total expenses; mental health services totaled 38.1M or 9.1% of the total costs; and indirect support expenses accounted for $16.7M or 4.0% of the total costs. Table 5 shows that the total costs per offender per day for all health care services statewide through August 2006 was $7.61 compared to $7.46 through the end of FY 2005. The average cost per offender per day for the last four fiscal year was $7.60.	Fourth Quarter Financial Report is provided at Tab J of the agenda packet.	No action required.
• Aging Offenders	Ms. Shelton again noted that the older offenders access the health care delivery system at a much higher acuity and frequency than younger offenders.		No action required.

Agenda Topic / Presenter	Prentation	Discussion	Action
	Older offenders were utilizing health care resources at a rate almost five times higher than the younger offenders. While comprising only about 5.9% of the overall service population, older offenders account for 27.7% of the hospitalization costs received to date. Dialysis costs continue to be significant averaging about $19.9K per patient per year. Providing dialysis treatment for an average of 180 patients through the 4th quarter of FY 2006 cost $3.6M.		
• Drug Costs	Total drug costs through the 4th quarter were $29.4M as shown at Table 9. Of this, $14.1M or just under $1.2M per month was for HIV medication costs which was about 48% of the total drug costs. Psychiatric drug costs were approximately $1.9M or about 6.4% of overall drugs and Hepatitis C drug costs was $1.7M and represented about 5.9% of the total drug costs.		No action required.
• Reporting of Reserves	Ms. Shelton stated that it is a legislative requirement that both UTMB and TTUHSC report if they hold any monies in reserve for correctional managed health care. UTMB reports that they hold no such reserves and report a total shortfall of $793,767 through the fiscal year end. TTUHSC reports that they hold no such reserves and report a total shortfall of $2,043,981 through fiscal year end.		No action required.
• CMHC Account Balances	A summary analysis of the ending balances, revenue and payments through August for all CMHC accounts is included at Table 10. The summary indicated that the net balance on all CMHC accounts on August 31, 2006 was $1,340,637.58. Pursuant to procedures outlined in Rider 69, a formal request was sent to the Legislative Budget Board asking for authorization to allocate and transfer the ending fund balance of approximately $1.3M to the university providers to partially offset their shortfalls for the recently completed fiscal year. Notification was received in late November that the request was not approved. The total amount of the fund balance as of fiscal year end is being lapsed back to the Sate General Revenue Fund as required by Rider 69.		No action required.

Agenda Topic / Presenter	Presentation	Discussion	Action
• Financial Monitoring	Ms. Shelton then reported that detailed transaction level data from both providers is being tested on a monthly basis to verify reasonableness, accuracy, and compliance with policies and procedures. Due to a delay in receiving the fiscal year end financial statements from UTMB, the financial monitoring for August is not yet complete. She noted that she will be reporting on the results of the testing to date and will follow-up with the complete August monitoring results in the September financial package.		No action required.
	The preliminary results of the testing performed on UTMB's financial information for August revealed employee relocation expenses not allowed under the CMHC-UTMB contract of $4,094.95. This item will be corrected on the November financials. The testing of detailed transactions performed on Tech's financial information for this same time period revealed that split funded employees being paid based on budgeted hours for each agency instead of actual hours worked at each agency. This situation is currently being discussed with Tech to determine a corrective course of action to be taken.		No action required.
• End of Year Summary	At Tab K is an end of year summary report which provides a brief comparison of the revenue and the major expense categories for UTMB, Tech and both universities combined broken out between medical and mental health for FY 2005 and 2006. The most significant increase for UTMB occurred in the medical onsite expenses. This is primarily due to the increase in the aging population and their corresponding high levels of encounters and costs, the Hepatitis C Program, the inclusion of more private prison units and general inflation in the area of healthcare. Additionally, UTMB has implemented a regional urgent care concept that has moved more of its ER-type care from offsite providers to onsite.		No action required.

Agenda Topic / Presenter	Presentation	Discussion	Action
- End of Year Summary (Cont.)	For Texas Tech this fiscal year, pharmacy expenses increased significantly. This is primarily due to the fact that TTUHSC cannot participate in 340B pricing and as such is much more vulnerable to price increases. The offsite increase for Texas is a result of higher acuity patients with a more expensive corresponding DRG rates and much higher OP and ER costs. Ms. Shelton concluded her report by stating that the combined expenses for the universities increased 2.6% for medical and 0.2% for mental health for an overall increase of 2.3%. This compares very favorably with the Consumer Price Index increase of 4.0% for medical care for the period of time from November 2005 through October 2006. Dr. Griffin thanked Ms. Shelton for the financial report and asked if there were any questions.	Dr. Walkes asked why the committee is not allowed to use the ending fund balance to partially offset the universities shortfalls? Mr. Sapp responded that under the prior November State Audit Report, one of the concerns the auditor's expressed was that transfer of the end of the year balances was over and above what the original contract rates were. As a result of that, the legislature attached a Rider through the Appropriations Bill that calls for any unexpended balances over the payment amounts to lapse after each year unless the Governor's Office and LBB approves it. Dr. Walkes then asked if the committee is able to request back that amount again? Mr. Sapp responded that they would as a part of the supplemental request. He further clarified that the reason the auditor's were concerned about that payment at the end of the year is that under normal state agency operations, any of those unexpended balances lapse while the universities have the ability to carry funding from one year to the next.	

Agenda Topic / Presenter	Discussion	Conclusion	Action
XV. Public Comments **James Griffin, M.D.** - Marthann Dafft	Hearing no further comments, Dr. Griffin stated that the next item on the agenda is public comments then called on Ms. Marthann Dafft. Ms. Dafft stated that she had come to the last meeting seeking help on behalf of her son who was not being treated for depression and not getting medication for his personality disorders. She further stated that Dr. Murray got with her after the meeting and that same day her son was transferred to the Skyview Unit, was admitted into a 30 day treatment program and was finally given medication. Ms. Dafft then said that the reason she was here at this meeting today was to thank Dr. Murray and was disappointed that she was not able to do so in person,. She also wanted to thank the Committee for the work that they do and hoped that other family members will take the opportunity and time to come sit in on a meeting to see what is being done. Ms. Dafft concluded by saying if there was anything she can do to assist the committee, to not hesitate to contact her. Dr. Griffin thanked Ms. Dafft for the comments. He also expressed his appreciation to the Committee members and their support staff, the CMHCC staff for their hard work and dedication.		No action required.
XVI: Date / Location of Next Meeting **- James D. Griffin, M.D.**	Dr. Griffin then noted that the next CMHC meeting is scheduled for 9:00 a.m. on March 8, 2007 to be held at the Dallas Love Field Main Terminal Conference Room A. He also stated that this date and location of the meeting may need to be rescheduled if it conflicts with the legislative session.		No action required.

Agenda Topic / Presenter	Discussion	Conclusion	Action
XVII Adjournment **James D. Griffin, M.D.**	Hearing no further discussions, Dr. Griffin thanked everyone for being in attendance and adjourned the meeting.		

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James D. Griffin, M.D., Chairman
Correctional Managed Health Care Committee

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Date:

Consent Item 2

TDCJ Health Services
Monitoring Reports

ATTACHMENT 1

Rate of 100% Compliance with Standards by Operational Categories First Quarter, Fiscal Year 2007 September, October, and November 2006																		
Unit	Operations/ Administration			General Medical/Nursing			CID			Dental			Mental Health			Fiscal		
	Items with 100% Compliance		*n*	Items with 100% Compliance		*n*	Items with 100% Compliance		*n*	Items with 100% Compliance		*n*	Items with 100% Compliance		*n*	Items with 100% Compliance		*n*
Byrd Facility	92%	49	53	68%	13	19	41%	12	29	77%	10	13	67%	6	9	100%	11	11
Goree Facility	93%	51	55	68%	13	19	48%	13	27	92%	12	13	63%	5	8	100%	11	11
Halbert Facility	88%	46	52	56%	14	25	72%	18	25	88%	14	16	100%	6	6	100%	11	11
Kyle Facility	94%	50	53	52%	11	21	94%	27	29	100%	16	16	60%	3	5	100%	11	11
North Texas ISF	88%	45	51	58%	11	19	62%	10	16	62%	8	13	16%	3	19	na	na	na
Robertson Facility	100%	53	53	43%	12	28	66%	16	24	56%	9	16	56%	9	16	100%	11	11
Sayle Facility	100%	53	53	45%	9	20	58%	14	24	81%	13	16	67%	4	6	100%	11	11
Travis County	96%	50	52	40%	8	20	92%	23	25	80%	12	15	55%	6	11	100%	11	11
Wynne Facility	91%	50	55	48%	11	23	55%	16	29	92%	12	13	73%	8	11	100%	11	11

n = number of applicable items audited.

Note *: The threshold of 100% was chosen to be consistent with other National Health Care Certification organizations.*

This table represents the percent of audited items that were 100% in compliance by Operational Categories.

100% Compliance Rate = number of audited items in each category that were 100% compliance with the Standard
number of items audited.

ATTACHMENT 2

Percent Compliance Rate on Selected Items Requiring Medical Records Review
First Quarter, Fiscal Year 2007
September, October, and November 2006

Unit	Operations/ Administration			General Medical/Nursing			CID/TB			Dental			Mental Health		
		Items in Compliance	*n*		Items in Compliance	*n*		Items in Compliance	*n*		Items in Compliance	*n*		Items in Compliance	*n*
Byrd Facility	100%	40	40	93%	136	147	86%	25	29	93%	56	60	95%	54	57
Goree Facility	100%	23	23	90%	115	128	94%	46	49	96%	48	50	84%	43	51
Halbert Facility	100%	20	20	52%	124	240	57%	17	30	94%	94	100	100%	45	45
Kyle Facility	92%	22	24	88%	212	242	98%	45	46	100%	100	100	88%	38	43
North Texas ISF	100%	1	1	80%	111	138	38%	5	13	73%	40	55	73%	69	94
Robertson Facility	100%	40	40	59%	124	209	62%	18	29	93%	79	85	93%	177	191
Sayle Facility	100%	12	12	74%	113	152	57%	32	56	88%	98	111	96%	48	50
Travis County	93%	28	30	47%	108	231	100%	36	36	97%	97	100	89%	66	74
Wynne Facility	100%	55	55	76%	247	324	90%	47	52	99%	79	80	97%	114	117

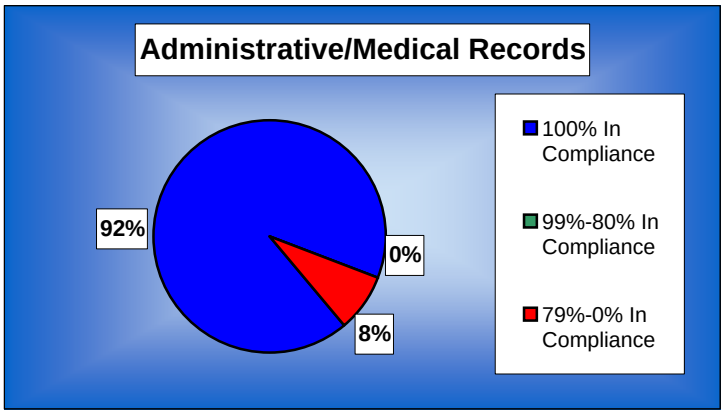
n **= number of records audited for each question.**

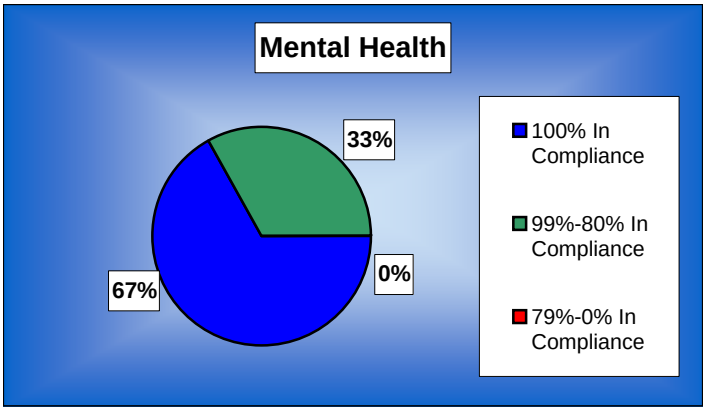
Note: Selected items requiring medical record review are reflected in this table.
The items were chosen to avoid having interdependent items counted more than once.

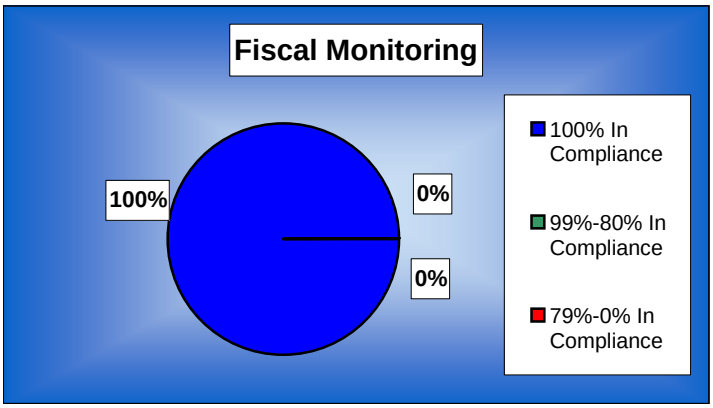
Average Percent Compliance Rate = Sum of medical records audited that were in compliance X 100
Number of records audited

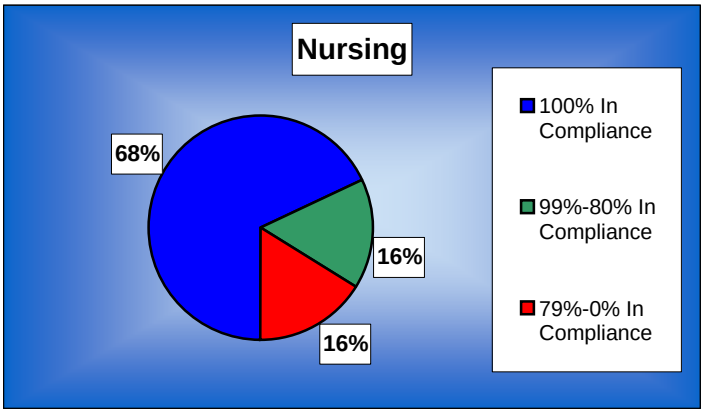
***The medical record review section of the Operations/Administration portion of the Operational Review Audit consists of only three questions, frequently with low numbers of applicable records.**

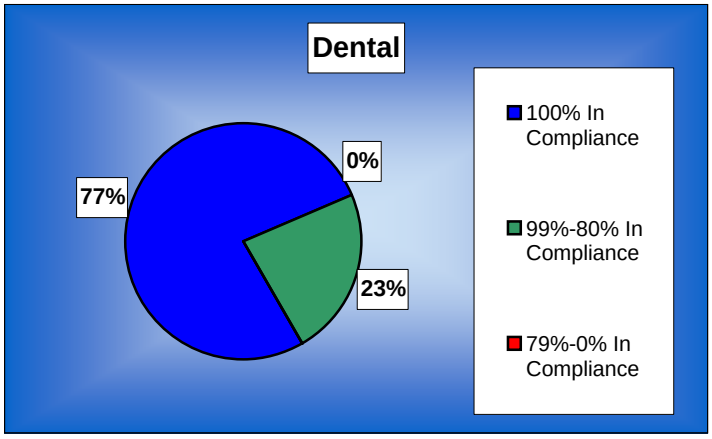
Quarterly Reports for
Compliance Rate By Operational Categories
Byrd Facility
October 3, 2006

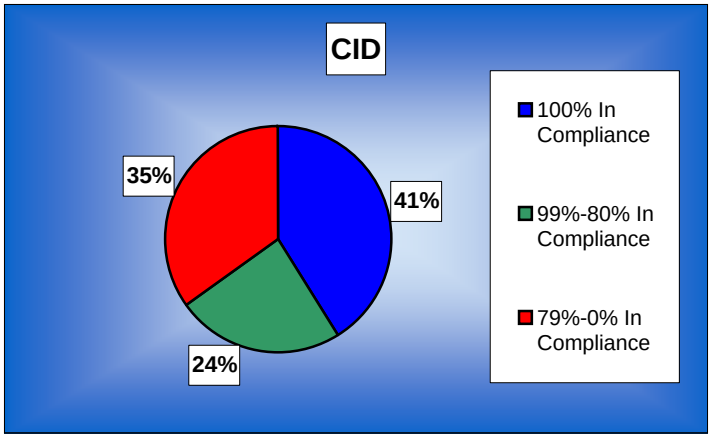




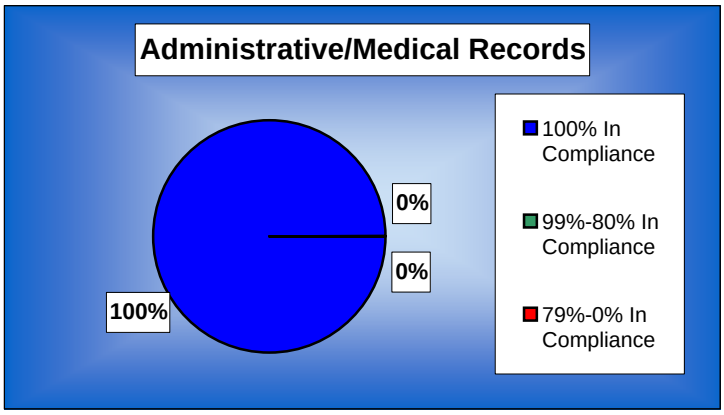


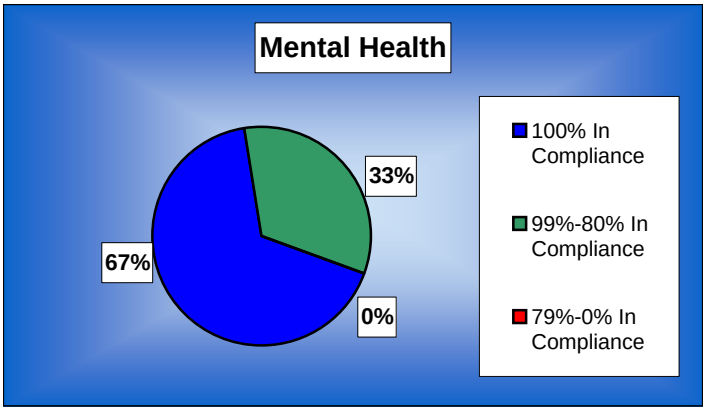


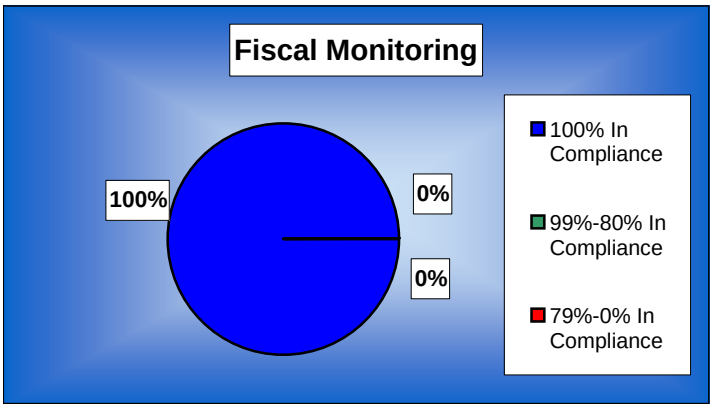


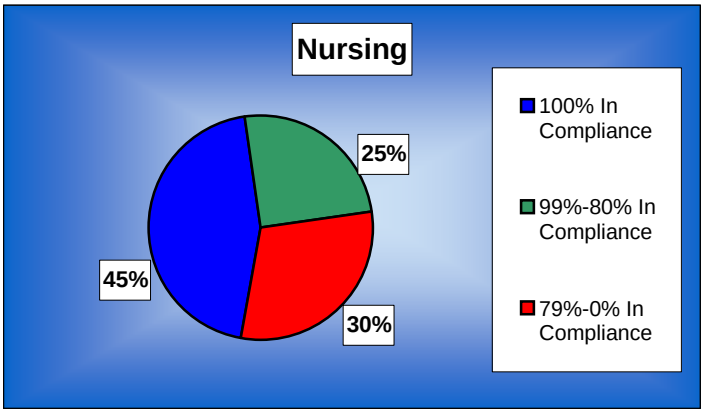


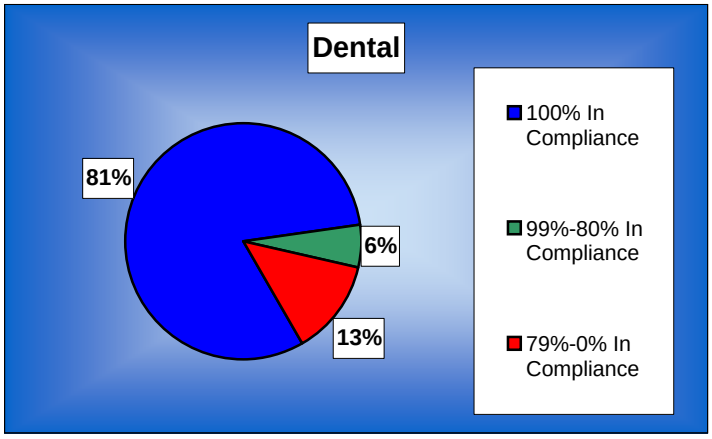
Quarterly Reports for
Compliance Rate By Operational Categories
Sayle Facility
September 7, 2006

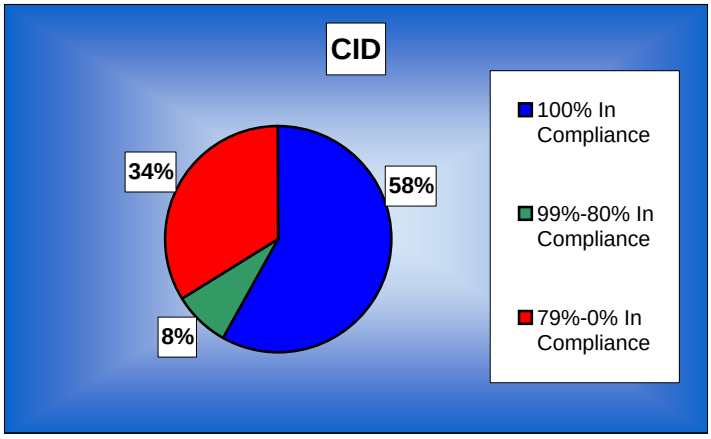




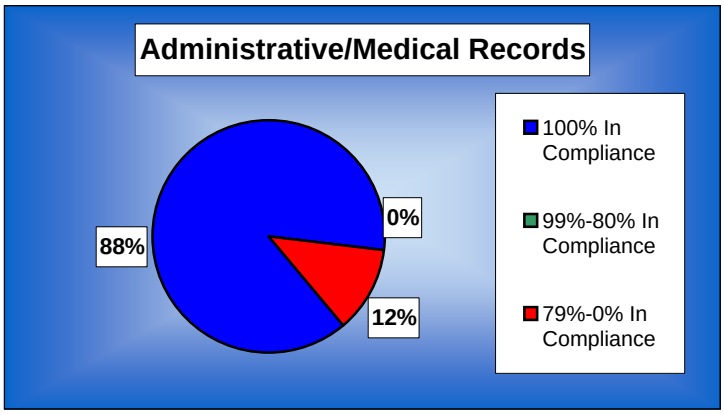


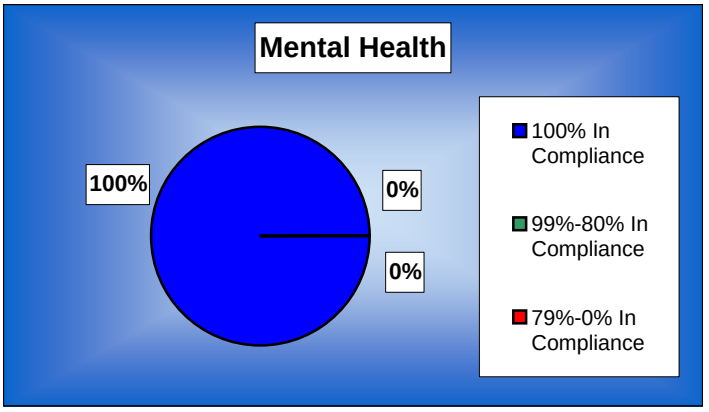


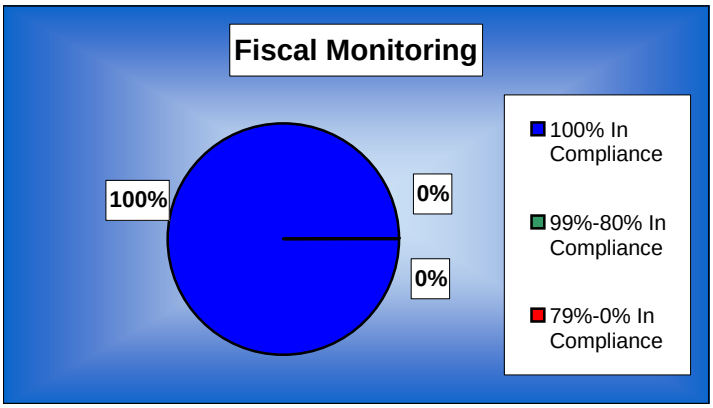


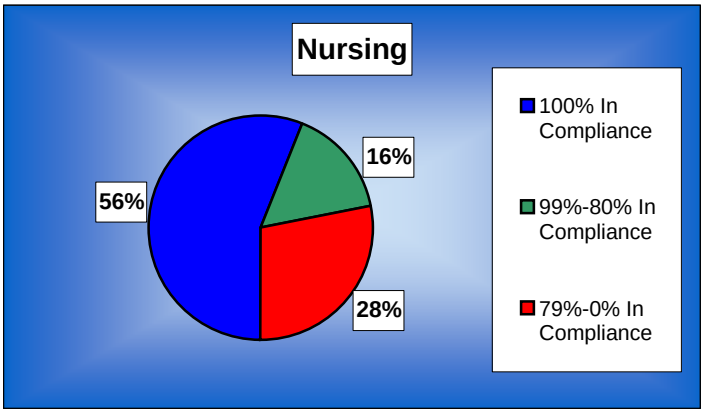


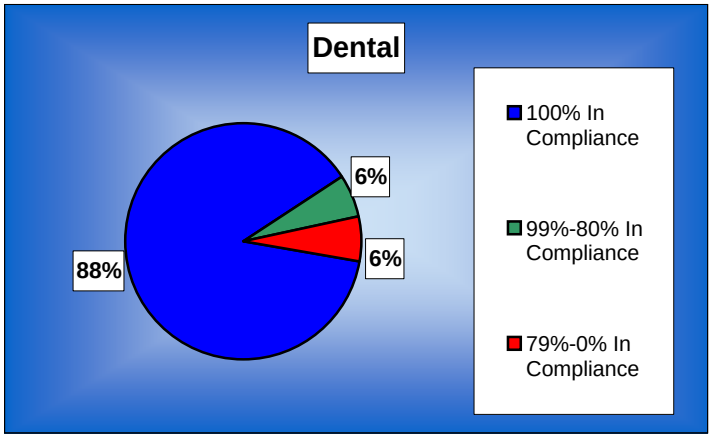
Quarterly Reports for
Compliance Rate By Operational Categories
Halbert Facility
November 2, 2006

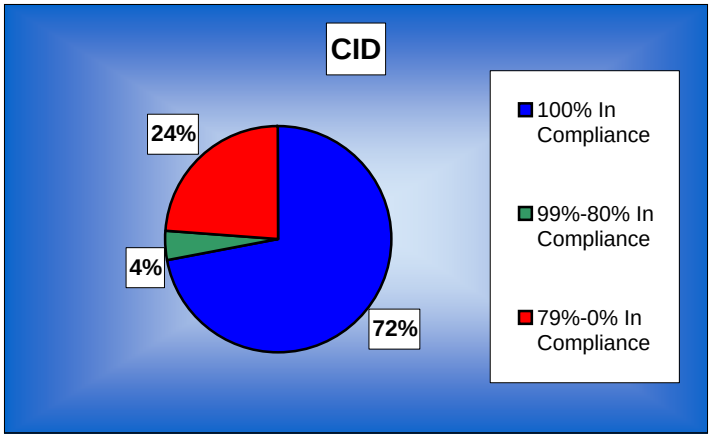




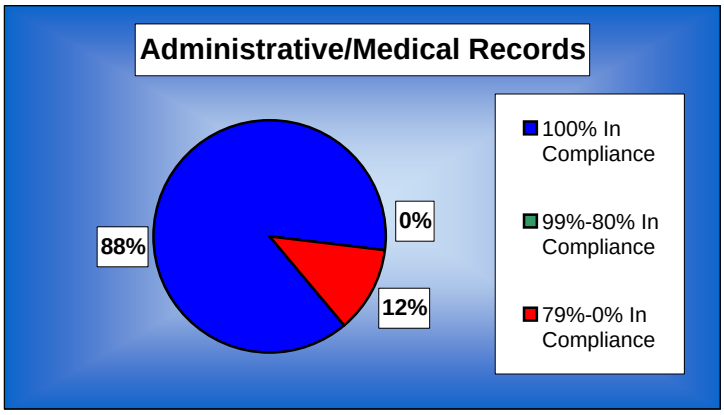


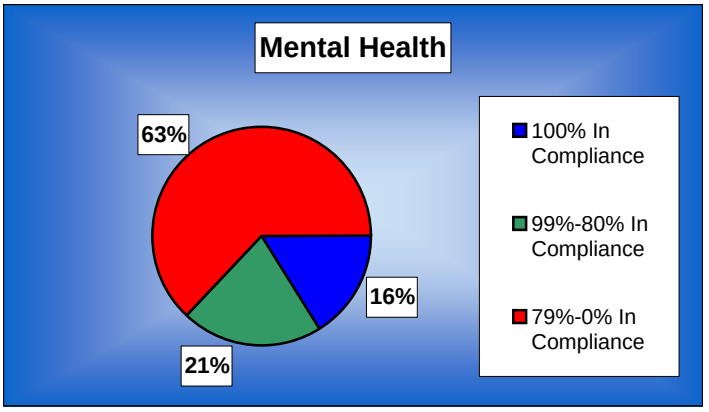


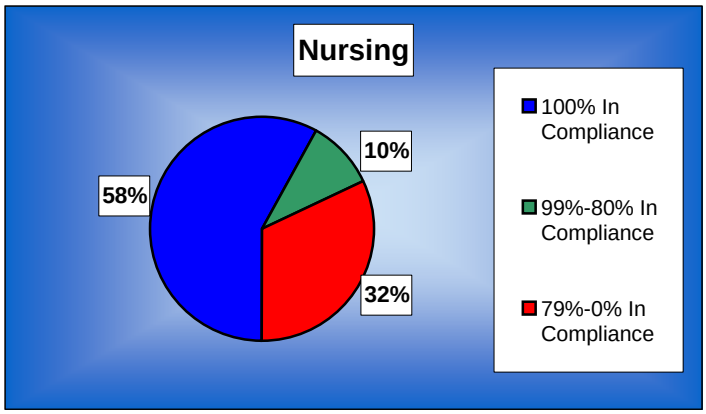


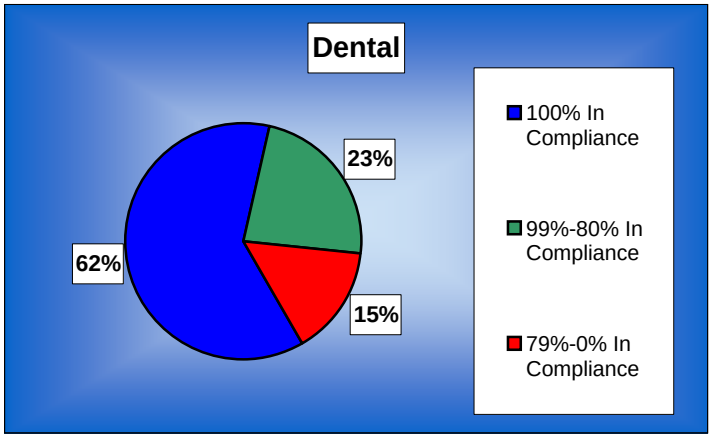


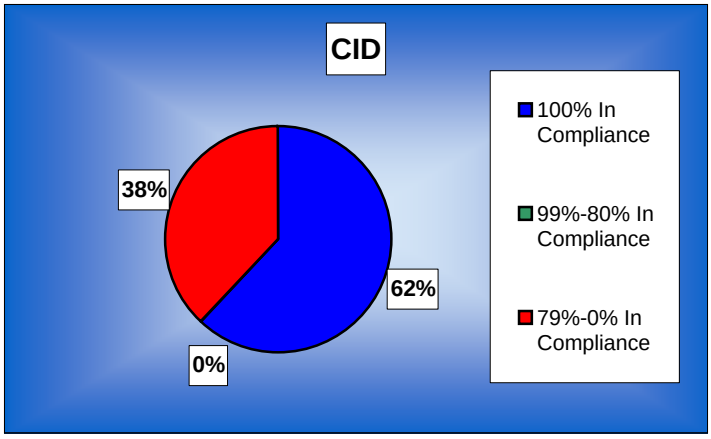
Quarterly Reports for
Compliance Rate By Operational Categories
North Texas ISF Facility
October 10, 2006



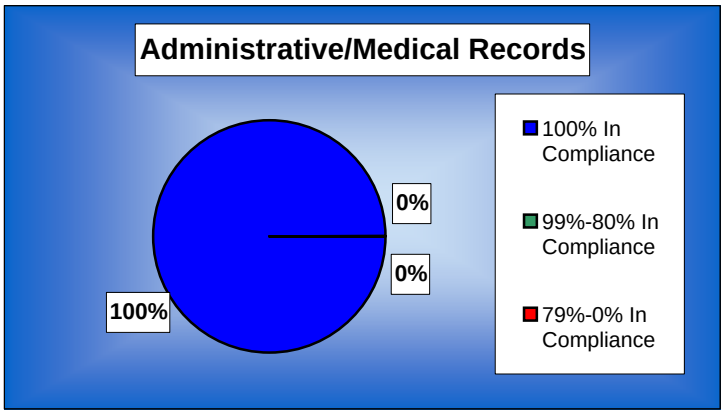


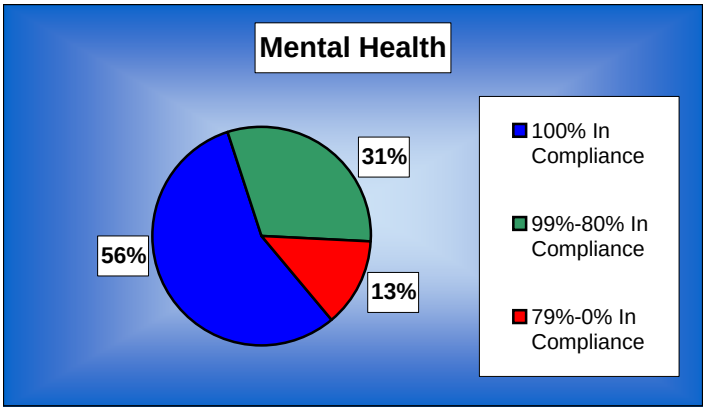


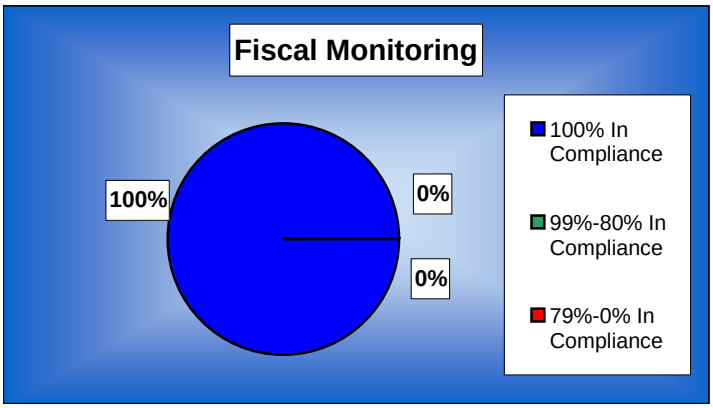


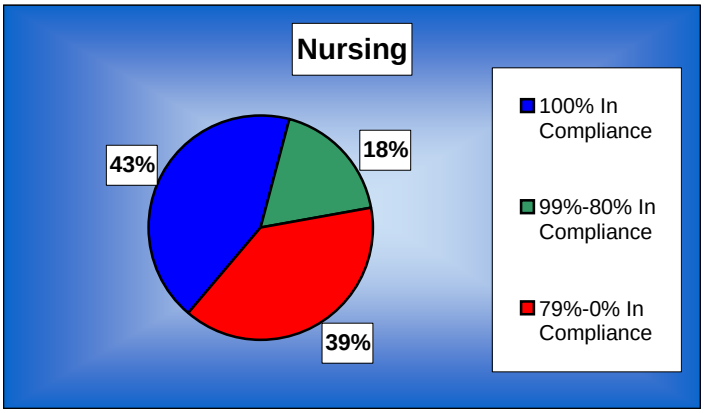


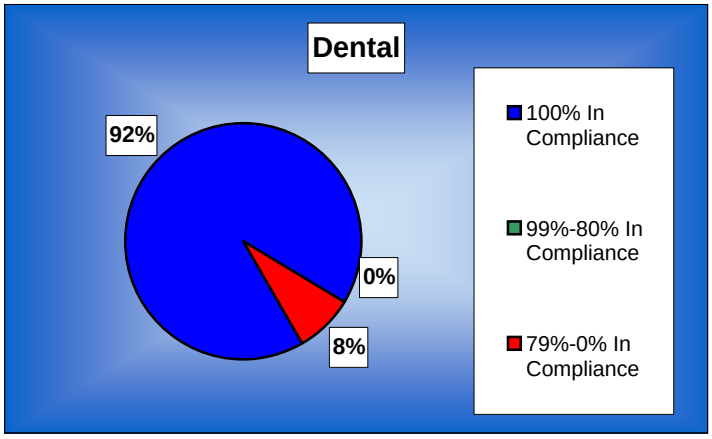
Quarterly Reports for
Compliance Rate By Operational Categories
Robertson Facility
September 6, 2006

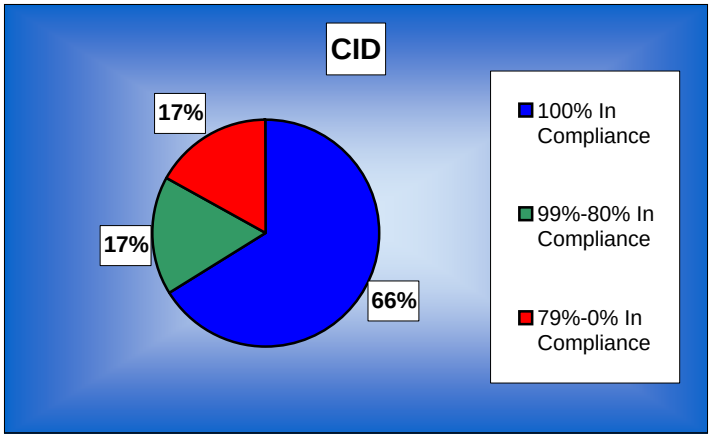




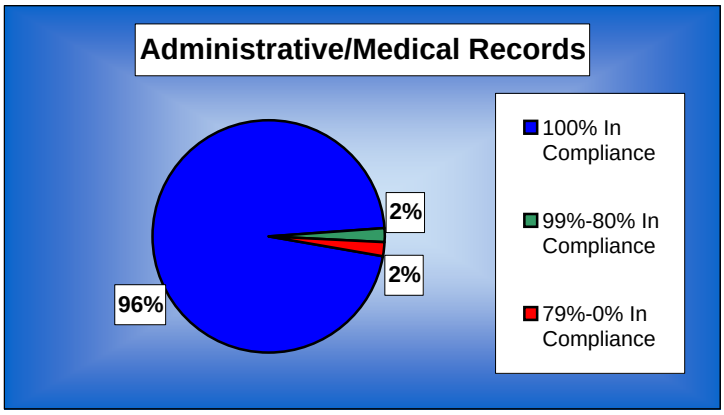


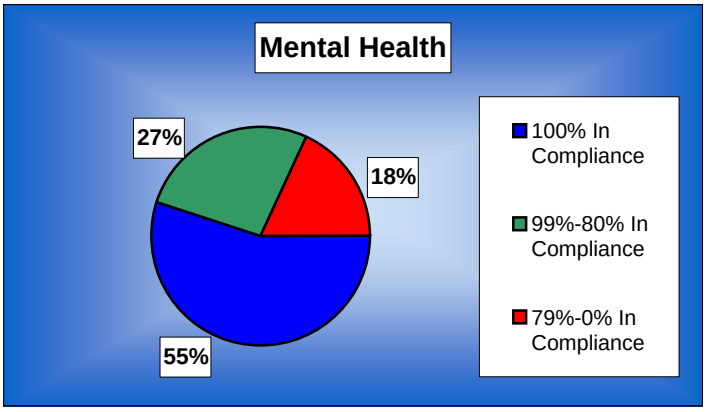


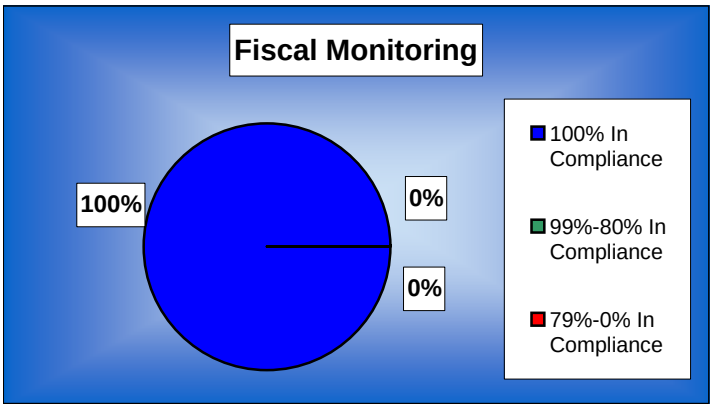


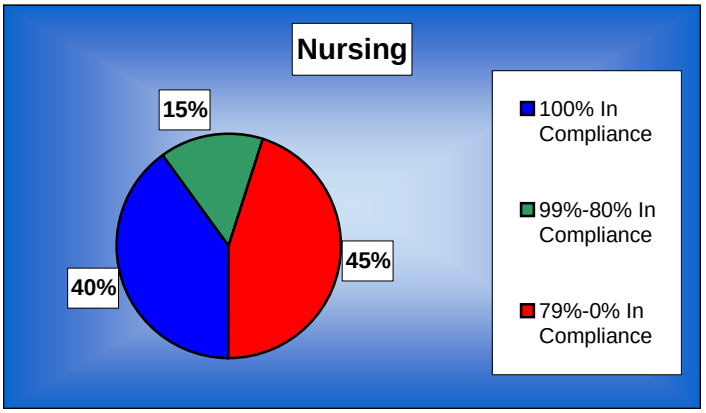


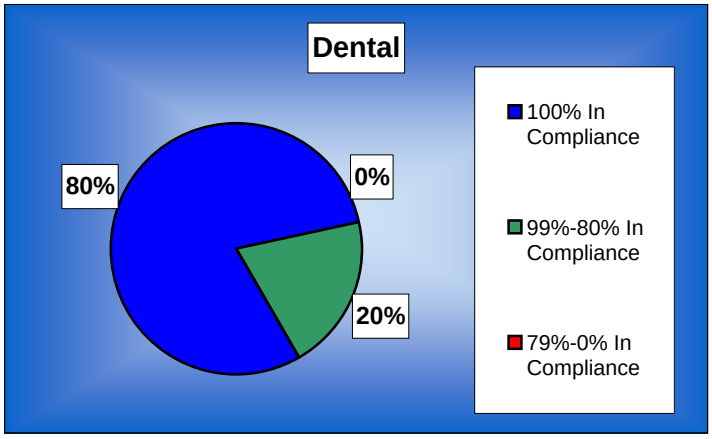
Quarterly Reports for
Compliance Rate By Operational Categories
Travis County Facility
November 3, 2006

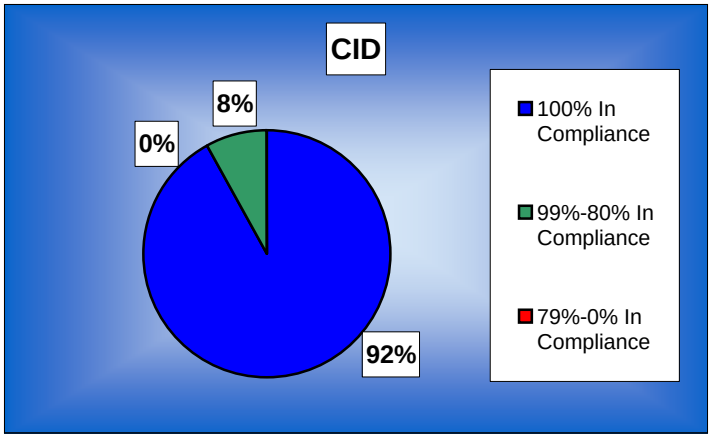




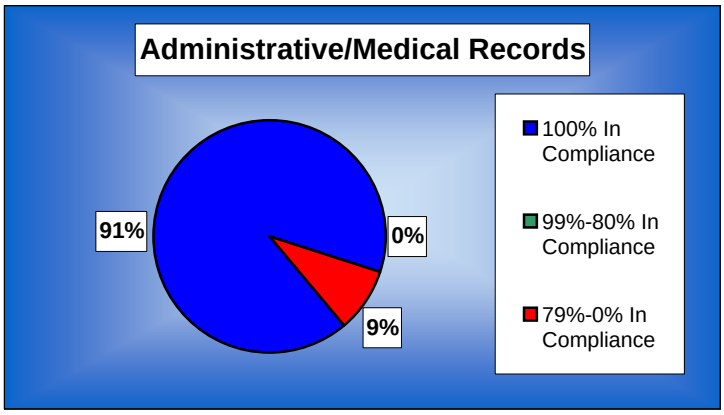


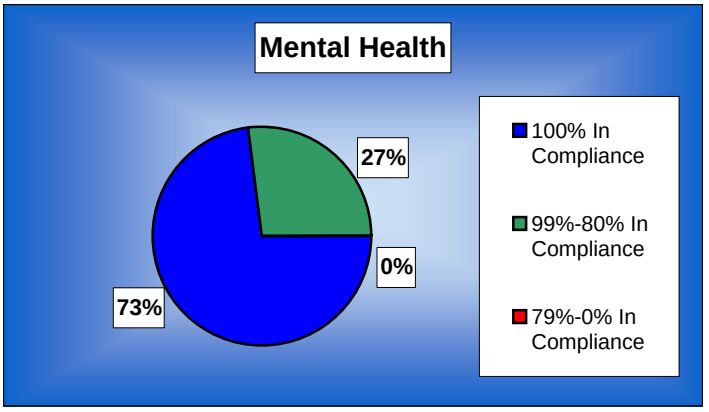


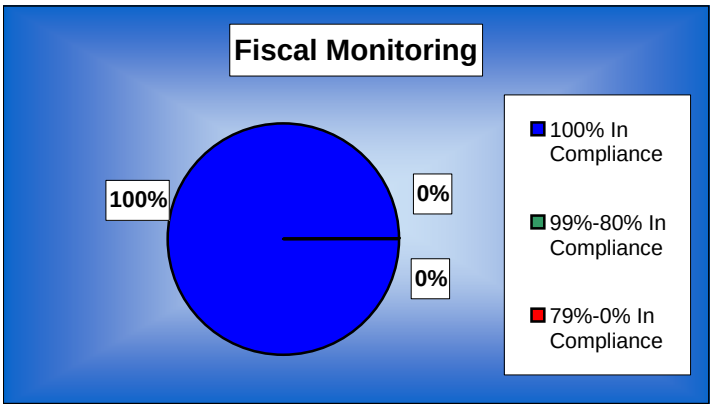


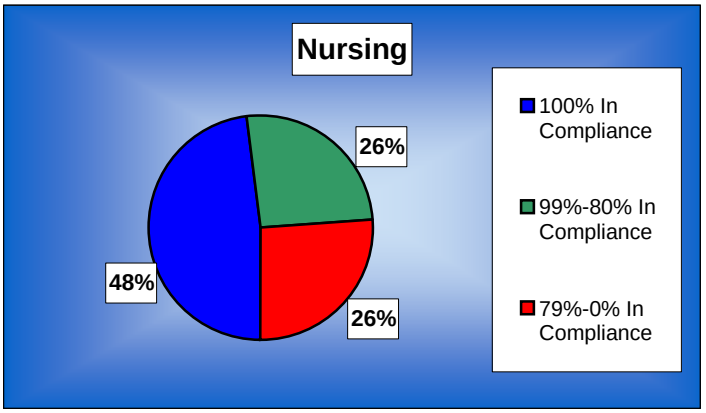


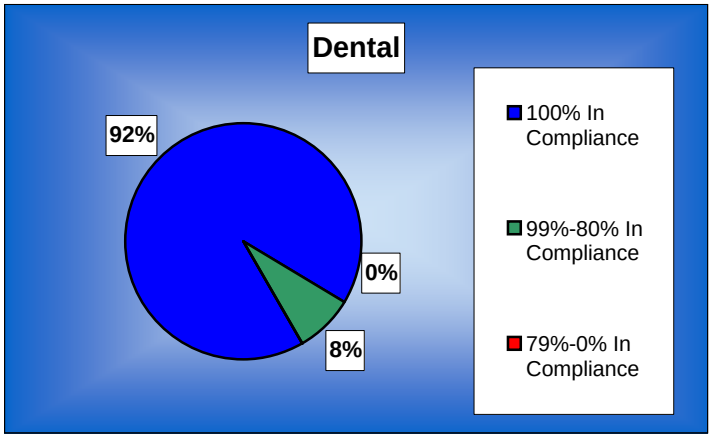
Quarterly Reports for
Compliance Rate By Operational Categories
Wynne Facility
October 5, 2006

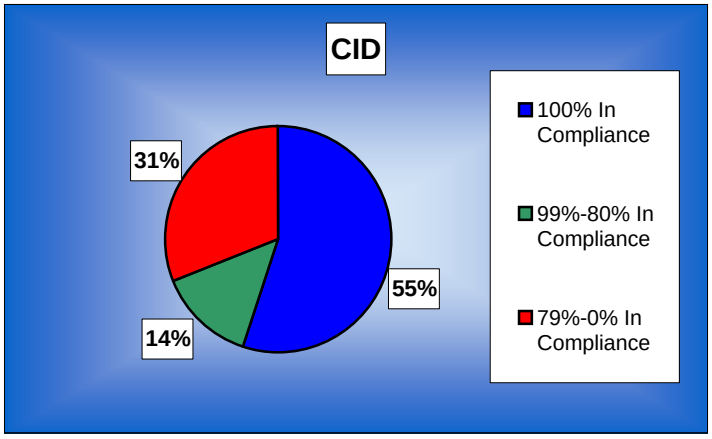












PATIENT LIAISON AND STEP II GRIEVANCE STATISTICS
QUALITY OF CARE/PERSONNEL REFERRALS AND ACTION REQUESTS

STEP II GRIEVANCE PROGRAM (GRV)									
FY2007	Total # of **GRV** Correspondence Received Each Month	Total # of Action Requests (Quality of Care, Personnel, and Process Issues)	% of Action Requests from Total # of **GRV** Correspondence	Total # of Action Requests Referred to **UTMB-CMHC**		Total # of Action Requests Referred to **TTUHSC-CMHC**		Total # of Action Requests Referred to **PRIVATE FACILITIES**	
					% of Total Action Requests Referred		% of Total Action Requests Referred		% of Total Action Requests Referred
Sep-06	507	24	4.73%	19	3.75%	5	0.99%	0	0.00%
Oct-06	547	29	5.30%	23	4.20%	6	1.10%	0	0.00%
Nov-06	505	23	4.55%	22	4.36%	1	0.20%	0	0.00%
Totals:	**1559**	**76**	**4.87%**	**64**	**4.11%**	**12**	**0.77%**	**0**	**0.00%**

PATIENT LIAISON PROGRAM (PLP)									
FY2007	Total # of **PLP** Correspondence Received Each Month	Total # of Action Requests (Quality of Care, Personnel, and Process Issues)	% of Action Requests from Total # of **PLP** Correspondence	Total # of Action Requests Referred to **UTMB-CMHC**		Total # of Action Requests Referred to **TTUHSC-CMHC**		Total # of Action Requests Referred to **PRIVATE FACILITIES**	
					% of Total Action Requests Referred		% of Total Action Requests Referred		% of Total Action Requests Referred
Sep-06	527	43	8.16%	32	6.07%	11	2.09%	0	0.00%
Oct-06	574	40	6.97%	34	5.92%	6	1.05%	0	0.00%
Nov-06	402	22	5.47%	14	3.48%	8	1.99%	0	0.00%
Totals:	**1503**	**105**	**6.99%**	**80**	**5.32%**	**25**	**1.66%**	**0**	**0.00%**

Texas Department of Criminal Justice
Office of Preventive Medicine
Monthly Activity Report

Month: September 2006

Reports Received	This Month	Same Month Last Year	Year to Date	Last Year to Date
Chlamydia	1	38	38	98
Gonorrhea	2	11	33	20
Syphilis	61	36	424	573
Hepatitis A	0	0	0	0
Hepatitis B (acute cases)	5	3	21	10
Hepatitis C	386	448	3405	3298
HIV Screens (non-pre-release)	5665	5659	51025	50466
HIV Screens (pre-release)	2675	3402	31694	3402
HIV + pre-release tests	3	2	63	2
HIV Infections	26	45	458	449
AIDS	3	15	91	268
Methicillin-Resistant *Staph Aureus*	329	210	4037	3352
Methicillin-Sensitive *Staph Aureus*	120	85	1304	1176
Occupational Exposures (TDCJ Staff)	17	12	173	142
Occupational Exposures Medical staff	4	3	53	52
Tuberculosis skin tests – intake (#positive)	126	295	3236	3066
Tuberculosis skin tests – annual (#positive)	29	72	540	721
Tuberculosis cases				
(1) Were diagnosed and reported upon incarceration into TDCJ and counted as residents of their county of origin	1	0	6	3
(2) Came into TDCJ on tuberculosis medications	1	3	15	15
(3) Were diagnosed and reported during their incarceration in TDCJ	2	0	14	19
TB cases under management	20	19		
Peer Education Programs	0	0	74	67
Peer Education Educators	0	0	454	828
Peer Education Participants	829	92	16,434	16,452
Sexual Assault In-Service (sessions/units)	15/8	N/A	53/97	N/A
Sexual Assault In-Service Participants	44	N/A	482	N/A
Alleged Assaults & Chart Reviews	37	N/A	37	N/A

NOTE: Some category totals may change to reflect late reporting.
Date Compiled: 4/3/07

Texas Department of Criminal Justice
Office of Preventive Medicine
Monthly Activity Report

Month: October 2006

Reports Received	This Month	Same Month Last Year	Year to Date	Last Year to Date
Chlamydia	8	13	46	111
Gonorrhea	2	6	22	39
Syphilis	58	67	631	496
Hepatitis A	0	0	0	0
Hepatitis B (acute cases)	2	0	23	10
Hepatitis C	433	371	3838	3669
HIV Screens (non-pre-release)	6392	6475	57417	56941
HIV Screens (pre-release)	2753	3481	35082	6883
HIV + pre-release tests	4	8	74	10
HIV Infections	53	49	511	498
AIDS	7	10	98	278
Methicillin-Resistant *Staph Aureus*	359	372	4597	3724
Methicillin-Sensitive *Staph Aureus*	117	129	1491	1305
Occupational Exposures (TDCJ Staff)	20	28	198	170
Occupational Exposures (Medical Staff)	8	2	61	54
HIV CPX Initiation	7	[redacted]	58	[redacted]
Tuberculosis skin tests – intake (#positive)	255	362	3668	3428
Tuberculosis skin tests – annual (#positive)	66	75	624	796
Tuberculosis cases				
(1) Were diagnosed and reported upon incarceration into TDCJ and counted as residents of their county of origin	0	1	6	4
(2) Came into TDCJ on tuberculosis medications	2	1	17	17
(3) Were diagnosed and reported during their incarceration in TDCJ	1	1	15	20
TB cases under management	21	16	[redacted]	[redacted]
Peer Education Programs	0	0	74	67
Peer Education Educators	0	0	454	828
Peer Education Participants	1071	195	18200	16934
Sexual Assault In-Service (sessions/units)	1/1	4/1	54/98	4/1
Sexual Assault In-Service Participants	5	7	487	7
Alleged Assaults & Chart Reviews	52	N/A	89	N/A

NOTE: Some category totals may change to reflect late reporting.
Date Compiled: 4/3/07

Texas Department of Criminal Justice
Office of Preventive Medicine
Monthly Activity Report

Month: November 2006

Reports Received	This Month	Same Month Last Year	Year to Date	Last Year to Date
Chlamydia	8	25	54	136
Gonorrhea	3	5	25	44
Syphilis	78	61	708	552
Hepatitis A	0	0	0	0
Hepatitis B (acute cases)	2	1	26	11
Hepatitis C	335	349	4173	4018
HIV Screens (non-pre-release)	6252	5742	63669	62683
HIV Screens (pre-release)	2201	3266	37722	10149
HIV + pre-release tests	1	8	75	18
HIV Infections	35	49	546	547
AIDS	2	11	100	289
Methicillin-Resistant *Staph Aureus*	293	283	5046	4405
Methicillin-Sensitive *Staph Aureus*	73	89	1611	1521
Occupational Exposures (TDCJ Staff)	12	6	214	183
Occupational Exposures (Medical Staff)	7	8	68	62
HIV CPX Initiation	6		64	
Tuberculosis skin tests – intake (#positive)	73	319	3835	3747
Tuberculosis skin tests – annual (#positive)	27	46	671	842
Tuberculosis cases				
(1) Diagnosed during intake and attributed to county of origin	0	0	6	4
(2) Entered TDCJ on TB medications	1	3	18	19
(3) Diagnosed during incarceration in TDCJ	0	2	15	22
TB cases under management	19	17		
Peer Education Programs	0	0	74	67
Peer Education Educators	0	0	454	828
Peer Education Participants	759	495	19615	17429
Sexual Assault In-Service (sessions/units)	13/5	10/3	64/102	14/4
Sexual Assault In-Service Participants	84	22	571	29
Alleged Assaults & Chart Reviews	40	N/A	129	N/A

NOTE: Some category totals may change to reflect late reporting.
Date Compiled: 4/3/07

HOSPITAL DISCHARGES*
First Quarter of FY-2007

Medical Provider	University	Number of Audits	Number of Deficiencies	Comments
Brownfield Regional	TTUHSC	0		
Cogdell Memorial	TTUHSC	0		
Hendrick Memorial	TTUHSC	0		
Hospital Del Sol	TTUHSC	3	0	No deficiencies noted
Hospital Galveston	UTMB	138	10	2 unstable and required readmission; 8 lacked discharge documentation
Mitchell County	TTUHSC	1	0	No deficiencies noted
Northwest Texas	TTUHSC	7	3	No discharge documentation
Pecos County	TTUHSC	1	1	No discharge documentation
Scenic Mountain	TTUHSC			
University Medical	TTUHSC	4	1	No discharge documentation
United Regional 11th St.	TTUHSC			

*The remainder of the hospitals were not selected during this quarter's random audit.

INFIRMARY DISCHARGES*
First Quarter of FY-2007

Medical Provider	University	Number of Audits	Number of Deficiencies	Comments
Allred	TTUHSC	0		
Beto	UTMB	5		No deficiencies noted
Clements	TTUHSC	0		
Connally	UTMB	2		No deficiencies noted
Estelle	UTMB	1	1	Blood pressure 171/102 documented on date of discharge
Hughes	UTMB	0		
Jester 3	UTMB	2		No deficiencies noted
Montford	TTUHSC	20		No deficiencies noted
Polunsky	UTMB	0		
Robertson	TTUHSC	1		No deficiencies noted
Telford	UTMB	2		No deficiencies noted
CT Terrell	UTMB	0		
Young	UTMB	11		No deficiencies noted

*The remainder of the infirmaries were not selected during this quarter's random audit.

CAPITAL ASSETS CONTRACT MONITORING AUDIT
BY UNIT
FIRST QUARTER, FISCAL YEAR 2007

September	Numbered Property On Inventory Report	Total Number of Deletions	Total Number of Transfers	Total Number of New Equipment
Robertson	68	0	1	0
Sayle	15	0	0	0

October	Numbered Property On Inventory Report	Total Number of Deletions	Total Number of Transfers	Total Number of New Equipment
Byrd	45	1	0	0
Goree	34	0	2	3
Wynne	49	0	6	0

November	Numbered Property On Inventory Report	Total Number of Deletions	Total Number of Transfers	Total Number of New Equipment
Kyle	11	0	2	0
Halbert	23	0	3	0
Travis County	29	0	1	2

CAPITAL ASSETS AUDIT
FIRST QUARTER, FISCAL YEAR 2007

Audit Tools	September	October	November	Total
Total number of units audited	2	3	3	8
Total numbered property	83	128	63	274
Total number out of compliance	0	0	0	0
Total % out of compliance	0.00%	0.00%	0.00%	0.00%

First Quarter FY2007

(September, October, November)

AMERICAN CORRECTIONAL ASSOCIATION
ACCREDITATION STATUS REPORT

University of Texas Medical Branch

Unit	Unit Type	Audit Date	% Compliance	
			Mandatory	**Non-Mandatory**
Hughes	ID	October 17 – 20, 2006	**100%**	**99.1%**
Murray	ID	October 23 – 25, 2006	**100%**	**99.1%**
Pack	ID	September 18 – 20, 2006	**100%**	**99.0%**
Stringfellow	ID	November 13 – 15, 2006	**100%**	**98.0%**
Stevenson	ID	October 30 – November 1, 2006	**100%**	**99.0%**

Texas Tech University Health Science Center

Unit	Unit Type	Audit Date	% Compliance	
			Mandatory	**Non-Mandatory**
Middleton	ID	November 6 – 8, 2006	**100%**	**98.8%**
Montford	ID	October 2 – 4, 2006	**100%**	**99.5%**
Neal	ID	September 11 – 13, 2006	**100%**	**98.6%**
Tulia	ID	September 25 – 27, 2006	**100%**	**99.7%**

Research, Evaluation and Development (RED) Group
Active Monthly Research Projects – Medical
Health Services Division

February 2007

Project Number: 408-RM03

Researcher:
Ned Snyder

IRB Number:
02-377

Research Began:
June 03, 2003

Title of Research:
Serum Markers of Fibrosis in Chronic Hepatitis C

Data Collection Began:
July 2003

Proponent:
University of Texas Medical Branch at Galveston

Data Collection End:
July 31, 2007

Project Status:
Data Collection

Projected Completion Date:
July 31, 2007

Units: Hospital Galveston

Project Number: 419-RM03

Researcher:
Robert Morgan

IRB Number:
L03-013

Research Began:
June 24, 2003

Title of Research:
Offender perceptions of Telemedicine vs. Face-to-Face Therapy

Data Collection Began:
July 01, 2003

Proponent:
Texas Tech University

Data Collection End:
May 31, 2005

Project Status:
Pending Manuscript Review

Projected Completion Date:
May 31, 2005

Units: System-wide

Project Number: 433-RM04

Researcher:
Ned Snyder

IRB Number:
03-357

Research Began:
March 19, 2004

Title of Research:
Secondary Prophylaxis of Spontaneous Bacterial Peritonitis with the Probiotic VSL #3

Data Collection Began:
March 22, 2004

Proponent:
University of Texas Medical Branch at Galveston

Data Collection End:
December 2008

Project Status:
Data Collection

Projected Completion Date:

Units: UTMB

Project Number: 450-RM04

Researcher:
Everett Lehman

IRB Number:
04.DSHEFS.02XP

Research Began:
September 30, 2004

Title of Research:
Emerging Issues in Health Care Worker and Bloodborne Pathogen Research: Healthcare Workers in Correctional Facilities

Data Collection Began:
November 16, 2004

Proponent:
Centers for Disease Control and Prevention; National Institute for Occupational Safety and Health

Data Collection End:
November 30, 2004

Project Status:
Formulating Results (Data Collection Complete)

Projected Completion Date:
December 31, 2006

Units: Lychner, Stringfellow

Project Number: 470-RM05

Researcher:
Amy Harzke

IRB Number:
HSC-SPH-05-0272

Research Began:
August 23, 2005

Title of Research:
Mortality related to hepatitis B and C infection in a large prison system, 1984 – 2003

Data Collection Began:
August 23, 2005

Proponent:
University of Texas at Austin, School of Public Health

Data Collection End:
September 01, 2006

Project Status:
Data Analysis

Projected Completion Date:
April 30, 2007

Units:

Project Number: 475-RM05

Researcher:
Robert Morgan

IRB Number:
L05-077

Research Began:
August 1, 2005

Title of Research:
Tailoring Services for Mentally Ill Offenders

Data Collection Began:
January 20, 2006

Proponent:
Texas Tech University

Data Collection End:
July 31, 2007

Project Status:
Data Collection

Projected Completion Date:

Units: Gatesville, Montford

Project Number: 486-RM05

Researcher:
William O'Brien

IRB Number:
05-298

Research Began:
January 17, 2006

Title of Research:
A Phase III randomized, double-blinded, placebo-controlled trial to investigate the efficacy, tolerability, and safety of TMC125 as part of an ART including TMC114/RTV and an investigator-selected OBR in HIV-1 infected subjects with limited to no treatment options (TMC 125-C206)

Data Collection Began:
January 17, 2006

Proponent:
University of Texas Medical Branch at Galveston

Data Collection End:
November 30, 2006

Project Status:
Data Analysis

Projected Completion Date:
April 17, 2007

Units: Hospital Galveston

Project Number: 490-RM06

Researcher:
Sharon Melville

IRB Number:

Research Began:
April 24, 2006

Title of Research:
Medical Monitoring Project (MMP)

Data Collection Began:
April 24, 2006

Proponent:
Texas Department of State Health Services; US Center for Disease Control (CDC)

Data Collection End:
April 30, 2010

Project Status:
Data Collection

Projected Completion Date:
April 30, 2010

Units: System-wide

Project Number: 497-RM06

Researcher:
Gail Kwarciany

IRB Number:
HSC-SN-06-0102

Research Began:
August 01, 2006

Title of Research:
Hope and System Distress in Incarcerated Oncology Patients Receiving Chemotherapy

Data Collection Began:
August 01, 2006

Proponent:
University of Texas Health Science Center at Houston, School of Nursing

Data Collection End:
November 30, 2006

Project Status:
Data Analysis

Projected Completion Date:
December 31, 2006

Units: UTMB

Project Number: 503-RM06

Researcher:
William O'Brien

IRB Number:
06-189

Research Began:
October 2006

Title of Research:
TMC125-C217 An open-label trial with TMC125 as part of an ART including TMC114/rtv and an investigator-selected OBR in HV-1 infected subjects who participated in a DUET trial (TMC125-C206 or TMC125-C216)

Data Collection Began:
October 2006

Proponent:
University of Texas Medical Branch at Galveston

Data Collection End:
October 2008

Project Status:
Data Collection

Projected Completion Date:

Units: UTMB

Project Number: 513-MR07

Researcher:
H. Morgan Scott

IRB Number:
N/A

Research Began:
November 21, 2006

Title of Research:
Do variable monthly levels of antibiotic usage affect the levels of resistance of enteric bacteria isolated from human and swine wastewater in multisite integrated human and swine populations?

Data Collection Began:
November 21, 2006

Proponent:
Texas A&M, Department of Veterinary Integrative Biosciences, College of Veterinary Medicine

Data Collection End:

Project Status:
Data Collection

Projected Completion Date:

Units: Beto, Byrd, Central, Clemens, Coffield, Darrington, Eastham, Ellis, Estelle, Ferguson, Jester I, Jester III, Luther, Michael, Pack, Powledge, Scott, Terrell, Wynne

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Medical Research Projects Pending Approval
February 2007

Project Number: 498-RM06

Researcher:
Marilyn Armour

IRB Number:
2005-12-0014

Application Received:
June 5, 2006

Title of Research:
Development of a Research Proposal to Examine the Impact of the Ultimate Penal Sentence on the Wellbeing of Survivors of Homicide Victims

Completed Application Received:

Proponent:
University of Texas at Austin, School of Social Work

Peer Panel Scheduled:

Project Status:
Pending OIG and OGC

Peer Panel Recommendations:

Units:

Project Number: 499-RM06

Researcher:
Albert D. Wells

IRB Number:

Application Received:
June 15, 2006

Title of Research:
Past Drug Use Among Recently Incarcerated Offenders in the TDCJ and Oral Health Ramifications

Completed Application Received:

Proponent:
UTMB

Peer Panel Scheduled:
February 5, 2007

Project Status:
Pending Health Services Division Director Approval

Peer Panel Recommendations:
February 5, 2007

Units:

Project Number: 515-MR07

Researcher:
Jacques Baillargeon

IRB Number:
06-249

Application Received:
October 27, 2006

Title of Research:
Disease Prevalence and Health Care Utilization in the Texas Prison System

Completed Application Received:

Proponent:
UTMB

Peer Panel Scheduled:
November 13, 2006

Project Status:
Pending Signed Research Agreement

Peer Panel Recommendations:
Recommend for Approval

Units:

Project Number: 523-MR07

Researcher:
Robert Morgan

IRB Number:
L06-193

Application Received:
December 11, 2006

Title of Research:
An Examination of the Combined Use of the PAI and the M-FAST in Detecting Malingering Among Inmates

Completed Application Received:
December 18, 2006

Proponent:
Texas Tech University, Department of Psychology

Peer Panel Scheduled:
December 20, 2006

Project Status:
Pending Researcher Response to Peer Panel Conditions

Peer Panel Recommendations:
Recommend Approval

Units: Montford

Project Number: 527-MR07

Researcher:
Ned Snyder

IRB Number:
05-277

Application Received:
December 22, 2006

Title of Research:
Capsule endoscopy versus traditional EGD for variceal screening: a head-to-head comparison

Completed Application Received:
January 29, 2007

Proponent:
UTMB

Peer Panel Scheduled:
January 22, 2007

Project Status:
Pending Health Services Division Approval

Peer Panel Recommendations:
Recommend Approval

Units:

TDCJ HEALTH SERVICES
ADMINISTRATIVE SEGREGATION MENTAL HEALTH AUDITS
FIRST QUARTER FY-2007

UNIT	DATE(S)	ATC 4 & 5	ATC 6	REF'D	REQ. FWD	OFFENDERS SEEN	OFFENDERS INTERVIEWED	STAFF INTERVIEWED
	(Audit dates)	(48-72 Hrs)	(14 Days)	(Referred for evaluation)	(Requests Forwarded)	Total	MHS Caseload/Non-caseload	MHS/Security
CONNALLY	9/6 & 9/7/06	100%	100%	0	9	496	81/75	2/6
CLEMENTS (ECB)	9/19 & 9/20/06	100%	90%	2	9	445	178/77	4/6
FERGUSON	9/25/06	100%	100%	0	7	413	19/112	3/6
McCONNELL	9/26 & 9/27/06	100%	100%	0	6	473	50/94	5/6
BETO	10/10/06	92%	100%	0	7	266	38/54	2/5
COFFIELD	10/18&10/19/06	100%	N/A	0	7	752	48/144	2/6
MT. VIEW	10/24/06	100%	100%	0	0	21	5/16	2/4
WYNNE	10/26/06	100%	100%	1	3	397	27/80	2/6
LEWIS (ECB)	11/15&11/16/06	100%	100%	0	10	430	45/122	2/6
MURRAY	11/20/06	100%	100%	0	2	81	13/27	3/4
POLUNSKY	11/21&11/22/06	100%	100%	2	6	445	70/109	4/10
HUGHES	11/28&11/29/06	100%	100%	1	11	461	75/149	5/6
TOTAL		1192	1090	6	77	4,680	649/1,059	36/77
AVERAGE		99.33%	99.09%	0.50	6.42	390.00	54.08/88.25	3.00/6.42

Consent Item 3(a)

University Medical Director's Report

The University of Texas Medical Branch

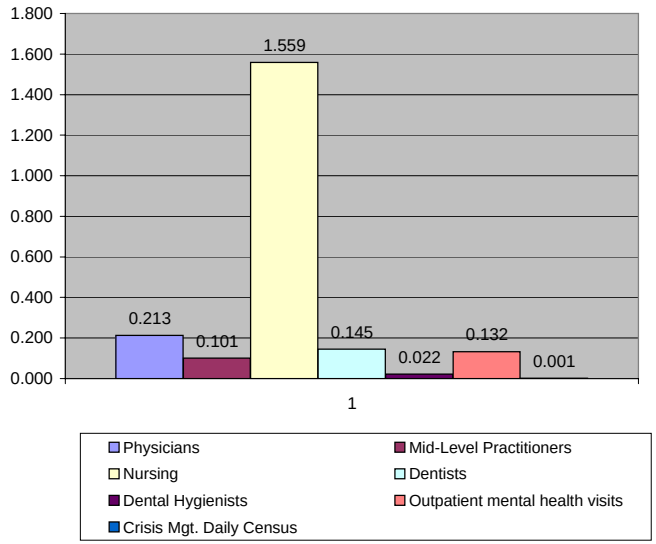
Correctional Health Care
MEDICAL DIRECTOR'S REPORT

FIRST QUARTER
FY2007

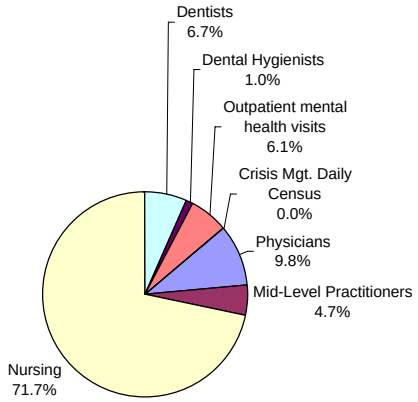
Medical Director's Report:

	September		October		November		Qtly Average	
Average Population	**120,245**		**120,174**		**120,307**		**120,242**	
	Number	**Rate Per Offender**	**Number**	**Rate Per Offender**	**Number**	**Rate Per Offender**	**Number**	**Rate Per Offender**
Medical encounters								
Physicians	25,707	0.214	26,497	0.220	24,757	0.206	**25,654**	**0.213**
Mid-Level Practitioners	12,202	0.101	13,199	0.110	11,204	0.093	**12,202**	**0.101**
Nursing	187,027	1.555	192,494	1.602	182,966	1.521	**187,496**	**1.559**
Sub-total	**224,936**	**1.871**	**232,190**	**1.932**	**218,927**	**1.820**	**225,351**	**1.874**
Dental encounters								
Dentists	16,940	0.141	18,393	0.153	17,052	0.142	**17,462**	**0.145**
Dental Hygienists	2,624	0.022	2,639	0.022	2,510	0.021	**2,591**	**0.022**
Sub-total	**19,564**	**0.163**	**21,032**	**0.175**	**19,562**	**0.163**	**20,053**	**0.167**
Mental health encounters								
Outpatient mental health visits	15,648	0.130	16,654	0.139	15,426	0.128	**15,909**	**0.132**
Crisis Mgt. Daily Census	106	0.001	98	0.001	100	0.001	**101**	**0.001**
Sub-total	**15,754**	**0.131**	**16,752**	**0.139**	**15,526**	**0.129**	**16,011**	**0.133**
Total encounters	**260,254**	**2.164**	**269,974**	**2.247**	**254,015**	**2.111**	**261,414**	**2.174**

Encounters as Rate Per Offender Per Month



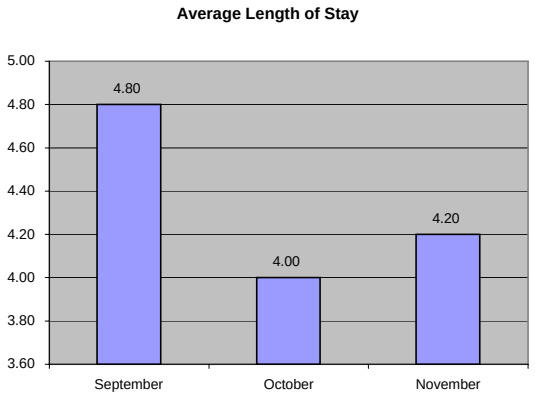
Encounters by Type

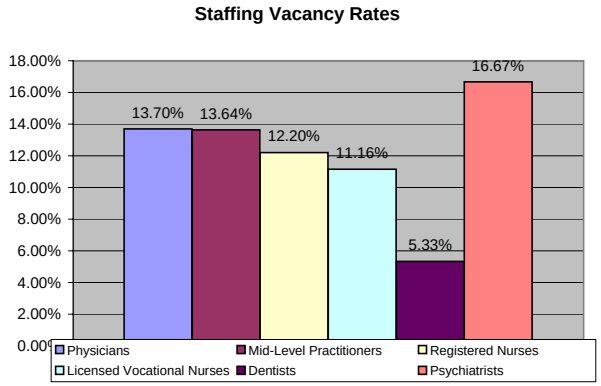


Medical Director's Report (Page 2):

	September	October	November	Qtly Average
Medical Inpatient Facilities				
Average Daily Census	126.00	121.00	114.00	**120.33**
Number of Admissions	490.00	496.00	499.00	**495.00**
Average Length of Stay	4.80	4.00	4.20	**4.33**
Number of Clinic Visits	1,732.00	1,808.00	1,599.00	**1,713.00**
Mental Health Inpatient Facilities				
Average Daily Census	1,037.27	1,034.39	1,039.27	**1,036.98**
PAMIO/MROP Census	710.00	724.61	723.70	**719.44**
Specialty Referrals Completed	1,053.00	1,245.00	1,063.00	**1,120.33**
Telemedicine Consults	655	624	524	**601.00**

	Average This Quarter			Percent
Health Care Staffing	**Filled**	**Vacant**	**Total**	**Vacant**
Physicians	63.00	10.00	73.00	13.70%
Mid-Level Practitioners	114.00	18.00	132.00	13.64%
Registered Nurses	367.00	51.00	418.00	12.20%
Licensed Vocational Nurses	669.00	84.00	753.00	11.16%
Dentists	71.00	4.00	75.00	5.33%
Psychiatrists	15.00	3.00	18.00	16.67%





Consent Item 3(b)

University Medical Director's Report

Texas Tech University
Health Sciences Center

Correctional Managed Health Care
MEDICAL DIRECTOR'S REPORT

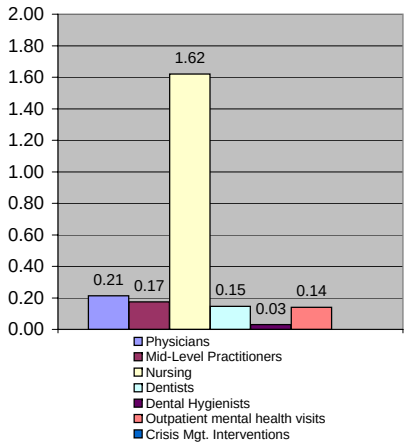
FIRST QUARTER
FY 2007

Medical Director's Report:

Average Population	September	October	November	Quarterly Average
	31,519.66	31,567.67	31,700.43	31,595.92

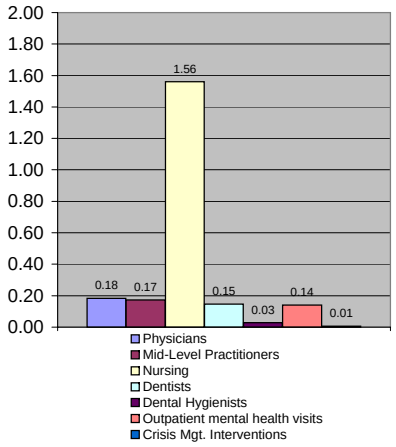
Medical Encounters	Number	Rate Per Offender	Number	Rate Per Offender	Number	Rate Per Offender	Number	Rate Per Offender
Physicians	6,360	0.202	5,663	0.179	5,428	0.171	5,817	0.184
Mid-Level Practitioners	5,371	0.170	5,690	0.180	5,346	0.169	5,469	0.173
Nursing	47,980	1.522	49,451	1.567	50,507	1.593	49,313	1.561
Sub-Total	**59,711**	**1.894**	**60,804**	**1.926**	**61,281**	**1.933**	**60,599**	**1.918**
Dental Encounters								
Dentists	4,644	0.147	4,151	0.131	5,022	0.158	4,606	0.146
Dental Hygienists	964	0.031	842	0.027	987	0.031	931	0.029
Sub-Total	**5,608**	**0.178**	**4,993**	**0.158**	**6,009**	**0.190**	**5,537**	**0.175**
Mental Health Encounters								
Outpatient mental health visits	4,433	0.141	4,212	0.133	4,692	0.148	4,446	0.141
Crisis Mgt. Interventions	188	0.006	204	0.006	181	0.006	191	0.006
Sub-Total	**4,621**	**0.147**	**4,416**	**0.140**	**4,873**	**0.154**	**4,637**	**0.147**
Total Encounters	**69,940**	**2.219**	**70,213**	**2.224**	**72,163**	**2.276**	**70,772**	**2.240**

Encounters as Rate Per Offender Per Month



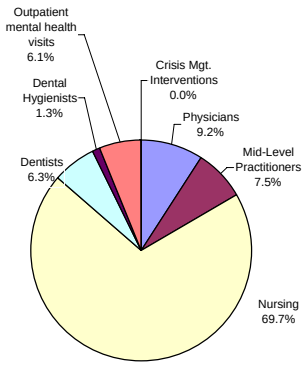
4th Quarter 2006

Encounters as Rate Per Offender Per Month



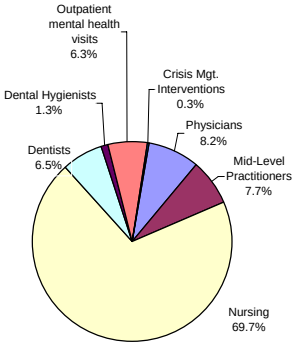
1st Quarter 2007

Encounters by Type



4th Quarter 2006

Encounters by Type

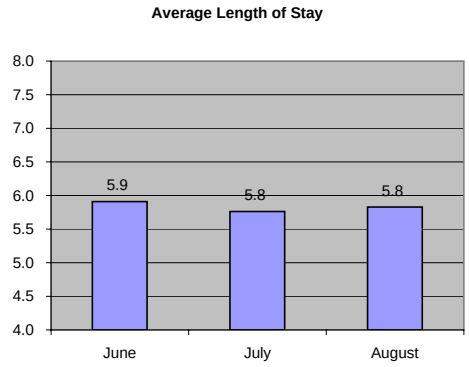


1st Quarter 2007

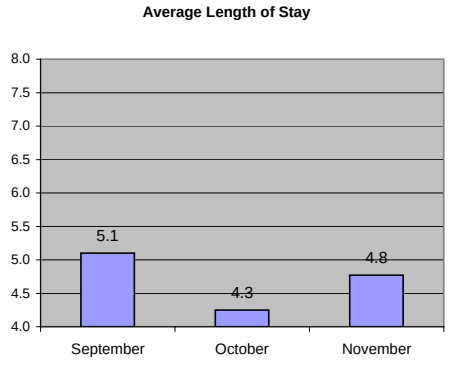
Medical Director's Report (page 2):

	September	October	November	Quarterly Average
Medical Inpatient Facilities				
Average Daily Census	76.03	65.53	80.53	**74.03**
Number of Admissions	247	255	247	**249.67**
Average Length of Stay	5.1	4.25	4.77	**4.71**
Number of Clinic Visits	574	684	589	**615.67**
Mental Health Inpatient Facilities				
Average Daily Census	546	543	545	**544.67**
PAMIO/MROP Census	414	428	419	**420.33**
Specialty Referrals Completed	1045	1096	1085	**1075.33**
Telemedicine Consults	334	287	351	**324.00**

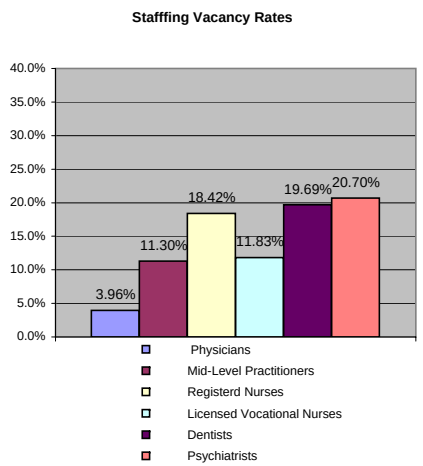
Health Care Staffing	Average This Quarter			Percent Vacant
	Filled	Vacant	Total	
Physicians	23.85	0.18	24.03	0.75%
Mid-Level Practitioners	25.96	2.22	28.18	7.88%
Registerd Nurses	165.09	30.77	195.86	15.71%
Licensed Vocational Nurses	327.98	52.89	380.87	13.89%
Dentists	19.67	2.5	22.17	11.28%
Psychiatrists	8.6	3.08	11.68	26.37%



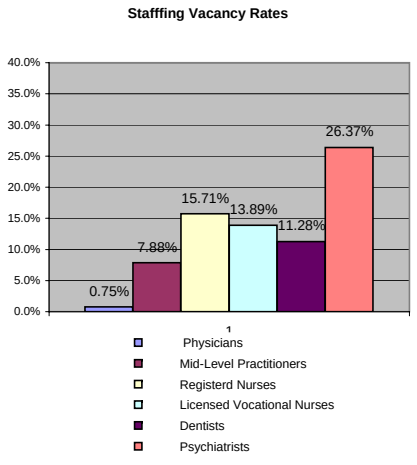
4th Quarter 2006



1st Quarter 2007



4th Quarter 2006



1st Quarter 2007

Consent Item 4

Summary of CMHCC Joint Committee / Work Groups

Correctional Managed Health Care
Joint Committee/Work Group Activity Summary

The CMHCC, through its overall management strategy, utilizes a number of standing and ad hoc joint committees and work groups to examine, review and monitor specific functional areas. The key characteristic of these committees and work groups is that they are comprised of representatives of each of the partner agencies. They provide opportunities for coordination of functional activities across the state. Many of these committees and work groups are designed to insure communication and coordination of various aspects of the statewide health care delivery system. These committees work to develop policies and procedures, review specific evaluation and/or monitoring data, and amend practices in order to increase the effectiveness and efficiency of the program. Many of these committees or work groups are considered to be medical review committees allowed under Chapter 161, Subchapter D of the Texas Health and Safety code and their proceedings are considered to be confidential and not subject to disclosure under the law. This summary is intended to provide the CMHCC with a high level overview of the ongoing work activities of these workgroups.

Workgroup activity covered in this report includes:

- System Leadership Council
- Joint Policy and Procedure Committee
- Joint Pharmacy and Therapeutics Committee
- Joint Infection Control Committee
- Joint Nursing Committee
- Joint Dental Work Group
- Joint Mortality and Morbidity Committee

System Leadership Council

Chair: Dr. Denise DeShields

Purpose: Charged with routine oversight of the CMHCC Quality Improvement Plan, including the monitoring of statewide access to care and quality of care indicators.

Meeting Date: February 8, 2007

Key Activities:

(1) Reviewed monthly detailed Access to Care Indicator data for the First Quarter of FY 2007. Discussed compliance issues and corrective actions taken.

ATC Indicators	Quarterly Average 80% Compliance or Above
#1: SCR physically triaged within 48 hrs (72 hrs Fri and Sat)	100%
#2: Dental chief complaint documented in MR at time of triage	100%
#3: Referral to dentist (nursiong/dental triage) seen within 7 days of SCR receipt	99%
#4: SCR/referrals (mental health) physically triaged within 48 hrs (72 hrs Fri/Sat)	97%
#5: MH chief complaint documented in the MR at time of triage	98%
#6: Referred outpatient MH status offenders seen within 14 days of referral/triage	100%
#7: SCR for medical services physically triaged within 48 hrs (72 hrs Fri/Sat)	97%
#8: Medical chief complaint documented in MR at time of triage	100%
#9: Referrals to MD, NP or PA seen within 7 days of receipt of SCR	93.4%

(2) Reviewed Statewide SLC Quality of Care Indicator data:

- Dental X-Ray Focus Study
- Review of Timeliness of Medication Delivery
- Recording of PUHLES entries for Mental Health outpatients

(3) Began preparations for selection of next fiscal year indicators.

(4) Reviewed processes related to the initiation of Sick Call Request verification audits

(5) Reviewed Medical Grievance Exception Report.

Joint Policy and Procedure Committee

Co-Chairs: Allen Sapp, CMHCC staff and Dr. Mike Kelley, TDCJ Health Services Division

Purpose: Charged with the annual review of each statewide policy statement applicable to the correctional managed health care program.

Meeting Date: January 11, 2007

Key Activities:

(1) Approved policy revisions to A-08.10 relating to Referrals to the Program for the Aggressive Mentally-ill Offender.

(2) Approved revisions to policies H-60.1 and H-65.1 relating to Health Records Organization and Maintenance and Retention/Destruction of Health Records.

(3) Approved revisions to policy I-70.2 ,Consent for Admission to Inpatient Psychiatric Care.

(4) Approved revisions to policy G-53.1, Suicide Prevention Plan.

(5) Approved Quarterly policy review and related revisions to 14 policies in Section E, Inmate Care and Treatment.

(6) Assigned Sections A (Governance and Administration) and Section F (Health Promotion and Disease Prevention) for next quarterly review cycle.

Joint Pharmacy and Therapeutics Committee

Chair: Dr. Monte Smith

Purpose: Charged with the review, monitoring and evaluation of pharmacy practices and procedures, formulary management and development of disease management guidelines.

Meeting Date: January 11, 2007

Key Activities:

(1) Received and reviewed reports from the following P&T subcommittees:

- Psychiatry
- HIV
- COPD
- GERD/Dyspepsia/Ulcers
- TYC Seizures
- DMG Triage

(2) Reviewed and discussed monthly reports as follows:

- Adverse drug reactions
- Pharmacy clinical activity
- Nonformulary deferrals
- Utilization related reports on:
    - HIV interventions
    - HIV utilization
    - Hepatitis C utilization
- Medication incident reports

(3) Discussion related to enfuvirtide (Fuzeon).

(4) Review of pharmacy policy 15-10 related to the storage of pharmaceuticals.

(5) Reviewed KOP eligibility requests for Acyclovir (Zovirax).

(6) Reviewed formulary addition request for Atazanavir (Reyataz).

(7) Discussed units of measure for over the counter medications available from Commissaries.

(8) Discussed formulary review for skin and mucous membrane agents.

(9) Reviewed revisions to wound care disease management guideline.

Joint Infection Control Committee

Chair: Dr. Mike Kelley

Purpose: Charged with the review, monitoring and evaluation of infection control policies and preventive health programs.

Meeting Date: October 12, 2006

Key Activities:

(1) Review of preventive medicine statistics related to hepatitis, tuberculosis, syphilis, chlamydia, gonorrhea, HIV and MRSA.

(2) Discussion of Hepatitis summit activities and processes for review and revision to hepatitis policies.

(3) Review of antibiotic susceptibility of *staphylococcus aureus* isolates

(4) Review of norovirus outbreak response and prevention activities.

(5) Reviewed HB 43 (HIV pre-release testing) statistics and compliance.

(6) Reviewed issues related to needle stick exposures.

(7) Discussed policy issues related to VRE isolation and Varicella.

(8) Discussed influenza vaccinations.

(9) Review of policy revisions relating to offender post-exposure prophylaxis.

(10) Reviewed 8 infection control policies for routine updating.

Joint Nursing Committee

Chair: Nancy Spain, R.N.

Purpose: Charged with the review, monitoring and evaluation of nursing policies and practices.

Meeting Date: August 8, 2006

Key Activities:

(1) Review of nursing policies related to licensed nurses roles in pronouncing death.

(2) Review of nursing issues related to DNA blood draws.

(3) Discussion of crash cart requirements.

(4) Review of nursing and health record forms related to code critiques.

Joint Dental Work Group

Co-Chairs: Dr. Sonny Wells and Dr. Brian Tucker

Purpose: Charged with the review, monitoring and evaluation of dental policies and practices.

Meeting Date: January 3, 2007

Key Activities:

(1) Review of dental staffing data.

(2) Discussion of non-compliance report issues.

(3) Review of oral surgery referrals

(4) Review of dental x-ray focus study.

(5) Discussion of ACA accreditation schedule and activities

(6) Review of section E policies relating to dental practices.

(7) Review of policy relating to chemical and hazardous material controls.

Joint Mortality and Morbidity Committee

Chair: Dr. Mike Kelley

Purpose: Charged with the ongoing review of morbidity and mortality data, including review of each offender death.

Meeting Date: January 10, 2007

Key Activity: Review and discussion of reports on offender deaths and determinations as to the need for peer review.

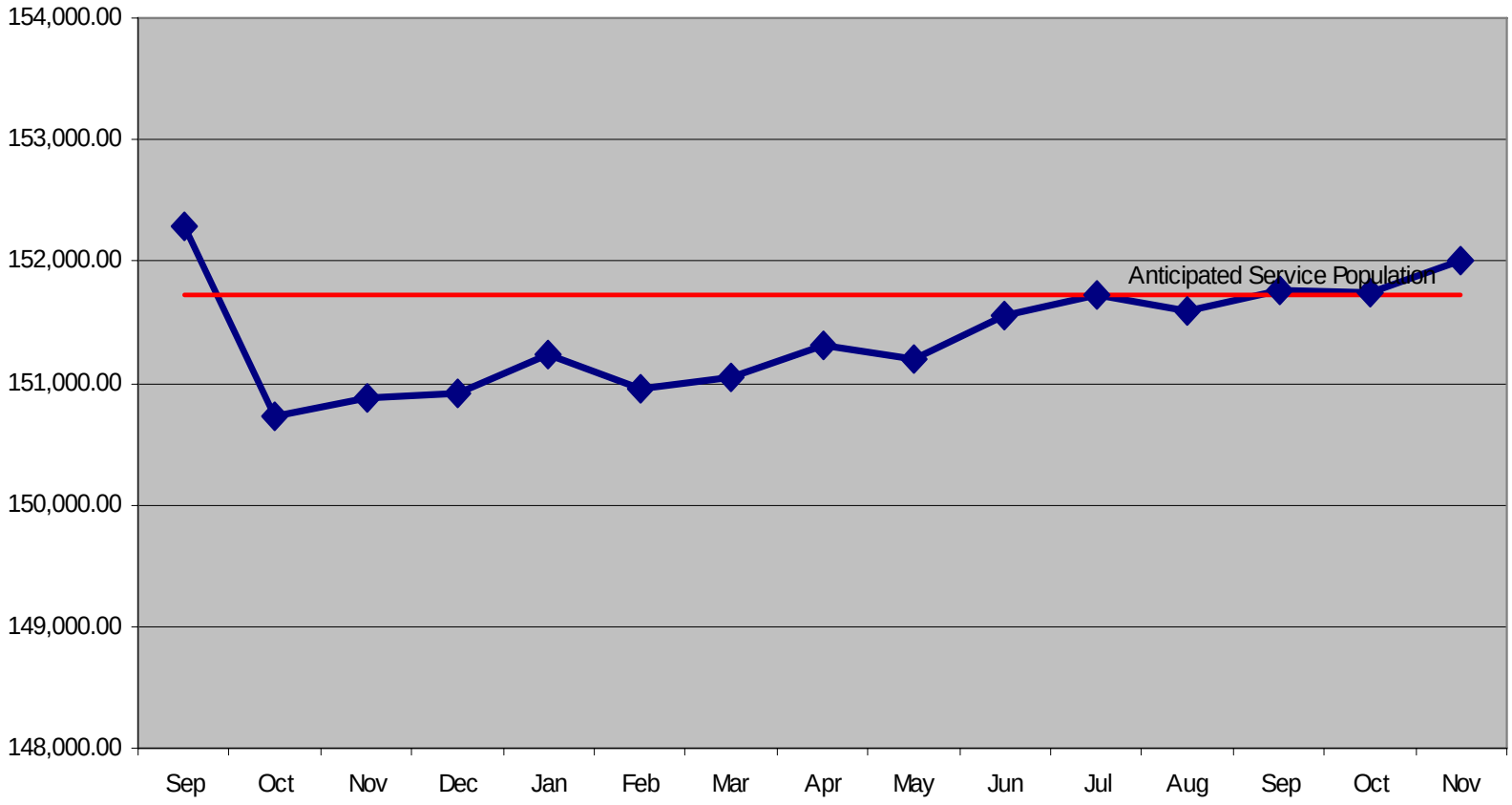
Tab C

Correctional Managed Health Care Committee

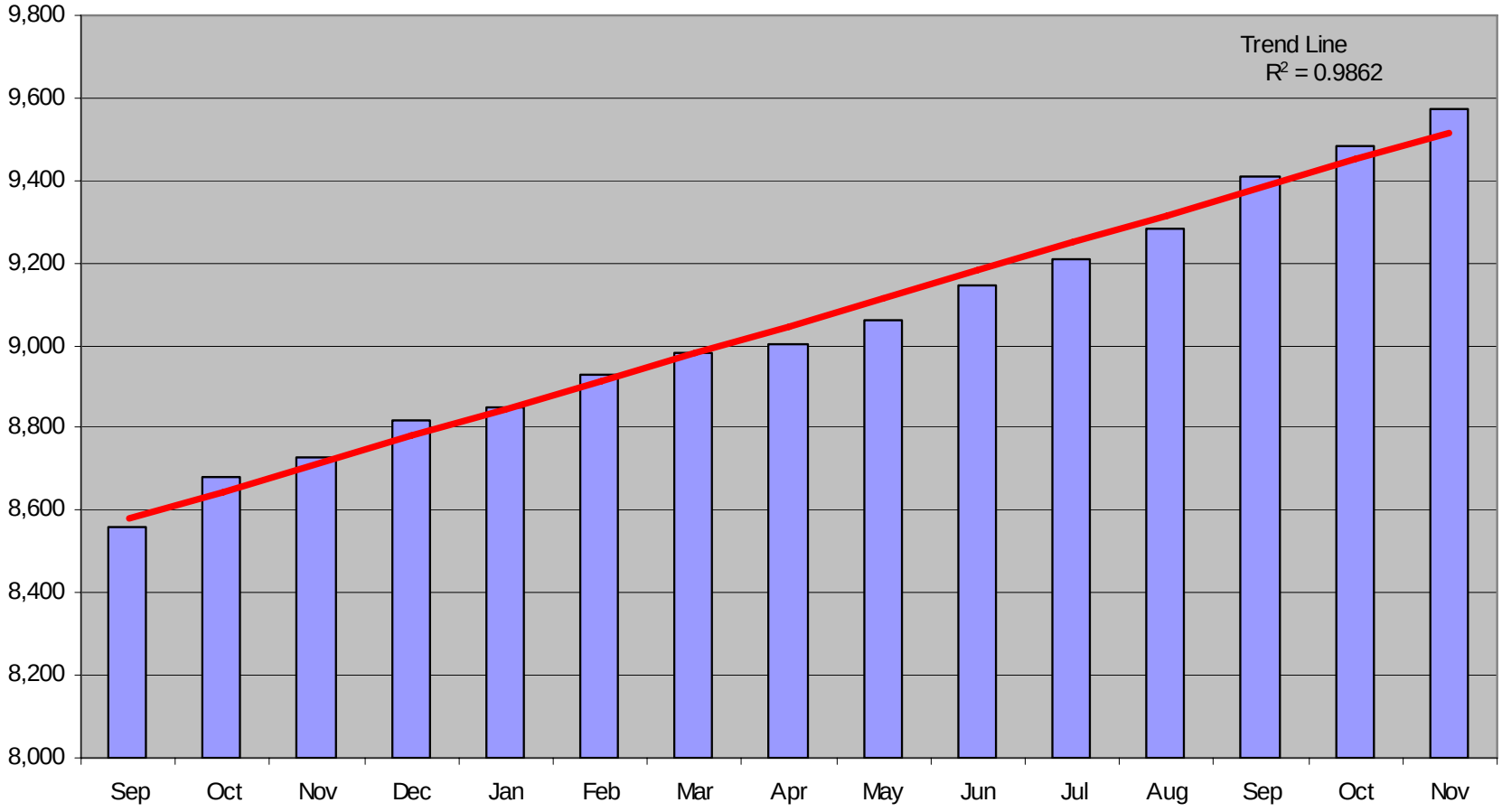
Key Statistics Dashboard

March 2007

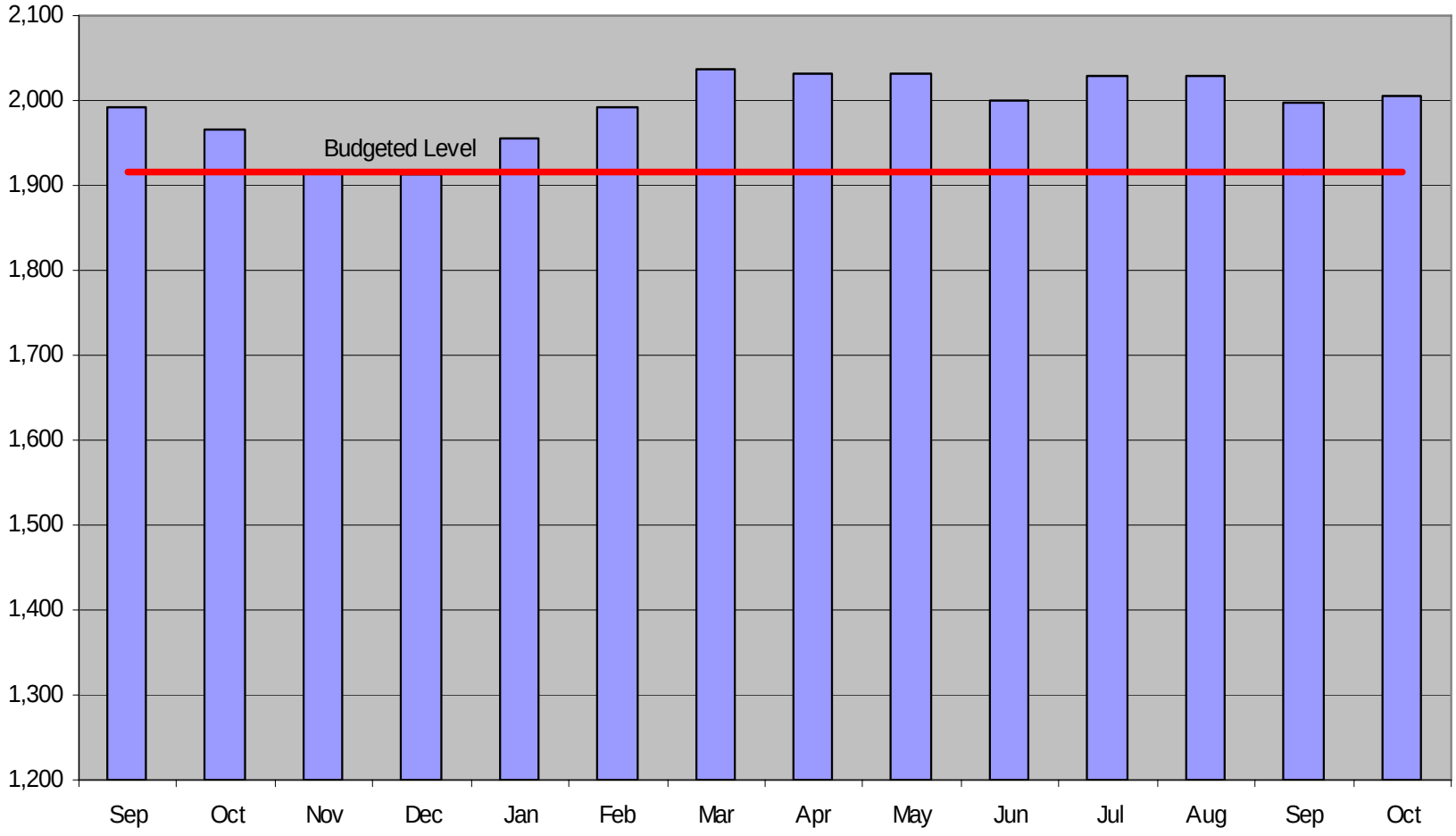
CMHC Service Population
FY 2006-2007 to Date



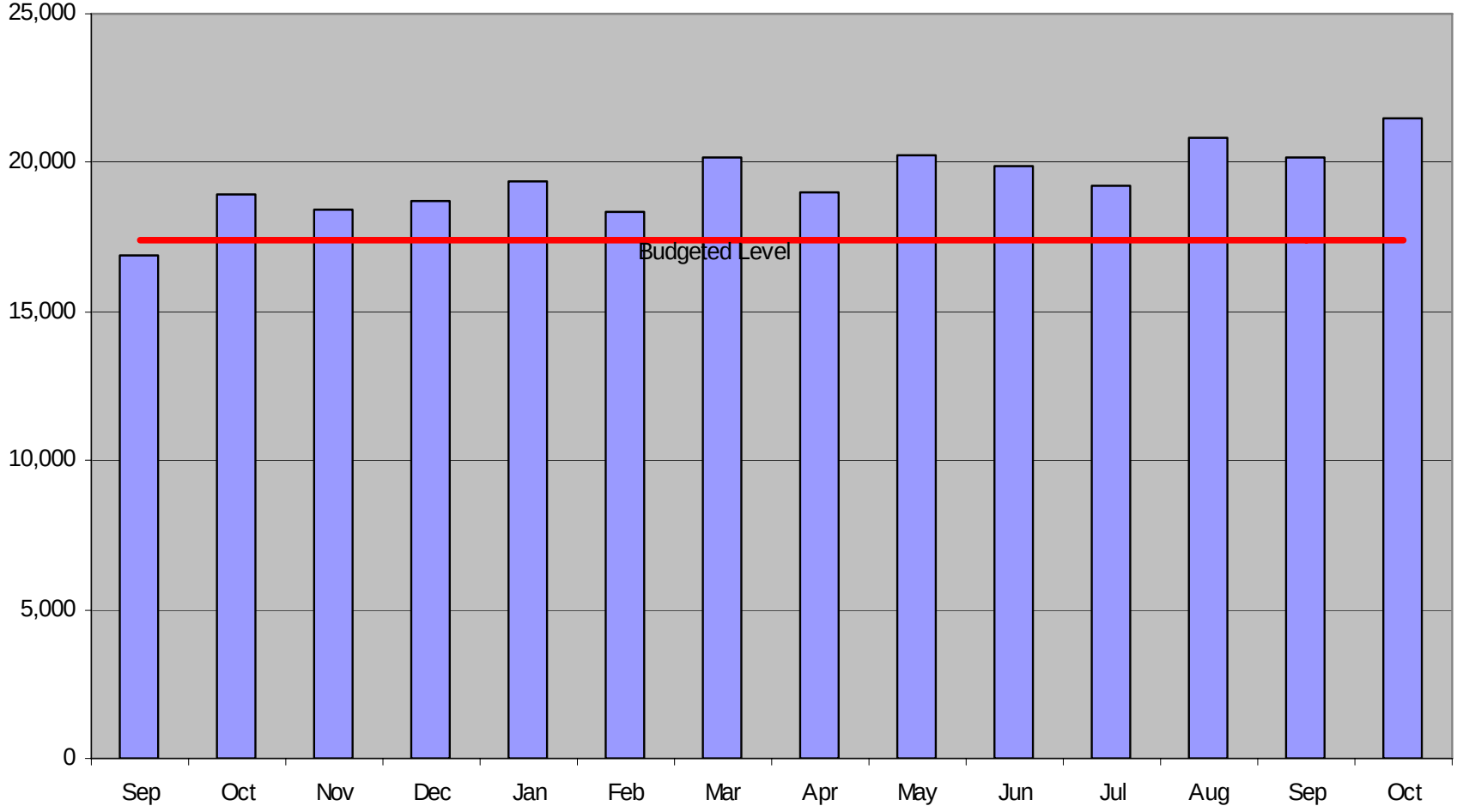
Offenders Age 55+



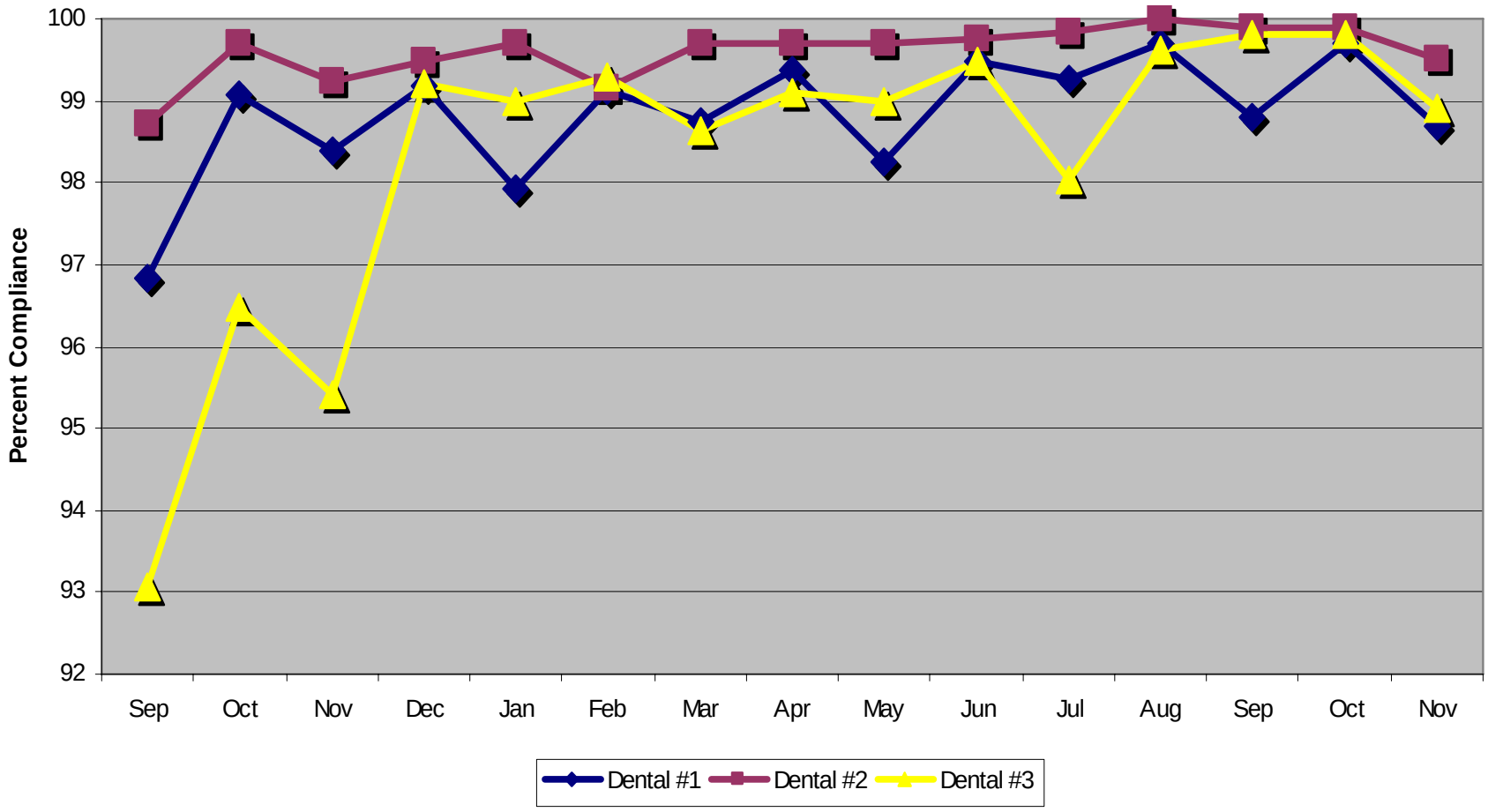
Psychiatric Inpatient Census



Psychiatric Outpatient Census



Dental Access to Care
Indicators FY 2006



Mental Health Access to Care
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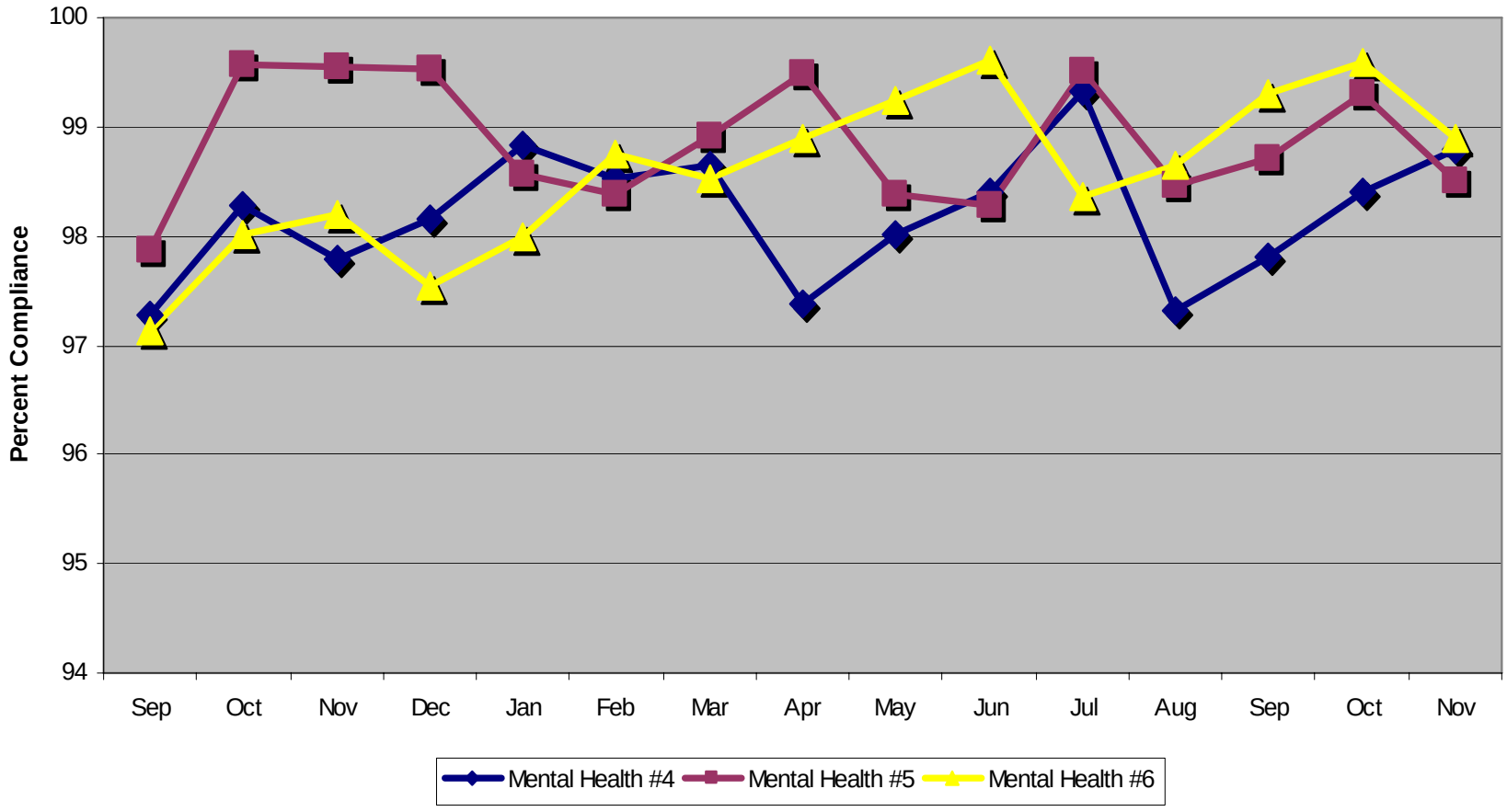
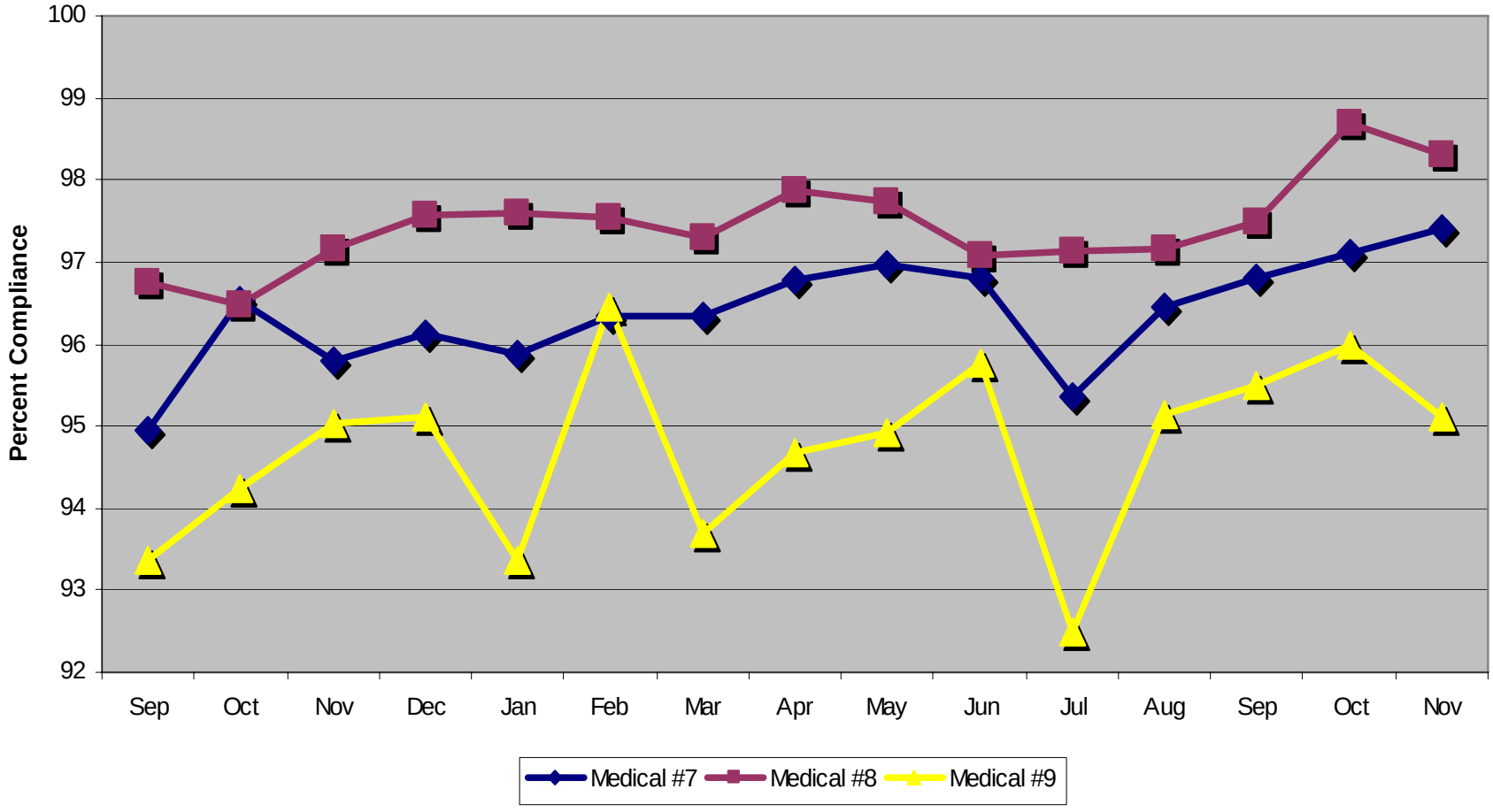
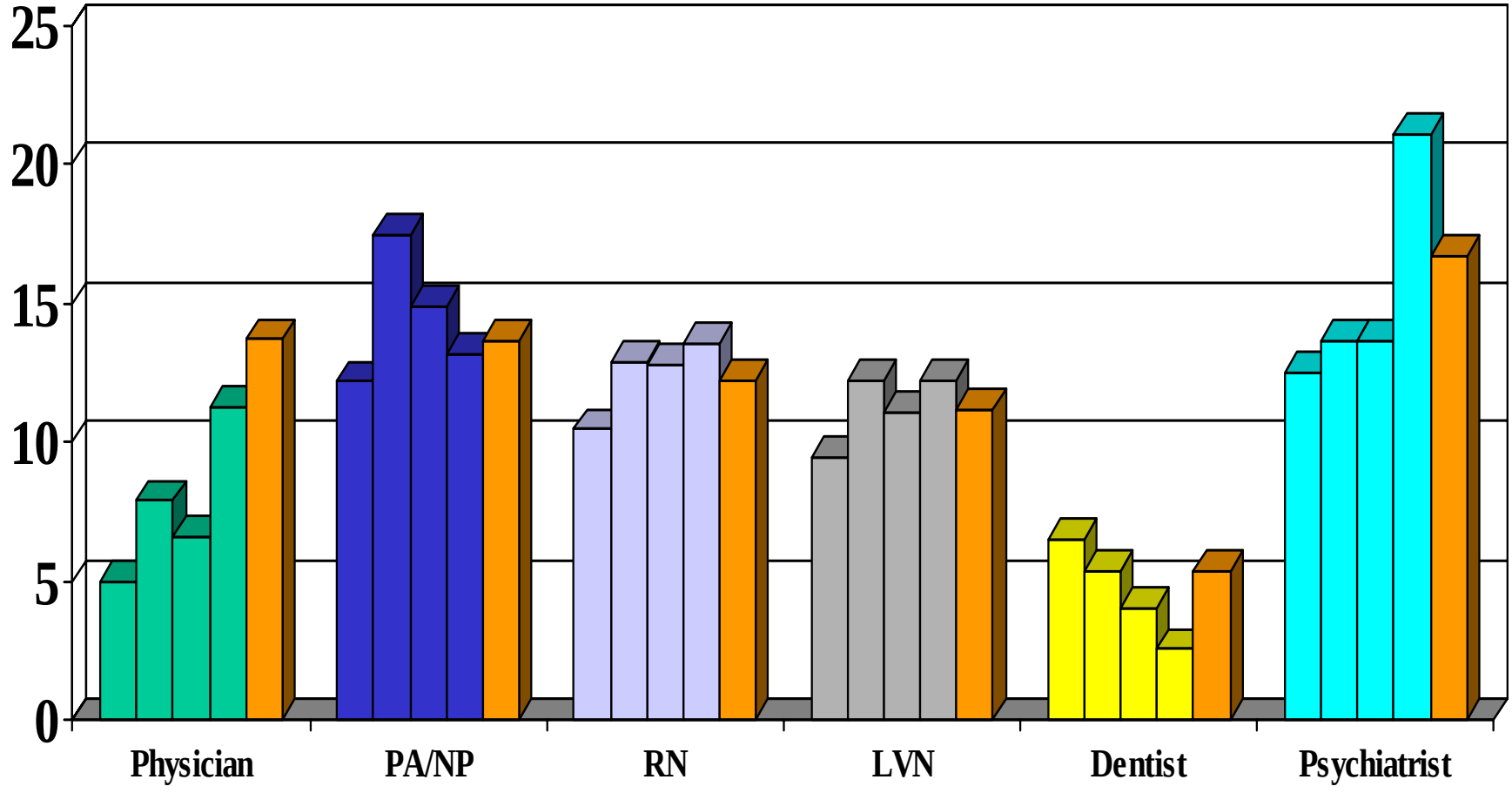


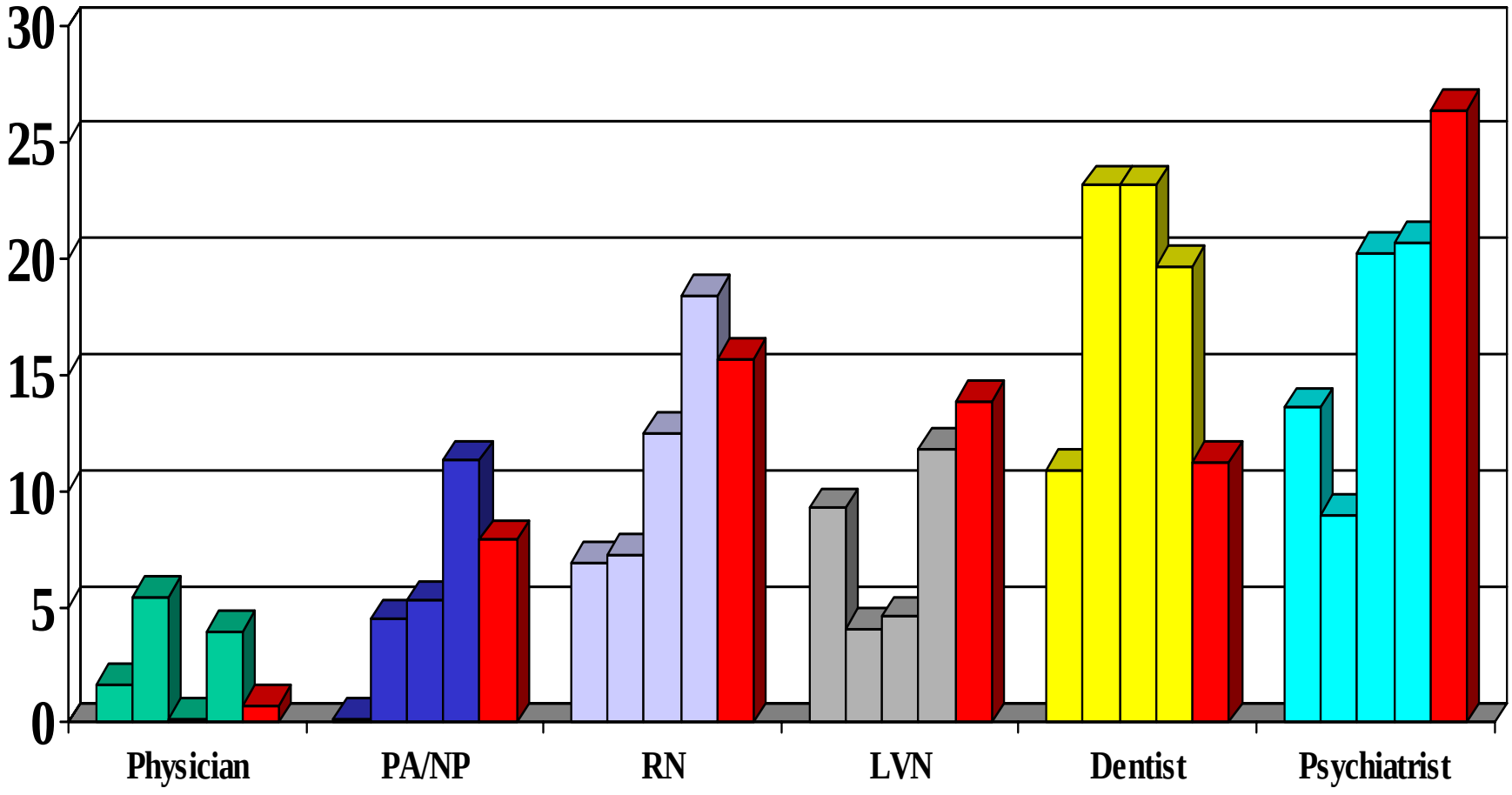
Medical Access to Care
Indicators FY 2006-2007 to Date



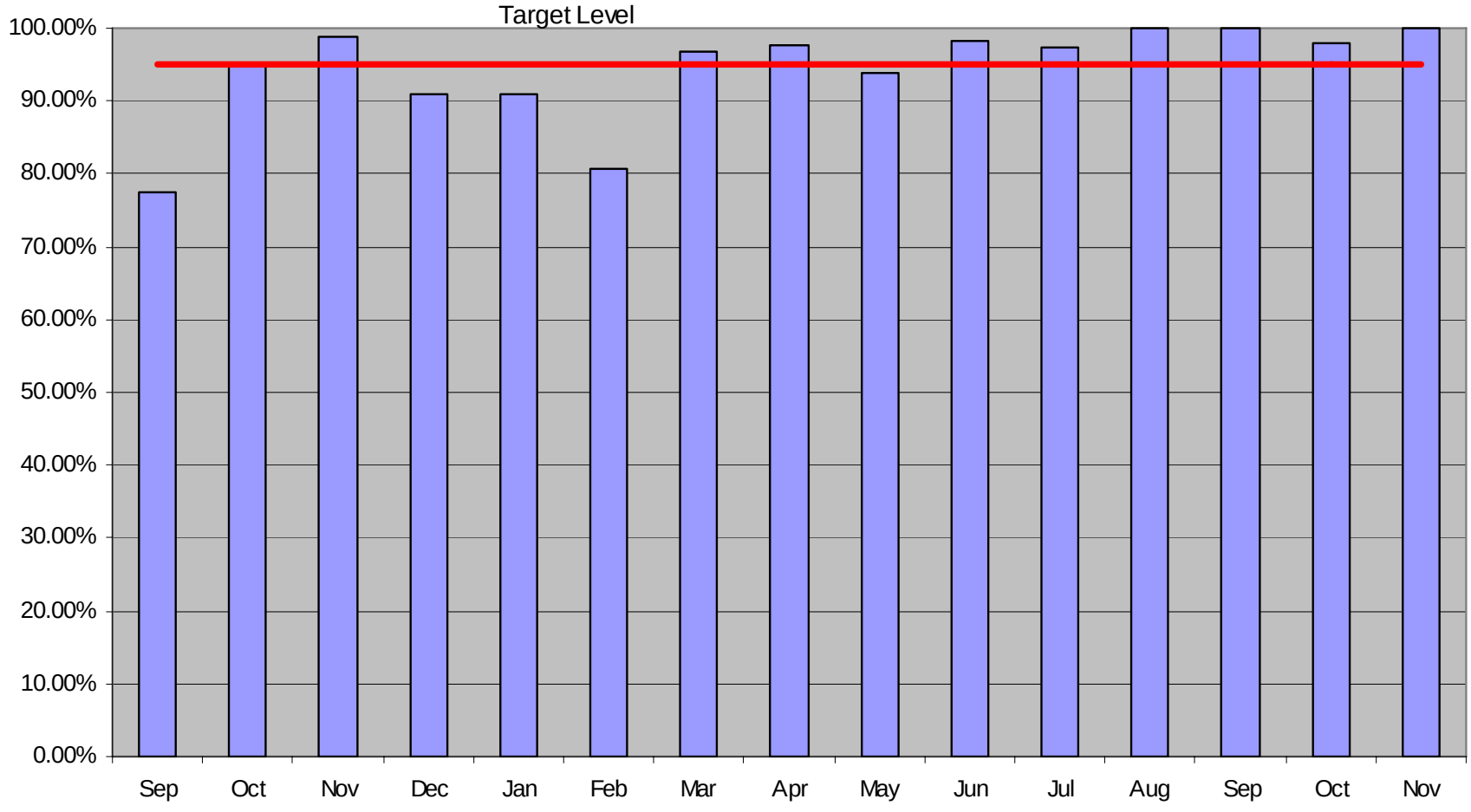
UTMB Vacancy Rates (%)
by Quarter FY 2006-FY 2007



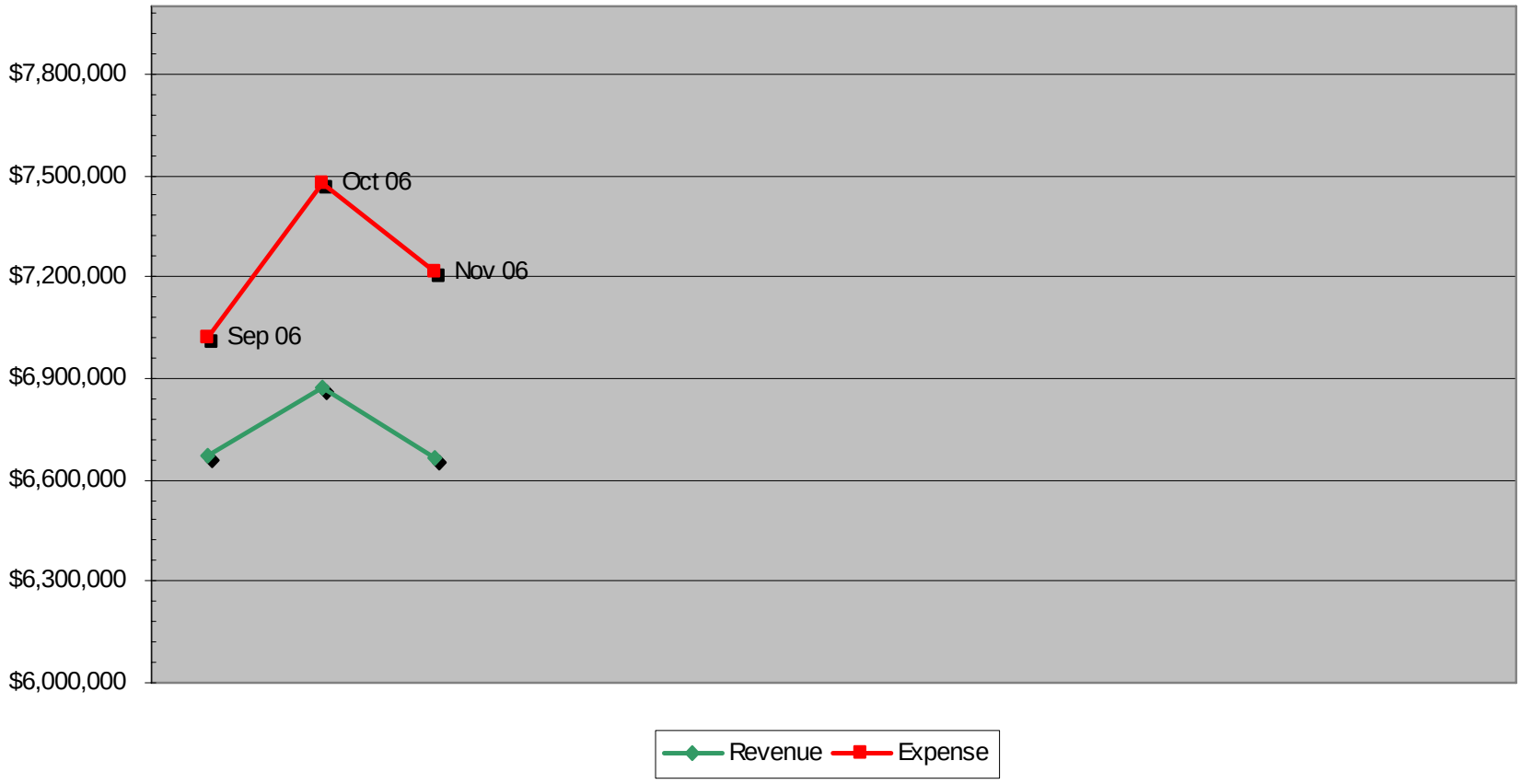
TTUHSC Vacancy Rates (%) by Quarter FY 2006-FY 2007



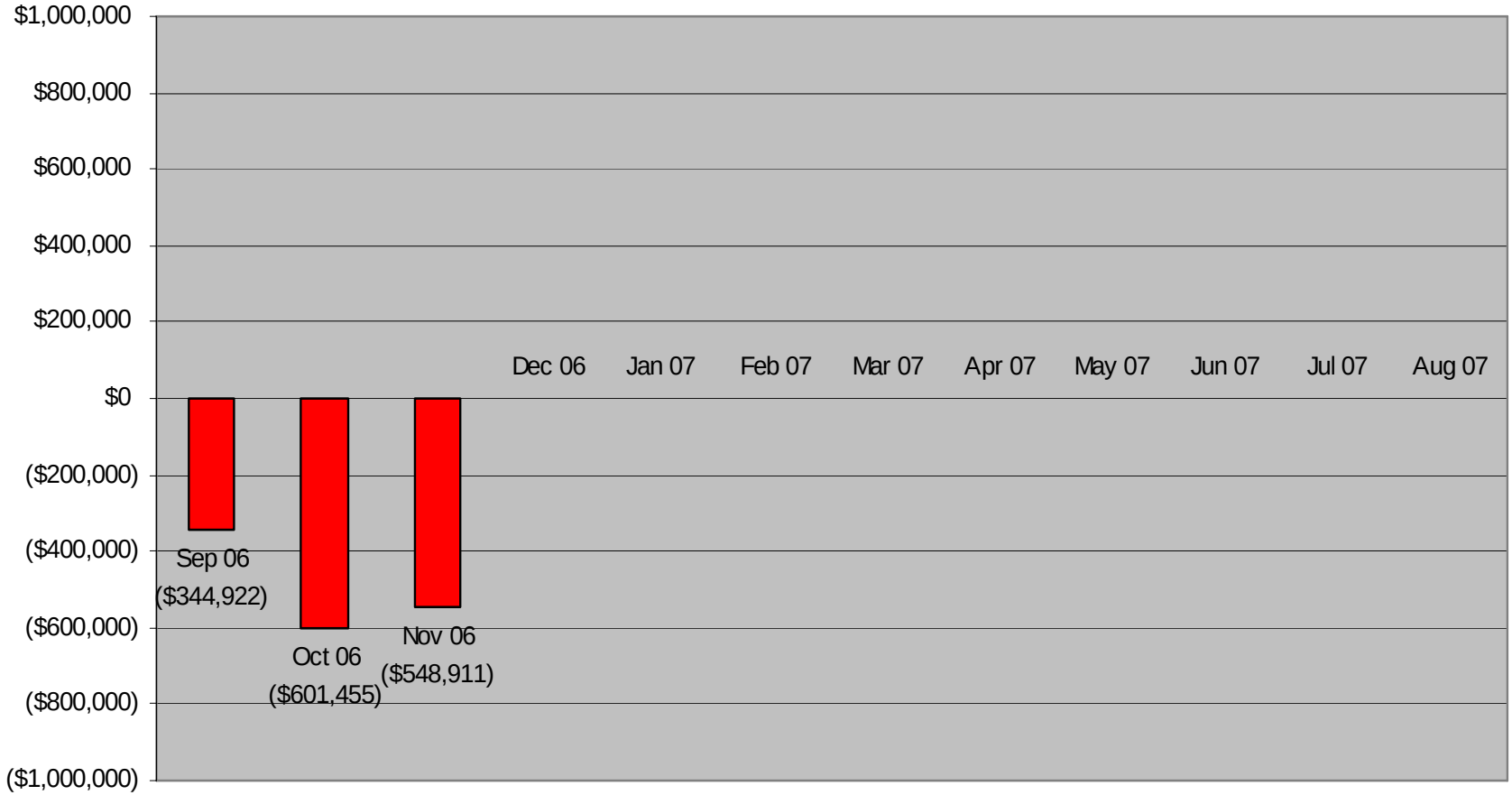
Percent of Timely MRIS Summaries



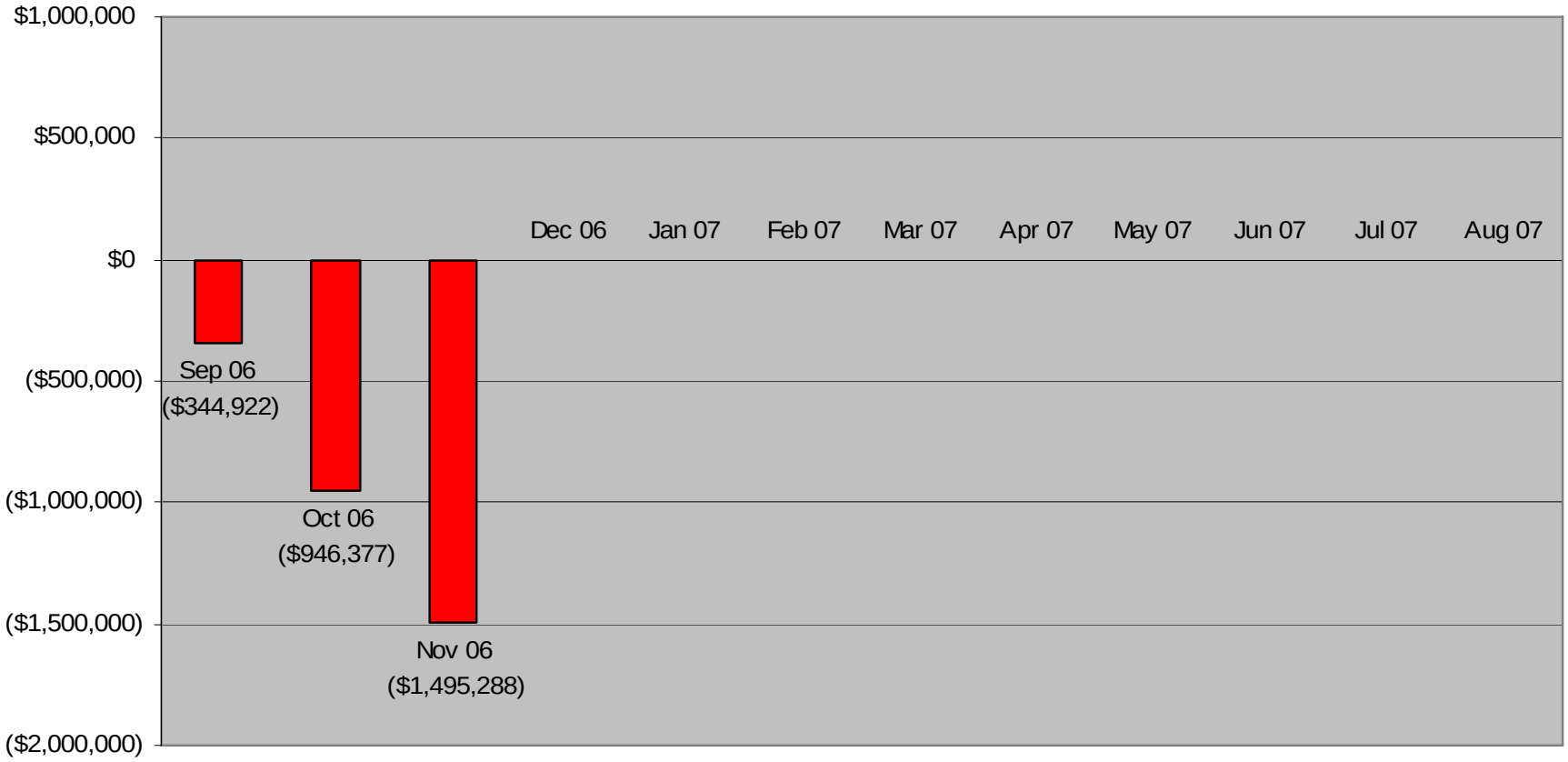
TTUHSC Revenue v. Expenses by Month
FY 2007



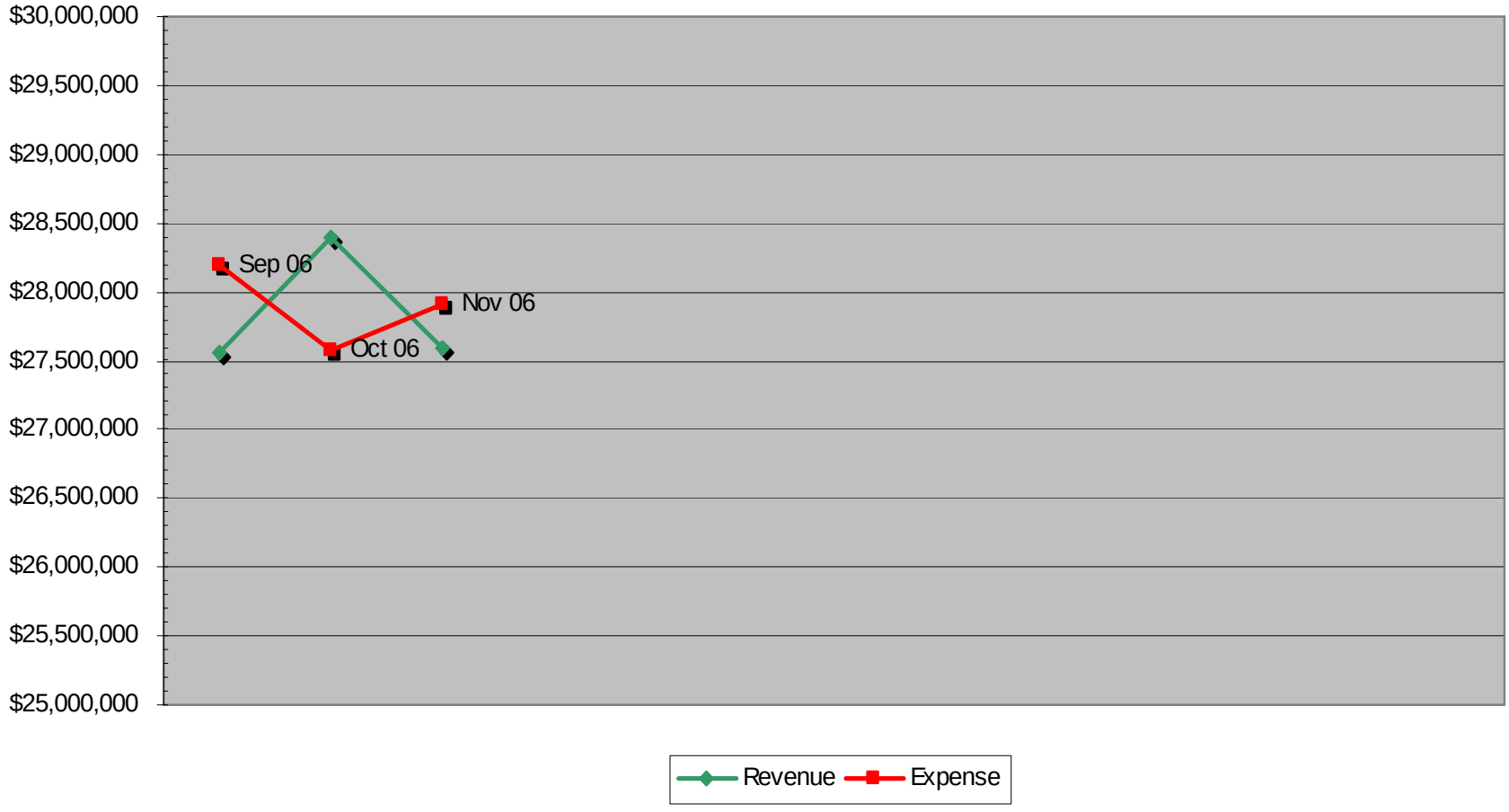
TTUHSC Loss/Gain by Month
FY 2007



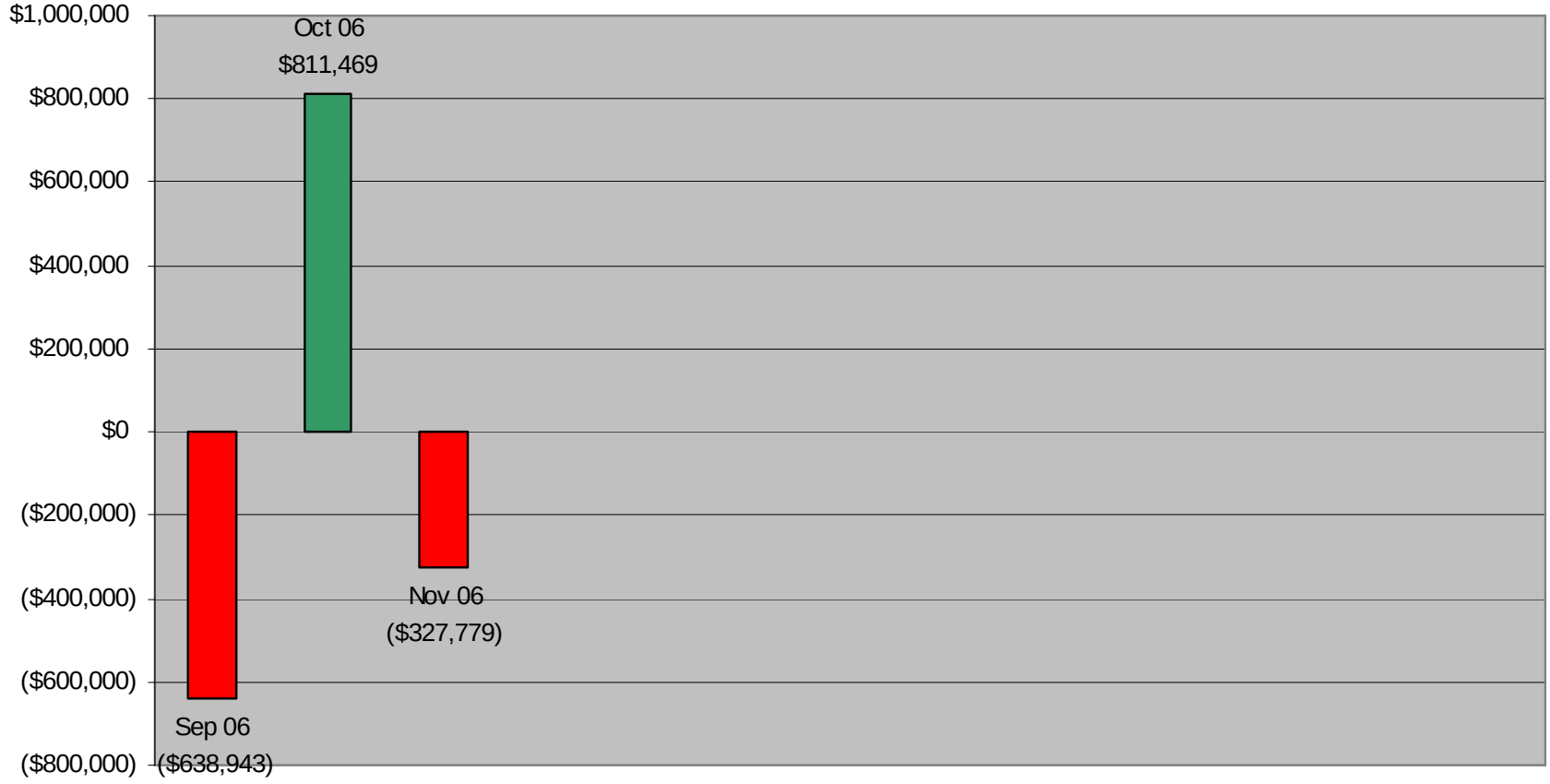
TTUHSC Cumulative Loss/Gain
FY 2007



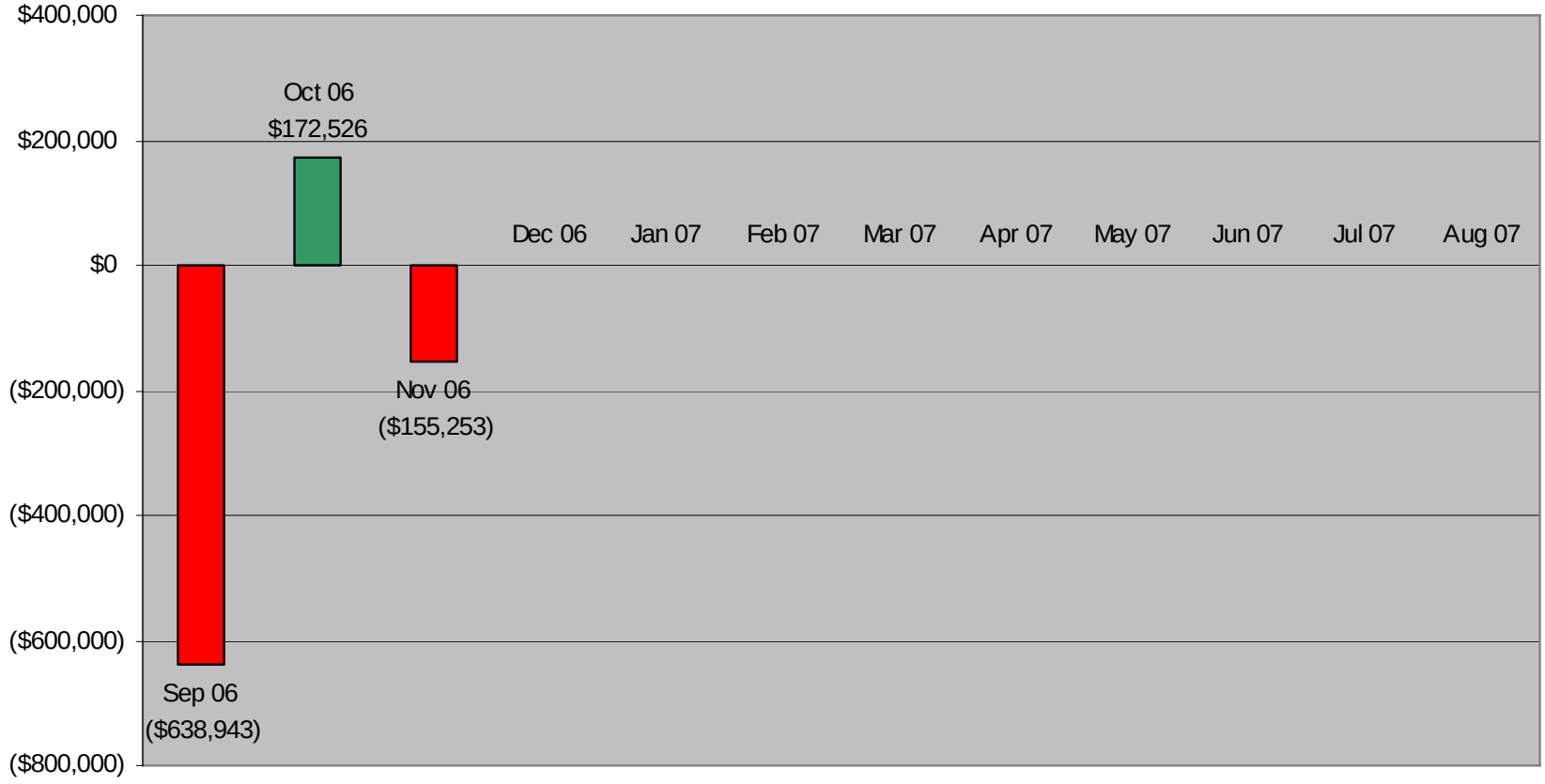
UTMB Revenue v. Expenses by Month
FY 2007



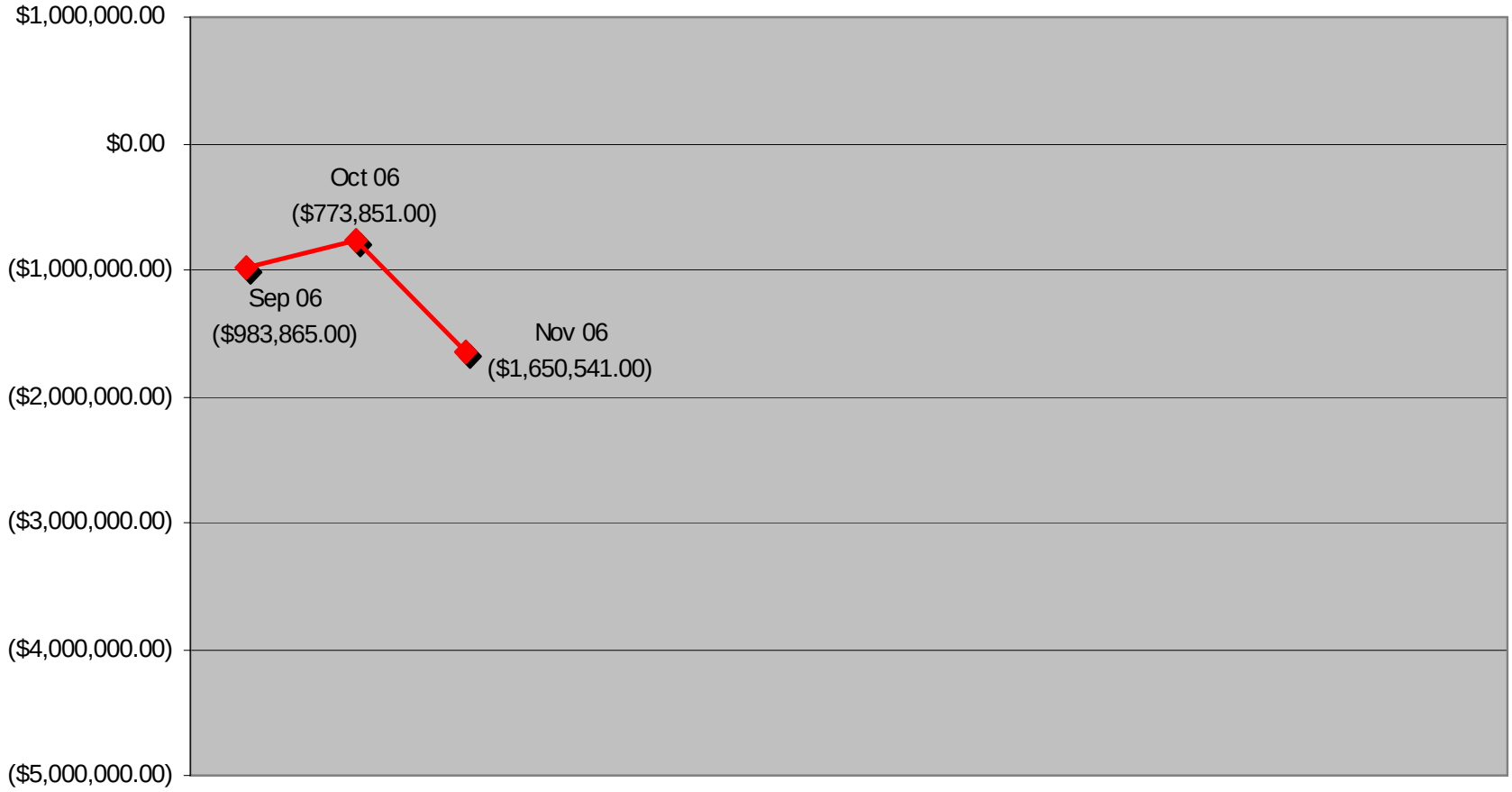
UTMB Loss/Gain by Month
FY 2007



UTMB Cumulative Loss/Gain
FY 2007



Statewide Cumulative Loss/Gain
FY 2007



Tab D

TEXAS DEPARTMENT OF CRIMINAL JUSTICE

HEALTH SERVICES DIVISION MEDICAL DIRECTOR'S REPORT

First Quarter FY-2007

Lannette Linthicum, M.D., CCHP-A, FACP

TDCJ Medical Director's Report

Office of Health Services Monitoring (OHSM)

Operational Review Audit (ORA)
Nine (9) ORAs were conducted at the following facilities: Byrd, Goree, Halbert, Kyle, North Texas ISF, Robertson, Sayle, Travis, and Wynne.

The ten (10) items most frequently found out of compliance were:

1. Item 4.02 requires that offenders identified as having potential mental health needs, have a Mental Health Evaluation completed by a Qualified Mental Health Professional within 14 days of identification/referral. Seven (7) of the nine (9) facilities were not in compliance with this requirement.

2. Item 4.04 requires each request and referral, for services to be documented by listing all problems written on the sick call request, in the medical record and in a log with the date received also documented. Seven (7) of the nine (9) facilities were not in compliance with this requirement.

3. Item 5.03 requires that facility Access to Care Worksheets from the previous three (3) months be verified for accuracy of seven (7) day referral to the provider from the sick call request submitted by offenders. Six (6) of the nine (9) facilities were not in compliance with this requirement.

4. Item 5.04 requires verification from the three (3) previous months of work sheets for offenders who submit a medical sick call request and referred to the provider be evaluated within seven (7) days of the receipt of the sick call received date. Six (6) of the nine (9) facilities were not in compliance with this requirement.

5. Item 5.06 requires offenders to be evaluated by a provider who are referred from triage and must be seen by a provider within seven (7) days of receipt of the sick call request to comply with American Correctional Association (ACA), National Commission on Correctional Health Care (NCCHC) Standards and Correctional Managed Health Care (CMHC) Policy and Procedure Manual. Six (6) of the nine (9) facilities were not in compliance with this requirement.

6. Item 5.09 requires the medical record of each offender receiving a therapeutic diet contain the type and duration not to exceed 365 days. Seven (7) of the nine (9) facilities were not in compliance with this requirement.

7. Item 5.10 requires the medical records of offenders who have been receiving therapeutic diets in excess of seven (7) days, reflects that nutritional counseling has been provided within 30 days of order, including the diet type and duration. Seven (7) of the nine (9) facilities were not in compliance with this requirement.

8. Item 5.11 requires Emergency Room Forms (HSM-16), are filled out completely and legibly to include assessment, intervention, medications administered, disposition and signature. Nine (9) of the nine (9) facilities were not in compliance with this requirement.

9. Item 5.12 requires offenders to have their medical record reviewed and a physical examination completed within 12-hours of placement in administrative segregation. Six (6) of the nine (9) facilities were not in compliance with this requirement.

Operational Review Audits (ORA) Cont.

10. Item 6.39 requires offenders who have been diagnosed with Methicillin-Resistant Staphylococcus Aureus (MRSA), Diabetes or Human Immunodeficiency Virus (HIV) Infection with an additional diagnosis of Methicillin-Sensitive Staphylococcus Aureus (MSSA), MRSA or Serious MSSA, has been placed on Directly Observed Therapy or if Directly Observed Therapy (DOT) was not utilized. If not, documentation reflecting compliance checks every forty-eight hours must be used. Six (6) of the nine (9) facilities were not in compliance with this requirement.

Office of Professional Standards (OPS)

A total of 3,062 correspondences were received and 181 Action Requests were generated during the first quarter of FY-2007. Patient Liaison Program received 1,503 correspondences and generated 105 Action Requests. Step II Grievance received 1,559 correspondences and generated 76 Action Requests.

Quality Improvement (QI) Access to Care Audits

74 Access to Care (ATC) audits were conducted during the first quarter of FY-2007. A total of 666 indicators were reviewed. 95 of the indicators fell below 80 percent compliance representing 14 percent of non-compliance.

Capital Assets Monitoring

Eight (8) facilities were audited in the first quarter of FY-2007: Byrd, Goree, Halbert, Kyle, North Texas ISF, Robertson, Sayle, Travis, and Wynne. Six (6) of the eight (8) facilities were within compliance. Travis County State Jail and the Goree Facility were not within the acceptable range. Corrective Action Plans (CAPs) were requested from the two (2) facilities. The Goree Facility has submitted their CAPs, which have been approved. CAPs are due January 15, 2007 for Travis County State Jail.

Office of Preventive Medicine

The Preventive Medicine Program Monitors the incidence of infectious disease within TDCJ. The following is a summary of this monitoring for the first quarter of FY-2007:

- There were 197 reports of suspected syphilis this quarter. 18,309 routing HIV screens conducted and 7,629 offenders identified for pre-release HIV tests for a total of 25,938 HIV tests performed. 114 new cases of HIV were identified and 12 new AIDS cases were identified. 75 offenders have been found to be HIV positive in pre-release testing during the first quarter FY-2007.

- 981 Methicillin Resistant Staphylococcus Aureus (MRSA) cases were identified compared to 865 during the same quarter of fiscal year 2005. The increase in MRSA probably represents an increase in obtaining cultures as a result of emphasis being placed by the System Leadership Council, as there was a similar percentage increase in Methicillin-Sensitive Staphylococcus Aureus (MSSA) cases reported.

- There was an average of 20 Tuberculosis (TB) cases under management per month during this quarter versus an average of 17 per month during the same quarter of the previous fiscal year.

- As of the first quarter FY-2007, the Office of Preventive Medicine has begun reporting on the activities of the Sexual Assault Nurse Examiner (SANE) Coordinator. This position audits the documentation and services provided by medical personnel for each sexual assault reported by the Office of the Attorney General. Currently, providers on 102 of the 106 facilities have been trained and 129 medical charts have been reviewed thus far in FY-2007. During this quarter 133 providers from 14 facilities were in serviced and trained.

Mortality and Morbidity

96 deaths were reviewed by the Mortality and Morbidity Committee in the first quarter of FY-2007. Ten (10) cases were referred to peer review committee. The chart below is a breakdown of those cases.

Peer Review Committee	Number of Cases Referred
Physician & Nursing Peer Review	3
Nursing Peer Review	3
Physician Peer Review	4
Total	**10**

Clinical Administration

Health Services Liaison Utilization Review Monitoring

During the first quarter of FY-2007 ten (10) percent of the combined UTMB and TTUHSC hospital (2,150) and infirmary (477) discharges were audited. The chart below is a summary of the audits showing the number of cases with deficiencies and the percentage.

Hospital Discharges FY-2007

Month	Unstable Discharges [1] (Cases with deficiencies)	Readmissions [2] (Cases with deficiencies)	Lacking Documentation (Cases with deficiencies)
September	0	0	2% (1)
October	1% (1)	1% (1)	5% (3)
November	8% (7)	0	0

Infirmary Discharges FY-2007

Month	Unstable Discharges [1] (Cases with deficiencies)	Readmissions [2] (Cases with deficiencies)	Lacking Documentation (Cases with deficiencies)
September	0	0	0
October	0	0	0
November	1% (1)	1% (1)	1% (1)

[1] Discharged patient offenders were unable to function in a general population setting.

[2] Discharged patient offenders required emergency acute care or readmission to tertiary level care within a 7 day period.

Accreditation

During the first quarter FY-2007, the American Correctional Association (ACA) accredited nine (9) facilities: Hughes, Middleton, Montford, Murray, Neal, Pack, Stringfellow, Stevenson, and Tulia. With these accreditations, the total ACA accredited facilities for TDCJ is 56 which include the TDCJ Correctional Training Academy.

Administrative Segregation Audits

Administrative Segregation Mental Health audits were conducted at 12 Facilities:
Beto, Clements (ECB), Coffield, Connally, Ferguson, Hughes, Lewis (ECB), McConnell, Mt. View, Murray, Polunsky, and Wynne.

- 11 facilities had a compliance of 100 percent for Access to Care to Mental Health.
- One (1) facility had a compliance of 92 percent.

Research, Evaluation and Development (RED) Group

The following is a summary of current and pending research projects as reported by the RED Group:

- Health Services Division Active Monthly Medical Research Projects - 12
- Medical Research Projects Pending Approval - 3
- Correctional Institution Division Active Monthly Medical Research Projects – 21.

Tab E

Texas Tech University Health Sciences Center

Managed Correctional Health Care

MEDICAL DIRECTOR'S REPORT

September – November 2006

First Quarter

- Allred Unit
- Highland Hospital
- Inpatient Costs

Tab F

The University of Texas Medical Branch

Managed Health Care

MEDICAL DIRECTOR'S REPORT

September – November 2006

First Quarter

- Magic Johnson
- HUB Program
- Multi Purpose Vehicle

Tab G

THE

BIENNIAL REPORT

OF THE

TEXAS CORRECTIONAL OFFICE ON OFFENDERS

WITH MEDICAL AND MENTAL IMPAIRMENTS

SUBMITTED TO

THE TEXAS BOARD OF CRIMINAL JUSTICE

FEBRUARY, 2007

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ADVISORY COMMITTEE MEMBERSHIP

GUBERNATORIAL APPOINTEES

Judy Briscoe, Chair *Term* 2/1/2006

- John Martin Bradley *Term 10/21/2008*
- Ellen Cokinos *Term 7/20/2008*
- Joseph Gutheinz *Term 7/20/2008*
- Kevin E. Haynes *Term 2/11/2011*
- Dr. Gabriel Holguin *Tern 2/01/2011*
- Christopher C. Kirk *Term 2/11/2011*
- Judge Jan Krocker *Term 7/20/2008*
- Ross Taylor, M.D. *Term 10/21/2010*

STATE AGENCIES/ORGANIZATIONS

- Texas Department of Criminal Justice
  - Correctional Institutional Division
  - Parole Division
  - Community Justice Assistance Division
- Texas Juvenile Probation Commission
- Texas Youth Commission
- Texas Education Agency
- Mental Health Association in Texas
- Texas Commission on Law Enforcement Officer Standards and Education
- Texas Council of Community Mental Health and Mental Retardation Centers, Inc.
- Texas Commission on Jail Standards
- Texas Council for Developmental Disabilities
- Health & Human Services Commission
- Department of Aging and Disability Services
- Department of Assistive and Rehabilitative Services
- Department of State Health Services
- National Alliance for the Mentally Ill – Texas
- ARC of Texas
- Correctional Managed Health Care Committee
- Board of Pardons and Parole

SECTION II.
EXECUTIVE SUMMARY

Since the establishment of the Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) in 1987, policy initiatives enacted by the Legislature have had a positive impact on the overall service delivery system for juvenile and adult offenders with special needs. In the last 19 years, Texas has, through legislative action, created a nationally recognized system that addresses all aspects of the criminal justice continuum. This has been accomplished by adopting statutory guidelines resulting in improved regulatory, procedural and programmatic practices in this state's response for this offender population.

Four (4) years ago, the Legislature again demonstrated its commitment by reauthorizing a $35 million funding package for the enhanced mental health/criminal justice initiative. This funding has allowed a renewed emphasis on the front end of the juvenile justice and adult criminal justice systems. In addition, legislation impacting pre-trial stages of the criminal justice system was enacted. These policy initiatives, coupled with the mental health/criminal justice initiative, should further strengthen the state's efforts to enhance the front end of the system.

During the past biennium, TCOOMMI initiated and/or completed the following activities relating to the new and existing legislative directives:

- **Cooperated with the Texas Commission on Jail Standards (TCJS), to study the current mental health screening and treatment practices of local jails**. A more detailed overview of this study is found in Section V of this report;

- **Developed a template for all competency evaluations to ensure compliance with art. 46.B, Code of Criminal Procedure**;

- **Implemented a new continuity of care process for offenders with special needs released from Texas Department of Criminal Justice (TDCJ) facilities**. A status report on this new initiative is found in Section IV of this report;

- **Continued the Rusk Diversion Project (a community-based competency restoration pilot) in cooperation with the Harris County Mental Health and Mental Retardation Authority (MHMRA) and the Harris County Sheriff's Department**. A summary of this program is provided in Section IV of this report;

- **Coordinated the implementation of a data cross-referencing process between local jails and MHMRAs**. This activity is the first of its kind in the country, used to identify current or former MHMR clients who are arrested and booked in county jails.

- **Expanded continuity of care activities to include local jails, to assist with pre- and post- planning for offenders with mental illnesses or other special needs.**

While not an exhaustive list, the above projects do represent further evidence of the Legislature's commitment to issues impacting offenders with special needs. This biennium saw continued progress toward establishing a comprehensive continuity of care system emphasizing its primary goals of public safety and treatment interventions. More importantly, TCOOMMI's efforts toward accomplishing these critical goals have eliminated or reduced duplication, improved coordination, collaboration and commitment to minimizing overall costs to local and state governments.

Although tremendous progress has been made; there is room for improvement and refinement. This report addresses areas of concern that require additional work to further Texas' goals in responding to offenders with special needs.

SECTION III.
OVERVIEW OF TCOOMMI and ADVISORY MEMBERS FUNCTIONS

TCOOMMI was created by the 70th Legislature to address the multi-faceted problems presented by juveniles and adults with mental illness, mental retardation and developmental disabilities. HB 93, 72nd Legislature, expanded TCOOMMI's role to include offenders with serious medical conditions, physical disabilities or who are elderly.

During the past biennium, the Advisory Committee was revised to reflect legislative or executive changes enacted by the 79th Legislature. Most notably, the number of members increased to 31, and the committee was directed to report to the Board of Criminal Justice.

Despite these membership changes, the Advisory Committee continued its work on addressing the following legislative mandates:

1. *To determine the status of offenders with special needs in the state criminal justice system;*

2. *To identify needed services for offenders with special needs;*

3. *To develop a plan for meeting the treatment, rehabilitation and educational needs of offenders with special needs, including a case management system and the development of community-based alternatives to incarceration;*

4. *To cooperate in coordinating procedures of represented agencies for the smooth and orderly provision of services for offenders with special needs;*

5. *To evaluate various in-state and out-of-state programs for offenders with special needs and recommend to the directors of current state programs methods of improving those programs;*

6. *To collect and disseminate information about available programs to judicial officers, law enforcement officers, probation and parole officers, social service and treatment providers;*

7. *To distribute money appropriated by the Legislature to political subdivisions, private organizations or other persons to be used for the development, operation, or evaluation of programs for offenders with special needs;*

8. *To apply for and receive money made available by the federal or state government or by any other public or private source to be used by the council to perform its duties;*

9. *To develop and implement pilot projects to demonstrate a cooperative program that identifies, evaluates, and manages, outside of incarceration, offenders with special needs;*

10. *To develop and implement a medically recommended intensive supervision or early release program for inmates who are elderly, physically handicapped, terminally ill or mentally retarded as established in HB 93, 72nd Legislature;*

11. *To monitor and coordinate the establishment of a continuity of care system for offenders with special needs;*

12. *To develop a process for reviewing all competency evaluations to determine compliance with statutory guidelines; and,*

13. *To develop and implement a continuity of care process for all 46.B defendants being returned to jail upon restoration of competency.*

Through collaboration, this diverse body of juvenile and adult criminal justice, health and human service and advocacy representatives, focus on creating a seamless system of care for juvenile and adult offenders with special needs.

The following sections of this report provide a detailed accounting of TCOOMMI's current and future activities toward fulfilling its responsibility to the Legislature and the citizens of this state.

SECTION IV.
TCOOMMI PROGRAMS

Prior to the 78th Legislative Session, TCOOMMI operated three (3) major programs:

(1) Community Based Programs, which includes the jail diversion and mental health/criminal justice initiative;
(2) Continuity of Care (COC); and
(3) Medically Recommended Intensive Supervision (MRIS).

SB 1 expanded TCOOMMI's programs to include Continuity of Care Services for 46.b defendants, and persons found "Not Guilty by Reason of Insanity" (NGRI). This section of the report will provide an overview of the TCOOMMI programs and an update on performance outcomes.

COMMUNITY-BASED SERVICES
ADULT PROGRAMS

The community-based services provided through TCOOMMI funding are a critical component to an offender's success on pre-trial, probation or parole. The most important factor is that the service is immediately accessible to the offender.

Prior to the mental health/criminal justice initiative in 2001, the majority of offenders served by TCOOMMI were parolees with mental impairments or other medical/psychological disabilities. Due to the pre-release planning of TCOOMMI's COC Program, all eligible parolees are referred to services four- to six- months prior to release, thus avoiding or minimizing the need for a waiting list. Typically the offender would have been released to a community with specialized parole officers and TCOOMMI-funded services. Those community providers not funded by TCOOMMI, would also receive a four- to six- month advance notice of the offender's pending release, thus avoiding a lengthy service delay upon release from prison or other correctional facility.

The probation system on the other hand was plagued with problems in accessing mental health services. The probationer could not gain access to the service due to waiting lists. In some circumstances it was months before an initial intake was conducted. For a probationer with serious mental illness, the lack of treatment contributes to the person's inability to comply with conditions of supervision, thus increasing the risk of recidivism and ultimate revocation.

The passage of the mental health/criminal justice initiative by the 77th Legislature provided the mechanism to address this service gap. The initiative helped create 84 specialized probation caseloads and targeted mental health treatment funding in selected sites across the state. The intent of the initiative was to provide accessible supervision and mental health treatment so that courts would have a sentencing alternative to incarceration.

In a 2005 study conducted on the Mental Health/Criminal Justice Initiative, TDCJ-Community Justice Assistance Division (CJAD) found that the model program had a

demonstrated impact on recidivism rates of those offenders served, when compared to other service categories. Those rates are found in the following chart:

Mental Health Initiative - Outcome Results: Offenders Receiving Model Services Have Significantly Lower Incarceration Rates Than Other Groups		
Group	Percent Arrested Two Year Follow-up	Percent Incarcerated Two Year Follow-up
Model	29.9%	13.1%
Initiative Caseload	32.4%	18.7%
Case Management	33.8%	19.4%
Non-Initiative Caseload	31.6%	20.1%
Sample Total	31.5%	16.8%

In large part, the initiative model was developed in accordance with programs operated by TCOOMMI for parolees with mental illnesses. For the past decade, the Parole Division, in conjunction with TCOOMMI, has implemented a team approach to working with offenders with special needs released from TDCJ facilities.

The Parole Division currently has 120 specialized caseloads that work with offenders with mental impairments or those who are terminally/seriously ill and physically disabled. TCOOMMI contracts with other governmental agencies for targeted treatment and case management services. The specialized parole officers coordinate with the case managers to develop supervision and treatment plans that best meet the needs of the offender. This close working relationship also allows for joint decisions relating to non-compliance or revocations.

In addition to this evaluation of the Mental Health/Criminal Justice Initiative, the following Legislative Budget Board (LBB) performance measure requires an evaluation of all adult offenders (probation and/or parole) served through TCOOMMI funded case management programs:

> *"The reincarceration rate of adult felony offenders with special needs on probation or parole supervision that have been in Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) programs for a minimum of twelve consecutive months, computed as the percentage of those that have been revoked and/or returned to TDCJ-Correctional Institutions Division (CID) within three years of entering the program. The rate is derived from the total population of releases for the fiscal year being reported."*

Based upon a recent evaluation of those offenders who met this narrowly defined performance measure criteria, **10.6%** was the recidivism rate documented for FY 2006.

In addition to the recidivism outcomes, other accomplishments of the programs include:

- **Improved coordination and collaboration between local probation and Mental Health/Mental Retardation (MHMR) agencies**. Joint staffings, co-location of offices, joint field or home visits with probation/parole and MHMR staff are but a few examples of the improved working relationship between the criminal justice and mental health systems.

- **Fewer revocations due to Probation/Parole officers and MHMRAs jointly working on supervision and treatment issues**. Prior to the initiative, non-compliance was decided solely at the supervisory entities' discretion with the courts. Now this collaboration ensures that mental health issues are not contributing to non-compliance.

- **Public safety issues rather than availability or a client's right to choose determines the intensity of MHMR services**. TCOOMMI requires all MHMR contract agencies to provide intensive service coordination and to monitor treatment compliance. Failure to comply with treatment requirements is reported immediately to criminal justice entities. As a result, illegal activities that may have occurred due to treatment non-compliance can be avoided or minimized.

- **Medicaid revenue generated by the adult program sites has increased by 44% since FY 2004.** During FY 2006 $2,787,000 in Medicaid revenue was collected compared to $1,945,000 in FY 2004. By increasing federal revenue, the programs were able to serve more clients without additional state dollars.

Though the initiative has proven successful, the following areas require further work:

- **Residential options as alternatives to incarceration need to be expanded**. Currently the majority of court or parole residential programs are geared toward offenders who have no mental health or other special needs. As a result, placement options available to the courts or parole are limited. Without structured residential alternatives, revocations to jail or prison - the most costly response for both local and state governments - may be the only viable option for decision makers.

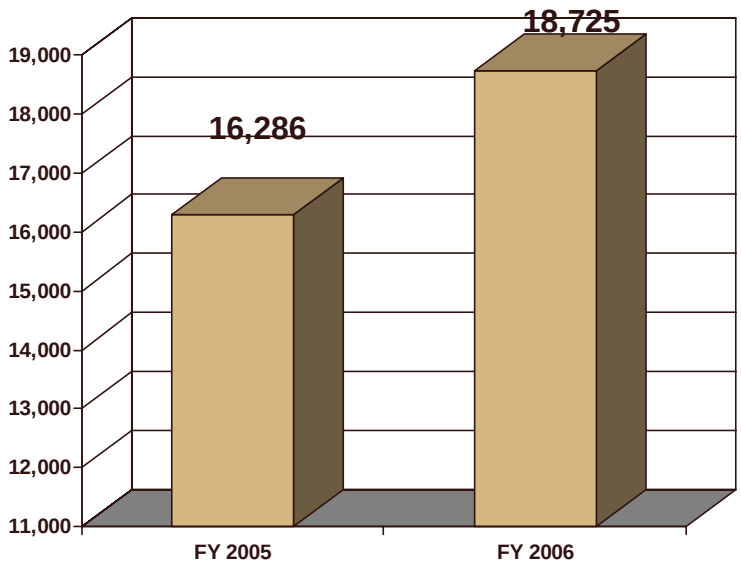
- **Increased access to substance abuse treatment for offenders with special needs is critical to a successful completion of probation or parole**. The availability of substance abuse treatment programs is an important factor in reducing recidivism. For the offender population with mental impairments, access to such treatment programs is in short supply.

COMMUNITY-BASED SERVICES
CONTINUITY OF CARE PROGRAMS

TCOOMMI funds a Continuity of Care program to provide a responsive system for local referrals from jails, family and other sources. Components of this program include but are not limited to:

- Screening and Linkage to Appropriate Services
- Federal Entitlement Application Processing
- Jail Screening
- Medication and Psychiatric Services
- Court Intervention

The following chart depicts the number of offenders served through the COC Program in FY 05 and 06.



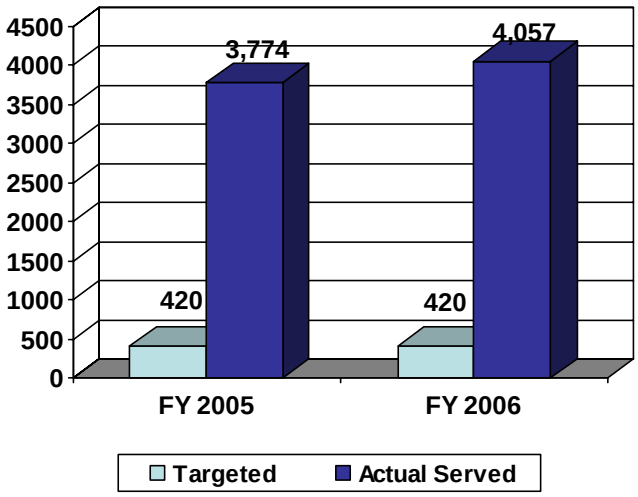
Historically, TCOOMMI has had limited funding for continuity of care services for offenders being released from jail to the community. During FY 07, several contract sites received additional funding to initiate pre- and post-release treatment activities for offenders with special needs being released on some form of supervision from local jails. It is anticipated that offenders being linked to services prior to release will show much lower re-arrest and re-incarceration rates compared to offenders who did not receive similar services. An evaluation of this new initiative will be provided in TCOOMMI's report to the Legislature in 2009.

JAIL DIVERSION PROGRAMS

During the past biennium, TCOOMMI contracted with six (6) sites for targeted jail diversion services. These services included: specialized mental health deputies, designated mental health staff assigned to screen offenders for mental health issues, resource information services for attorneys or court personnel, advocacy for the offender with attorneys, court personnel and/or bond release programs, and referrals for further medical evaluation or commitment.

In addition, TCOOMMI provided one-time funding for the sites to be used for specialized training programs for law enforcement and local probation or parole officers; computers for required database reports; and teleconference equipment used for electronic assessment and other telemedicine services.

The following chart reflects the number of offenders served through the Jail Diversion Program in FY 05 and 06:



The Jail Diversion contract sites have identified a number of positive outcomes derived from their programs including:

1. Specialized deputies are trained to identify and respond to situations involving persons with mental illnesses. As a result, persons who historically may have been arrested for their behavior are now diverted to more appropriate treatment options.

2. Mental Health Courts have provided high risk offenders opportunities for successful completion of probation. Judges who understand that relapse may require more intensive treatment and supervision rather than revocation is a fundamental concept of mental health courts. Public safety concerns are still addressed, but through increased treatment as opposed to incarceration.

3. Mental health liaisons to the courts and jails increase opportunities for pre-trial diversion when appropriate. Knowing the mental health needs of defendants allows

the courts and jails to make more informed decisions regarding release and/or treatment.

Overall, the jail diversion component of TCOOMMI's community-based program has far exceeded initial expectations. During the next biennium, formal evaluation these programs to determine impact on recidivism and associated costs will be initiated.

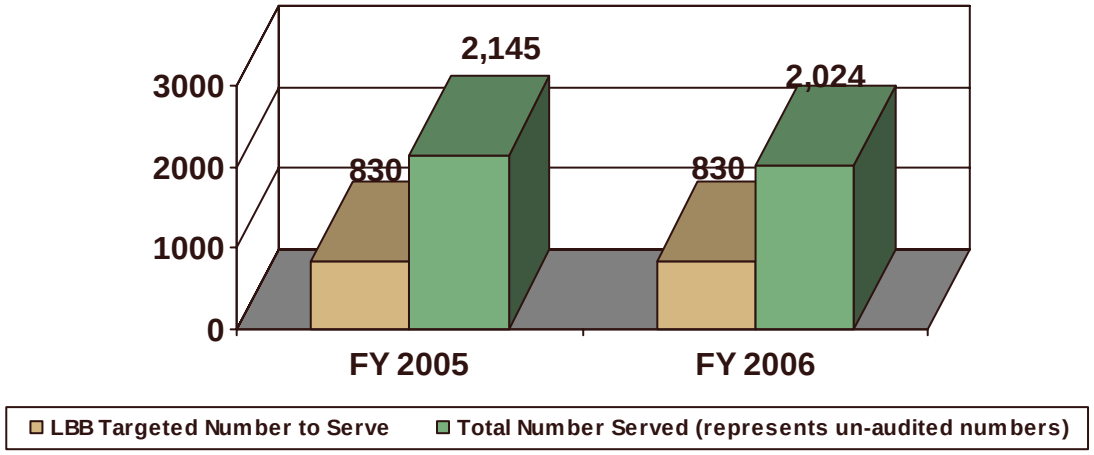
JUVENILE JUSTICE PROGRAMS
JUVENILE PROBATION

To provide a more responsive front-end service delivery system, the Legislature appropriated $9.5 million to provide supervision and treatment services to youth on local probation and on parole from the Texas Youth Commission (TYC). Juvenile service programs are designed as a family-based, multi-service approach to meet the mental health needs of youth in the Texas juvenile justice system, ages 10-18, who have been assessed with severe emotional disturbances.

Twenty-two (22) statewide service programs provide a wrap-around, case management philosophy and managed care practices, with a strong emphasis on flexible programming. TCOOMMI contracts with local MHMRs for the following services that support this treatment model:

- Assessments for service referral;
- Service coordination and planning;
- Medication and monitoring;
- Individual and/or group therapy and skills training;
- In-home services such as Multi-Systemic Therapy or Functional Family Therapy;
- Family focused support services;
- Benefit eligibility services; and
- Transitional services.

During the past biennium, juvenile offender programs jointly operated and funded by TCOOMMI and Texas Juvenile Probation Commission (TJPC) exceeded expectations in the overall number of juveniles served. As depicted on the following chart, in FY 06, LBB Performance targets were exceeded by 244%.



According to a recent study conducted by TJPC, the service model of increased home contact appears to have the most positive impact on juvenile offender outcomes. The following chart provides a comparison of outcomes based on number of home contacts between the treatment team and juvenile/family:

Percent Successful by Contact FY 05

Average number of home contacts per week	Percent of successful outcomes
0 to .99	33%
1 to 1.99	73%
2 or More	74%

In addition, other accomplishments include the following:

1. **The number of juveniles served exceeded LBB performance targets by 244%.** A contributing factor to this outcome is the Medicaid revenue generated by providers. By increasing federal funding, service capacity can be expanded beyond that allowed with current general revenue.

2. **Increased on-site monitoring has resulted in quicker responses to service delivery problems.** Eliminating or minimizing barriers to service has yielded increased efficiencies and effectiveness of the juvenile programs.

3. **Improved communication between the mental health and juvenile justice systems has minimized redundancies and fostered better collaboration.** By targeting funding specifically for specialized supervision and treatment services, the juvenile probation officer and MHMR staff work as a team to decide the most appropriate course of action for the juvenile and his/her family. In addition, each team member has fully defined roles and responsibilities thus minimizing duplication of effort.

4. **Implementing the Resiliency and Disease Management (RDM) model has improved decision making on treatment strategies.** The RDM model offers a uniform and standardized approach to service delivery that is developed on evidence based practices.

5. **Identification and screening practices for program eligibility have improved.** By enhancing the screening activities, resources can be focused more narrowly on those juveniles with the most serious mental health issues.

6. **An additional multi-systemic therapy (MST) program was added in Bexar County.** The MST program is a nationally recognized intervention strategy for dealing with seriously disturbed children and their families. Due to the severity of illness among the juvenile offender population, the additional MST program is a much-needed response to those juveniles in crises.

Despite these accomplishments, program sites report the following areas in need of continued improvement:

- Increased residential and substance abuse treatment options are needed as alternatives to TYC. Without such resources, juveniles may be placed in institutional environs that are not designed to provide the type of specialized treatment required for these youth.

- Recruitment of available licensed staff for requisite services. Rural areas typically have more problems in recruiting licensed professional staff than urban areas. In addition, TCOOMMI's emphasis to provide more treatment in the youths' homes, rather than the office, has been cited as a factor.

TEXAS YOUTH COMMISSION

According to TYC approximately 49% of committed youth have a diagnosed mental health problem. In order to provide an appropriate aftercare treatment plan for those juveniles being released on parole, TCOOMMI contracts with local MHMR centers for an array of post-release services. Those services, which are provided primarily through a fee-for-service contractual arrangement, include:

- Individualized assessments;
- Service coordination;
- Medication monitoring;
- Advocacy services;
- Transitional services to other treatment programs for youth being discharged from parole; and,
- Benefit eligibility services.

During the past biennium, 146 youth were served by TCOOMMI's programs. Depending upon the age and the clinical assessment of need, the juveniles may have been served either in an adult or juvenile program once released on parole. Based upon TYC and TCOOMMI's collaboration, the following accomplishments were made during the biennium:

1. Referrals for post-release mental health services increased by 32%. This increase is in large part due to TYC's efforts to educate facility staff on identifying youth whose mental health status may require post-release services.

2. Joint trainings between TCOOMMI and TYC staff have enhanced each agency's understanding of roles and responsibilities for pre- and post-release services.

3. Improved coordination and communication with local MHMR providers has greatly improved access to mental health services for those eligible for MHMR services.

INSTITUTIONAL SERVICES
CONTINUITY OF CARE

During the past biennium, TCOOMMI conducted a comprehensive evaluation of the COC program for offenders with special needs being released from TDCJ facilities. Based upon this review, the following issues require improvement or modification:

1. Offenders released on either a flat or state jail discharge rarely showed up for post-release appointments for treatment. According to post-release statistical information, 9% of state jail and 12% of flat discharges showed up for appointments with medical or mental health providers after their release. Since these offenders accounted for over 37% of the total number of referrals, a significant level of resources were wasted on pre- and post-release coordination. Unlike offenders released on parole, mandatory supervision or probation, state jail and flat discharge populations are no longer under the purview of a supervising entity. As a result, no enforcement authority exists to require their participation in post-release treatment.

2. Offenders released on some form of supervision may have a condition of "P" (psychological) placed on their plan by the Parole Board. Those offenders would be referred to TCOOMMI for continuity of care services with the local MHMR for post-release services. According to an analysis of offenders with a "P" condition, 65% did not have a diagnosis that qualified for MHMR services. Again, significant resources were expended in the pre- and post-release referral and intake process for these offenders who didn't qualify for MHMR services.

3. Finally, the overall COC process was extremely time-consuming. Copying medical or other records, completing the applications for pre- social security applications, faxing materials to the workers who would eventually be responsible for post-release coordination, and, of course, travel to and from prison units in their jurisdiction all represented significant time and resource expenditures.

To improve the efficiency and the effectiveness of the COC process, TCOOMMI, in cooperation with correctional care providers, contract providers, parole, Board of Pardons and Parole and Health Services, conducted numerous strategy sessions. As a result of these strategy sessions, the following revised COC procedures were implemented September 1, 2006.

1. **COC workers now have access to the electronic medical records (EMR) system used by the institutional health care provider.** Offender records can now be obtained from their offices as opposed to going to the units. This has proven to be an extremely effective strategy for improving the COC programs' efficiency.

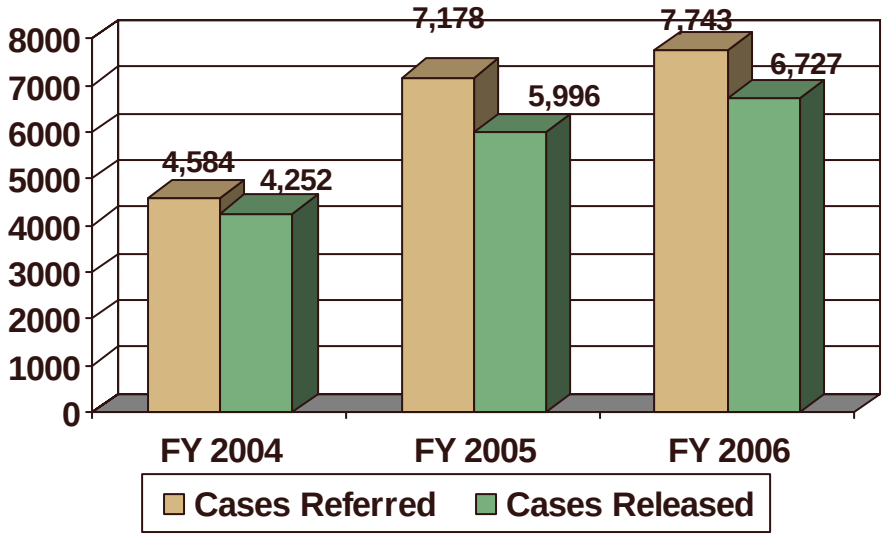
2. **Referrals for COC services are assigned to the workers in the community where the offender is scheduled to be released.** This has eliminated a significant amount of repetitive effort associated with the prior referral process.

3. **Notice is now sent to the offender to solicit his/her interest in post-release treatment.** Due to the high number of no-shows for flat or state jail discharges, automatic referrals for post-release care have been eliminated. If the offender returns the letter marked with an affirmative answer, COC activities will be initiated. By determining the offenders' desire for aftercare treatment prior to release, COC activities are targeted only for those offenders with an expressed interest in services. This reduces the amount of COC resources previously expended on "No-Shows".

4. **With the exception of offenders with terminal or serious medical conditions, social security applications are being initiated after the person's release to the community.** The low approval rate and length of time to receive eligibility determination (12-18 months) for offenders with mental illnesses did not justify the expense associated with workers traveling to the units to complete the pre-release application.

Due to the short period of time the new COC process has been in place, an assessment of its efficiency and effectiveness cannot be determined at this time. During the next year, TCOOMMI will closely monitor the activities to ensure the integrity and intent of the COC program have not been compromised as a result of the new procedures. One area that will be impacted is the number of referrals and releases.

For FY 06, the COC referrals and releases closely mirrored those numbers in previous years. The following chart reflects a comparison of program numbers for the past three (3) years.



With the new COC system, it is anticipated that the numbers for FY 07 and future years will be significantly lower when compared to previous COC numbers. While the numbers may decrease, the new process should result in better recidivism outcomes by targeting efforts and resources to offenders most in need. The quality of the services should also improve since fewer referrals will place less time demands on the workers.

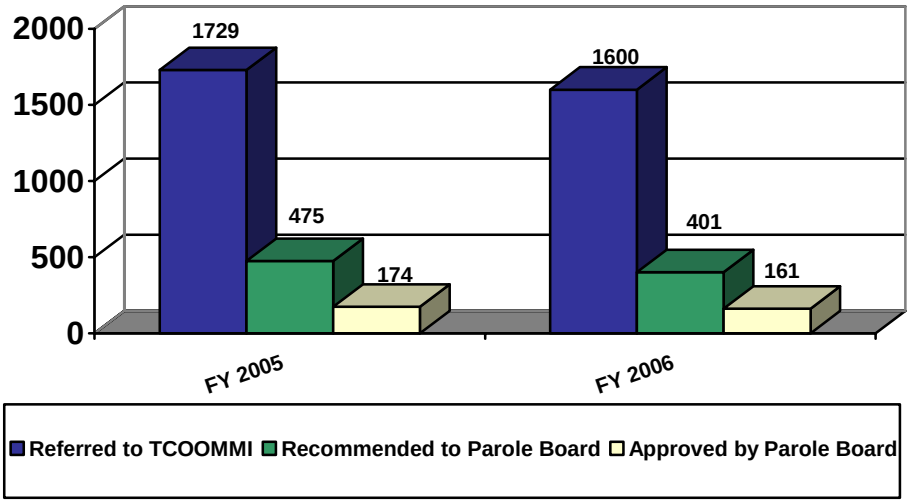
MEDICALLY RECOMMENDED INTENSIVE SUPERVISION

The MRIS program allows for the early release from prison for certain categories of offenders. The following provides a brief explanation of statutory provisions for MRIS:

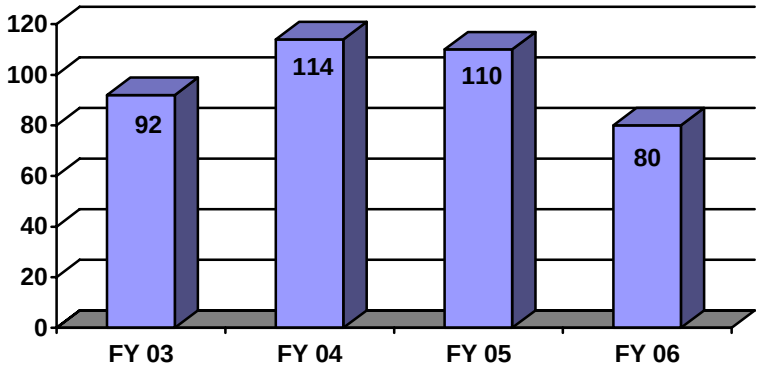
- Excludes sex offenders and offenders sentenced to death;
- Includes 3G offenders (aggravated convictions) who have a terminal illness and/or require long-term care;
- Establishes a parole panel to be composed of the presiding officer and two (2) members to make release determinations on eligible offenders and those pending deportation;
- Establishes that eligible offenders determined to be non-U.S. citizens, deportable and not a threat to public safety, may be released to immigration authorities; and,
- Directs TCOOMMI to present relevant information to the parole panel concerning the potential release of eligible offenders.

Although the statutory provisions are broad in respect to the medical or psychiatric conditions allowed for consideration, TCOOMMI has historically focused its resources toward those with the most serious medical problems. The following charts provide a comparison between FY 05 and FY 06 approval and denial rates, inmate deaths and inmate refusals.

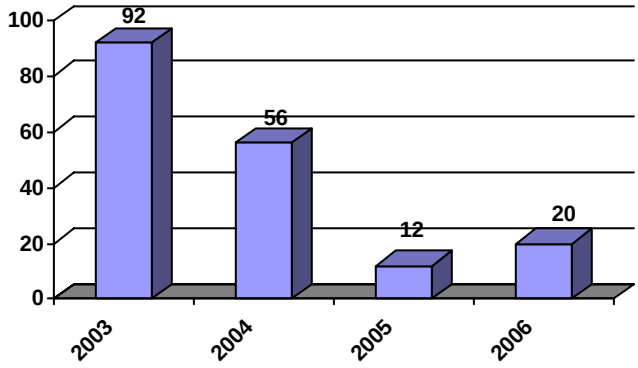
MRIS – APPROVALS AND DENIALS



INMATE DEATHS DURING THE MRIS PROCESS



INMATE REFUSALS FOR MRIS



As noted on the first chart, the percentage of approvals for FY06 compared to FY05 was 40% to 36%. One factor in this increased approval rate may be the revised referral process initiated during the last year.

To ensure that timely referrals were made for those offenders with terminal illnesses or long term care needs, unit physicians became responsible for initiating the referrals rather than TCOOMMI. Previously TCOOMMI would request medical summaries for any referral received from internal and external sources. This process typically resulted in unit medical staff completing medical paperwork on offenders whose condition was not clinically appropriate for early release. This, in turn, resulted in considerable work by TCOOMMI and medical staff on processing referrals that had minimal, if any, likelihood of being approved for MRIS. The new MRIS referral process allows for targeting staff resources toward offenders with a diagnosis that is determined clinically appropriate by health care staff.

An evaluation of the new MRIS process will be conducted at the end of the calendar year. The analysis will include a review of approval rates, processing time, and number of deaths among offenders who were not referred to MRIS, but were statutorily eligible. The findings of the study will be presented in TCOOMMI's next biennial report to the 81st Legislature.

SECTION V.
CONTINUITY OF CARE INITIATIVES

During the past biennium, significant progress was made toward creating a more comprehensive continuity of care system. Much of that progress was made as a result of the new legislative mandates that focused TCOOMMI's efforts on the front end of the criminal justice system. Enhanced continuity of care activities include the following:

1. Requiring local jails and MHMRAs to cross-reference inmate census against the state mental health database.

2. Coordinating with the Texas Commission on Jail Standards (TCJS) to develop a more reliable screening process at intake and booking.

3. Expanding continuity of care activities for 46.B defendants.

4. Implementing and revising the Memoranda of Understanding (MOU) between TDCJ and the Health and Human Service system

A more detailed overview of these activities is provided in the following section.

LOCAL JAIL/MHMRAS DATA CROSS-REFERENCING INITIATIVE

During the 79th Legislative Session, the TCJS submitted a report to the Legislature describing problems associated with mentally ill offenders in local jails. This report, prepared in cooperation with TCOOMMI, highlighted a significant problem in the appropriate and timely identification of individuals with mental illnesses within the jail setting. In response, the Legislature included two (2) separate Riders on TCJS and Department of State Health Services (DSHS) appropriations that were designed to improve the identification process in county jails. The riders read as follows:

SB I, Art. V, Commission on Jail Standards, Rider #2:

It is the intent of the legislature that the Commission on Jail Standards amend its rules and procedures to require county and local jails to:

a) check each offender upon intake into jail against the Department of State Health Services' CARE system to determine if the offender has previously received state mental healthcare;

b) record whether the CARE system was checked on the initial intake screening form; and

c) include any relevant mental health information on the mental health screening instrument and, if sentenced to the Department of Criminal Justice, on the Uniform Health Status Update form.

The Commission shall use funds appropriated above to include in its annual inspection of county and local jails a determination of each jail's

compliance with the requirement to check each offender upon intake against the Department of State Health Services' CARE database for previous mental healthcare. The Commission on Jail Standards shall report any jails that are found to not be in compliance with the screening requirements to the Texas Correctional Office on Offenders with Medical and Mental Impairments of the Texas Department of Criminal Justice on a quarterly basis.

SB I, Art. II, Rider #80:

The Department of State Health Services shall use funds appropriated above to require local mental health authorities to conduct CARE system database checks within 72 hours of referrals for local and county jails to determine if offenders have a history of state mental healthcare and report such information to the requesting jail. Quarterly reports of activities shall be provided to the Texas Department of Criminal Justice - Texas Correctional Office on Offenders with Medical or Mental Impairments as part of the community of care mandate.

Since September 1, 2005, TCOOMMI has worked with the TCJS and DSHS to establish a standardized process for local jails and MHMRAs to cross-reference inmate census against the statewide Client Assessment Registry (CARE) system. Coordinating this activity between 238 local jails and 39 MHMRAs has been challenging for a number of reasons, including:

1. **Historically, local jails and MHMR Centers may not have worked well together due to misunderstandings on each of their respective roles and responsibilities.** Local jails view MHMRAs as the entity responsible for providing mental health treatment to their inmates, despite the fact that counties are financially and legally responsible for all medical treatment of jail inmates. Local MHMRAs have traditionally been prohibited from using state funds to provide treatment to jail inmates, regardless of whether that offender was an active client of that agency. Understandably, these issues have done little to foster a cooperative relationship between the two entities.

2. **Local jails, particularly small ones, are not using technology in their routine record keeping.** As a result, inmate information submitted to local MHMRAs was manually produced, thus requiring a labor intensive effort by the MHMRA to enter the inmate information into a data system.

3. **The type and level of information provided to the local jails on client matches varied from location to location.** In some counties, the jail received a mere yes or no to indicate MHMR status. Other reports provided much more comprehensive information such as dates of service, diagnosis, treatment and service provider (i.e., state hospital or local MHMRA).

Despite these and other initial start-up problems, the cross-referencing initiative has shown promising results during its initial stages.

1. Requiring a 72 hour turnaround time for returning cross-referencing results has improved the timeliness of identification. As a result, the jail should be able to avoid delays in treatment or additional psychiatric assessment due to the diagnostic information provided by the CARE system.

2. Identifying current or former clients of the MHMR system through this data matching process should facilitate a more active role the mental health system plays within the jail. Prior to the cross-referencing activity, there was no standardized method for notifying MHMR of a client's arrest and incarceration. As a result, the center would close the client's case due to failure to appear for appointments. The new identification process should result in increased efforts by the MHMR to provide assistance to the jail "in-treatment" strategies, and facilitate pre-release planning activities for post-release treatment needs of the offender.

3. Planning activities for expanded resources can now be supported with the prevalence rate data. Any attempt to obtain increased funding from local or state government must be substantiated with reliable numbers. With the cross-referencing system, local jails, MHMRAs and state agencies are better equipped to justify their requests for increased funds.

4. Improved identification at time of intake could result in fewer days in jail for defendants with mental illnesses. Over ten (10) years ago, the Legislature mandated local magistrates release certain categories of defendants with mental illnesses from jail on a pre-trial basis. For the most part, this statutory provision has never been used; primarily due to the lack of treatment services in which the courts would require the defendant to participate as a condition of release. With current jail crowding, this potential diversion strategy for defendants who are active MHMR clients could provide a viable alternative to incarceration.

In addition to these promising results, a number of concerns have been raised as well. These concerns include:

1. Prevalence data is not based on current eligibility criteria for MHMRA services. A good example of this problem is demonstrated in information obtained from the Heart of Texas Region MHMR Center's FY 06 reports on inmate cross-referencing activities:

Heart of Texas Region MHMR Center			
	Total Booked into Jail	CARE Match	Qualifying Diagnosis
1st Quarter	6240	1229	236
2nd Quarter	6272	1212	292
3rd Quarter	7344	1299	417

By using the current target population criteria for MHMR services (schizophrenia, bipolar disorder and clinically severe depression) the prevalence rate drops considerably. From a fiscal standpoint, that is a positive outcome due to the

significant financial costs associated with treatment for the seriously mentally ill. The downside, however, is that inmates with a non-target mental health or substance abuse diagnosis still require treatment. This must be factored in as a population in need of some services.

2. The data is limited in that it only reflects those individuals who were able to access the public mental health system. According to DSHS, funding restrictions allow for only one-third of the eligible population to receive services. It could therefore be argued that if the service capability were extrapolated to the jail population, a significant underreporting of seriously mentally ill is occurring.

3. The identification of a seriously mentally ill defendant is rarely forwarded to the courts for their consideration. Although isolated activities exist in some jurisdictions to notify the courts of a defendant's mental condition, it is oftentimes inconsistent and fragmented. In order for the courts to consider a defendant's mental illness as a mitigating factor or impose treatment conditions as part of their probation sentence, there must be a uniform process established to share mental health information between the jail and court personnel.

4. The cross-referencing activity is labor intensive both on jail and MHMR personnel. Although TCOOMMI has routinely provided funding to local jails and MHMRAs to purchase computers or reimburse for staff time associated with the cross-referencing activity, all costs associated with this activity are not covered in existing funds. As a result, the level and quality of implementation has been affected by resource issues.

Despite the problems encountered, this initiative is a much needed step in the right direction for Texas. Once the cross-referencing activities are further refined, the results should be a valuable resource tool for local and state decision makers in their policy development.

JAIL INTAKE / SCREENING PROCESS

During the past decade, TCOOMMI has worked closely with TCJS on a variety of issues impacting county jails. This collaboration has included: implementing of a Memorandum of Understanding (MOU) between TCOOMMI, Texas Commission on Law Enforcement Officer Standards and Education (TCLEOSE) and TCJS (Appendix II); a report to the 79th Legislature on mental health issues in local jails; studies on reliability of mental health identification in jails; revising the uniform health status form to include prior MHMR service history; and developing a mental health / suicide screening form for jail personnel to administer to all inmates at time of intake and booking.

Due to the increased legislative attention directed toward jail diversion for mentally ill defendants, TCJS and TCOOMMI improved the intake screening process by revising the instrument used to flag mental health / suicide issues of inmates. To ensure a comprehensive approach to this effort, TCOOMMI created an ad hoc working group to develop an improved screening instrument for local jails.

Through a combination of meetings, interviews with jail staff and on-site visits, the working group identified a number of concerns regarding the screening process:

1. Responses to the screening questions may be influenced by a defendant's reluctance to answer anything that may impact his/her criminal charges. Many defendants have had repeated encounters with law enforcement, therefore, are very familiar with the right to remain silent, and consult with an attorney prior to questioning. As a result, the individual may be less than forthcoming in his/her responses during the screening process.

2. Jail staff indicated that some of the questions intended to flag possible mental retardation were producing false positives. For example, one question on the screening form was, "What season is it?" This question could be difficult for an individual with cognitive defects such as mental retardation. Although the obvious intent of the question was to name the season of the year (summer, fall, etc.), the responses oftentimes included football, hunting, or basketball. Since it is Texas, football and hunting are considered seasons, so the question understandably was noted as answered correctly.

3. Defendants may be under the influence of drugs and/or alcohol at the time of intake and booking. As a result, responses to the screening questions may include mixed answers that are highly suspect.

These and other problems identified during on-site visits or conversations with jail staff indicated a need to revise the mental health screening form.

The revised screening instrument developed by the working group is found in Appendix I. This form, being piloted by several county jails, appears to be a more reliable screening instrument for flagging possible mental illness, mental retardation or suicidal ideation. To assess its effectiveness, TCOOMMI and the TCJS staff will be evaluating the form by comparing it to the MHMR client database. Although this activity will be limited in scope due to the large percentage of mentally ill persons who are unable to access MHMR services, it will nonetheless provide a baseline for some comparison. As the evaluation will not be completed prior to the submission of this report, outcomes will not be available until late next year. When the results are finalized, the information will be forwarded to the appropriate decision makers for review and consideration.

In addition to these concerns, the workgroup identified specific problems associated with the screening of defendants with mental retardation. The following are a few concerns identified regarding mental retardation screening:

1. Unlike persons with mental illnesses, offenders with mental retardation are typically not current or former clients of MHMR; therefore cross-referencing activities are not productive. The majority of mental retardation services are provided to persons with severe disabilities. As a result, the offender with mild mental retardation will in all likelihood have no prior experience with the MHMR.

2. Questions that could be good indicators of mental retardation or other cognitive disabilities may be falsely answered to avoid punitive outcomes. For example, eligibility for Social Security benefits is a very good indicator of a disability. If that question was included on the intake form, the most likely response would be negative for fear that their benefits would be terminated. In reality, the Social Security Administration has a system in place with local and state criminal justice agencies to identify persons with benefits who are incarcerated. The defendant, however, does not know this, therefore would in all probability answer, "No".

3. Unless the person with mental retardation has another disability, such as mental illness, their behavior would probably not raise any flags to their condition. Offenders with mental retardation will typically follow directions, present no management problems and will quietly fade into the general population. As a result, they could be processed, sentenced and perhaps sent to prison without anyone knowing of their mental retardation.

CONTINUITY OF CARE - 46.B DEFENDANTS

During the 78th Legislative Session, statutory provisions for competency proceedings were revised. As part of this process, a rider was included in TDCJ's appropriations directing TCOOMMI to establish a continuity of care process for 46.B defendants. The 79th Legislature included a similar rider that reads as follows:

SB I, Art. V, Rider #66:

Out of the funds appropriated above in Strategy B.1.1, Special Needs Projects, the Texas Correctional Office on Offenders with Medical or Mental Impairments shall coordinate with the Texas Department of State Health Services, county and municipal jails, and community mental health and mental retardation centers on establishing methods for the continuity of care for pre-and post-release activities of defendants who are returned to the county of conviction after the defendant's competency has been restored. The Council shall coordinate in the same manner it performs continuity of care activities for offenders with special needs.

In response to this rider, TCOOMMI, in collaboration with DSHS, established a process to be notified when a 46.B defendant was being discharged from a state hospital and returned to the jail. In addition, TCOOMMI developed a process with the local MHMRs to inform them of the defendants return to jail so that pre-release activities could be initiated as appropriate. The following chart reflects the FY 06 outcomes for those defendants referred by the state mental hospitals.

Total*	Incarc. TDCJ		Incarc. Jail		Served TCOOMMI		Served MHMR		Not Served		Hospital		Refused		Moved		Other	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
830	118	14%	209	25%	13	2%	188	23%	233	28%	26	3%	11	1%	9	1%	23	3%

Since TCOOMMI received no additional funds for this activity, implementation has in large part been incorporated within existing contractual requirements with local MHMRAs. Where no such contract was in place, TCOOMMI had minimal, if any, enforcement capability to ensure that continuity of care services were provided by the local MHMR.

In order to address this problem, TCOOMMI initiated continuity of care contracts with all local MHMRAs for FY 07. Dependent on the site and number of estimated 46.B referrals, funding was targeted either as a fee for service activity for smaller sized MHMRs, or for staff positions in mid- to -larger sites.

Regardless of the funding amount, the objective is to establish a continuity of care process for all 46.B defendants who may be released from jail after an acquittal, sentence of probation or dismissal of charges. With recidivism rates for mentally ill offenders directly linked to availability of post-release treatment services, the expansion of continuity of care activities for 46.B defendants is considered to positively impact recidivism.

Due to the relatively short period of time these new continuity of care services have been in place, no outcome data is available. TCOOMMI anticipates, however, that sufficient data will be collected during the next biennium to evaluate its potential impact on recidivism and report findings to the 81st Legislature.

MEMORANDA OF UNDERSTANDING

The Legislature appropriated funds to TCOOMMI to establish a continuity of care system for offenders with special needs. In a previous section of this report, an overview of the programs operated and funded by TCOOMMI described specific programmatic activities associated with continuity of care. This section will address a broader scope of continuity of care activities as required by Chapter 614.013 - 614.017, Health and Safety Code.

Currently, Texas is the only state in the country with a legislatively mandated continuity of care system for offenders with special needs. While other states may have some legislative directives regarding continuity of care, none have one that addresses the entire criminal justice continuum - starting with initial arrest and progressing to the ultimate release of an offender on parole.

To implement a comprehensive system of care involving multiple local and state governmental entities, the Legislature requires the development and implementation of Memoranda of Understanding (MOUs) between the affected agencies. The legislation requires the MOUs to address the following areas:

1. Identify offenders with special needs in the criminal justice system, and report prevalence rate data to TCOOMMI;

2. Develop interagency rules, policies, procedures and standards for coordinating care and exchange of information regarding offenders with special needs;

3. Identify services needed by offenders with special needs; and

4. Establish a process for reporting implementation activities to TCOOMMI.

During the past biennium, TCOOMMI coordinated with each MOU agency in finalizing or revising the MOUs to strengthen the roles and responsibilities of each affected entity in the continuity of care process. Copies of these MOUs can be found in Appendix II of this report.

One of the most critical activities of the MOU involves the cross-referencing of offender/client information between criminal justice and health and human service agencies. By cross-referencing data, each involved agency can obtain a more complete and accurate picture of the offenders' current and past service history. In addition, this activity should minimize duplication of effort by providing agencies with information on what the offender is currently receiving or could be eligible to receive in the way of treatment, vocational, housing or other similar services. Cross-referencing of data can also establish more reliable prevalence rates on offenders with special needs within the criminal justice system. A good example of this cross-referencing activity is the one between TDCJ and DSHS to identify offenders with mental illnesses.

During the past several years, TDCJ has routinely provided DSHS a complete file of every adult offender on probation, parole or in the correctional institutional division. Actual matches have resulted in a prevalence rate of 17-19%. The following chart reflects the results of the data matching activity in February 2006.

Texas Department of Criminal Justice
CARE* Match Rates
February 2006

	Total	CARE* Matches
Probationers:	430,312	57,719 (13%)
Parolees:	77,167	21,097 (27%)
CID:	151,528	45,628 (30%)
Total:	659,007	124,444** (19%)

* Client Assignment and Registration System (CARE)
** Data includes all persons served by MHMR and is not limited to current target populations of Schizophrenia, Bipolar or Major Depression

There are, however, recognized limitations to the data that warrant discussion and future work:

1. As previously cited in this report, the numbers of seriously mentally ill represented in the DSHS database is not an indication of actual numbers in the state. Due to resource limitations, DSHS estimates that current service capacity is available to only one-third of the population with an eligible diagnosis for mental health services. As a result, the TDCJ prevalence rates represent a snapshot of the number of offenders with mental illnesses in the criminal justice system.

2. Offenders who may have received mental health services from another public or private provider are not reflected in the DSHS data. Veterans, for example, may have received behavioral health services at the Veterans Hospital, as opposed to the local MHMR. Likewise, individuals or families with independent insurance may have

been treated on an in/out-patient basis by a private psychiatrist. Again, this service information would not be reflected in the DSHS database; therefore the accuracy of the prevalence rate data is impacted.

3. Diagnostic practices that may impact the appropriate identification of mental illness in minority populations may result in underreporting. Due to the disproportionate number of minorities in the criminal justice system, there may be a significantly higher number of offenders with mental illness in the TDCJ system, but have never been diagnosed as such.

In order to more appropriately identify those offenders who meet current service criteria of the state mental health system, TDCJ and DSHS collaborated to develop a matching criteria based solely on the target populations of schizophrenia, bipolar and major depression. Based on a revised cross-referencing using the new criteria, the following results were found:

	Number	Percent of Total	Percent of all Active Clients*
Matched Clients Meeting Criteria	**50,174**	**100.00%**	**7.66%**
			Percent of all Incarcerted Clients**
Incarcerated Clients Age 22 and Over	**14,698**	**29.29%**	**9.87%**
With Major Depresion	4,540	9.05%	3.05%
With Bipoloar Disorder	2,871	5.72%	1.93%
With Schizophrenia	2,814	5.61%	1.89%
With a Non-PPDx or Crisis	4,473	8.91%	3.00%
Incarcerated Clients Under Age 22	**1,780**	**3.55%**	**1.20%**
With Major Depresion	261	0.52%	0.18%
With Bipoloar Disorder	169	0.34%	0.11%
With Schizophrenia	53	0.11%	0.04%
With a Non-PPDx or Crisis	1,297	2.59%	0.87%
			Percent of all Parole Clients†
Parole Clients Age 22 and Over	**7,192**	**14.33%**	**9.35%**
With Major Depresion	2,515	5.01%	3.27%
With Bipoloar Disorder	1,603	3.19%	2.08%
With Schizophrenia	1,665	3.32%	2.16%
With a Non-PPDx or Crisis	1,409	2.81%	1.83%
Parole Clients Under Age 22	**297**	**0.59%**	**0.39%**
With Major Depresion	39	0.08%	0.05%
With Bipoloar Disorder	24	0.05%	0.03%
With Schizophrenia	9	0.02%	0.01%
With a Non-PPDx or Crisis	225	0.45%	0.29%
			Percent of all Probation Clients‡
Probation Clients Age 22 and Over	**24,468**	**48.77%**	**5.70%**
With Major Depresion	9,524	18.98%	2.22%
With Bipoloar Disorder	6,633	13.22%	1.55%
With Schizophrenia	2,627	5.24%	0.61%
With a Non-PPDx or Crisis	5,684	11.33%	1.32%
Probation Clients Under Age 22	**4,174**	**8.32%**	**0.97%**
With Major Depresion	849	1.69%	0.20%
With Bipoloar Disorder	687	1.37%	0.16%
With Schizophrenia	151	0.30%	0.04%
With a Non-PPDx or Crisis	2,487	4.96%	0.58%

*Includes prison/state jail, active parolees, & on probation as of May 31, 2006: 655,043
**Includes prison and state jail as of May 31, 2006: 148,914
†Includes active parolees as of May 31, 2006: 76,925
‡Includes clients on probation as of May31, 2006: 429,204

As noted, revising the criteria for the data cross-referencing process resulted in a significant decrease in prevalence rates, from 19% to 7.6%. Utilizing the new criteria is beneficial for a number of reasons:

1. By restricting the data to those individuals with the most serious mental illnesses, TDCJ/TCOOMMI can direct its resources to those offenders requiring the most intensive treatment and supervision;

2. Agency planning activities for service and resource needs can be conducted on more reliable prevalence data; and

3. Future reporting activities to the Legislature will clearly reflect prevalence rates of target and non-target offender populations.

SECTION VI.
CONCLUSION

Based upon the accomplishments noted in this report, continued progress has been made toward establishing a comprehensive continuity of care system for offenders with special needs. There is, however, a great deal of work to be done in the next biennium.

In addition, several issues that have been identified by the TCOOMMI office and advisory committee that warrant continued work during the next biennium. Those issues include:

1. TDCJ/TCOOMMI should continue and increase its coordination with the United States Veterans Administration (VA) to identify offenders who may be eligible for VA services or benefits. Veteran hospitals and out-patient services offer a significant resource for the adult offender with special needs. Currently, there is no uniform process, other than self-reporting, for identifying veterans who are on probation, parole or in jail. TDCJ/TCOOMMI is developing a Memorandum of Understanding with the VA to establish a cross-referencing system for identifying all eligible veterans in the criminal justice system. If successfully implemented, a much needed resource for medical, mental health and substance abuse treatment could be accessed, thus reducing resource demands on the local or state system of care.

2. Efforts to utilize and/or expand upon technology to assess or treat and conduct hearings for offenders with special needs should be continued. The benefit of telemedicine or interactive video conferencing in the criminal justice system has been demonstrated by TDCJ's medical providers for inmates, University of Texas Medical Branch and Texas Tech University. Adopting similar capabilities in the pre-trial assessment phase and competency status hearings between state hospitals and the courts are examples of potential use. In a state the size of Texas, with ever-increasing demands for specialty care or services, increased use of video conferencing systems could offer a viable and cost effective response to these problems.

3. An evaluation should be done to determine if TCOOMMI should continue working on juvenile issues or programs should be evaluated. The significant and ever-increasing demands of the adult system result in less-than-adequate attention to juvenile issues. There is no argument that juvenile offenders warrant the highest priority to keep them from progressing further into the criminal justice system. There are, however, questions as to whether TCOOMMI is the best entity to respond to issues affecting juvenile offenders with special needs.

4. Continued coordination with the Department of Family and Protective Services to identify offenders who have open cases with Child Protective Services is warranted. Children whose parents are offenders and who have been neglected or abused are at high risk for involvement in the juvenile or adult criminal justice system. Improved coordination between the criminal justice and protective services as a prevention strategy is a positive step in the right direction.

5. To whatever extent possible, universities should serve as a resource to TCOOMMI to evaluate and/or research activities related to offenders with special needs. There are current gaps in information, such as prevalence rates on offenders with mental retardation or traumatic brain injury that warrant additional attention for planning purposes. Universities could play a critical role in assisting the state in these and other research endeavors.

6. Continued examination of expanding the DPS database to include the CARE system is warranted. Allowing law enforcement to run a person's prior or current MHMR history at time of initial encounter can contribute to earlier identification and diversion of persons with mental illness.

SECTION VII.
APPENDICES

APPENDIX I	Intake Screening Form
APPENDIX II	Memoranda of Understanding

DRAFT

_____ County

Screening Form for Suicide and Medical and Mental Impairments

Name: _____ Date of Birth: _____

State I.D. Number (if known) _____

Date: _____ Completed By: _____

Does arresting officer or any other person believe that the inmate is at risk due to **medical condition**, **mental illness, mental retardation,** or **suicide concern**? (Circle one or more if applicable)

Comments: _____

SELF-REPORT QUESTIONS:

Any current medical problems, recent hospitalizations or serious injuries or concerns about withdrawal?
Yes ☐ No ☐ _____

Medications? Yes ☐ No ☐ _____

Have you ever received services for mental health or mental retardation? Yes ☐ No ☐ _____

Do you receive a social security check? Yes ☐ No ☐ _____

Have you ever been in special education? Yes ☐ No ☐ _____

Do you hear any noises or voices that other people don't seem to hear? Yes ☐ No ☐ _____

Have you ever been very depressed? Yes ☐ No ☐ _____

Do you feel this way now? Yes ☐ No ☐ _____

Have you had thoughts of killing yourself in the last year? Yes ☐ No ☐ _____

Are you thinking about killing yourself today? Yes ☐ No ☐ _____

Have you ever attempted suicide? Yes ☐ No ☐ When? _____ Why? _____ How? _____

Have you experienced a recent loss? Yes ☐ No ☐ _____

STAFF OBSERVATIONS:

Comments:

Does the individual seem (circle all that apply): **confused**, **pre-occupied**, **hopeless**, **sad**, **paranoid**, **in an unusually good mood**, or **believes he/she is someone else**?

Is this person's speech (circle all that apply): **rapid**, **hard to understand**, **hesitant**, or **childlike**?

Observed to be under the influence of: Alcohol? ☐ Drugs? ☐ Withdrawals? ☐

Observed to have visible signs of self harm (i.e., cuts on arms, etc.): Yes ☐ No ☐

Additional Comments: _____

revised 8/28/2006

Figure: 37 TAC §159.21(a)

MEMORANDUM OF UNDERSTANDING

Between the Texas Correctional Office on Offenders with Medical or Mental Impairments and the Texas Commission on Law Enforcement Officer Standards and Education and the Texas Commission on Jail Standards

For the purpose of establishing a continuity of care and service program for offenders with mental impairments, elderly, physically disabled, terminally ill, or significantly ill, the Texas Correctional Office on Offenders with Mental and Medical Impairments (TCOOMMI), the Texas Commission on Law Enforcement Officer Standards and Education (TCLEOSE) and the Texas Commission on Jail Standards (TCJS) (The Entities) agree to the following:

1. AUTHORITY AND PURPOSE:

Texas Health and Safety Code, §614.016 authorizes TCOOMMI, TCLEOSE, and the TCJS to establish a Memorandum of Understanding (MOU) that identifies methods for:

- Identifying offenders in the criminal justice system who are mentally impaired, elderly, physically disabled, terminally ill or significantly ill;

- Developing procedures for the exchange of information relating to offenders who are mentally impaired, elderly, physically disabled, terminally ill, or significantly ill by TCOOMMI, TCLEOSE and the TCJS for use in the continuity of care and services program; and

- Adopting rules and standards that assist in the development of a continuity of care and services program for offenders who are mentally impaired, elderly, physically disabled, terminally ill, or significantly ill.

2. ALL ENTITIES AGREE TO THE EXTENT POSSIBLE:

a) Coordinate on the development of policies, rules or standards that promote the exchange of information (including electronic) about offenders with special needs without consent of the individuals involved for the purpose of providing or coordinating services among the entities;

b) Coordinate on the development of systems that provide for the timely identification of offenders with special needs who come into contact with law enforcement or jail personnel;

c) Distribute relevant training seminar and/or educational information toward improving the knowledge and understanding of the identification and management of offenders with special needs;

d) Inform each other of any proposed rule or standard change which could affect the continuity of care system. Each agency shall be afforded thirty (30) days after receipt of proposed change(s) to respond to the recommendations prior to the adoption;

e) Provide annual status reports to TCOOMMI on the implementation of initiatives outlined in this MOU;

f) Provide opportunities for cross-training for each others staff; and

g) Provide technical assistance and professional consultation to the affected entities toward enhancing the coordination and response to offenders with special needs.

3. TCOOMMI SHALL:

a) Provide technical assistance toward the development of improved medical and psychiatric screening standards;

b) Provide training and technical assistance to state or local law enforcement or jails on enhancing identification and management strategies for offenders with special needs;

c) Monitor and coordinate the implementation of the activities of this MOU;

d) Provide reports to the Legislature on the status of implementation of activities; and

e) Participate in any relevant research or studies relevant to offenders with special needs who come into contact with law enforcement or who are incarcerated in county jails.

4. TCLEOSE SHALL:

a) Coordinate with TCOOMMI on the development of curriculum changes relating to offenders with special needs for pre and/or in-service training requirements for peace officers;

b) Provide annual status reports to TCOOMMI on the number of peace officers who have received training and/or certification in specialized mental health or related course work; and

c) Coordinate with TCOOMMI on any research and/or evaluation activities designed to measure the effectiveness of specialized peace officer training.

5. TCJS SHALL:

a) Develop rules and/or standards to enhance the mental health and medical screening processes utilized by the local jails;

b) Monitor the implementation of any screening standard through on-site audits conducted by TCJS staff in the course of routine jail inspections;

c) Encourage local jails to develop written procedures with local mental health or health/human service agencies that describe activities for cross-referencing inmate census with the above referenced social service agencies;

d) Provide quarterly reports to TCOOMMI on MOU implementation activities; and

e) Coordinate with TCOOMMI on any proposed rule or standard change involving offenders with special needs.

6. REVIEW AND MONITORING:

a) TCOOMMI, TCLEOSE, and TCJS shall monitor implementation of the Continuity of Care and Service Program as outlined in this MOU. The intent of all agencies is to provide timely communication, discussion and resolution of transitional problems should any occur.

b) This MOU shall be adopted by the Texas Correctional Office on Offenders with Medical and Mental Impairments, the Texas Commission on Law Enforcement Officer Standards and Education and the Texas Commission on Jail Standards. Subsequent to adoption, all parties to this memorandum shall annually review this memorandum and provide status reports to the Texas Correctional Office on Offenders with Medical and Mental Impairments. Amendments to this Memorandum of Understanding may be made at anytime by mutual agreement of the parties.

7. Renewal: This agreement shall be reviewed for renewal every four years.

Certification

This Memorandum of Understanding is adopted to be effective: _____ 2007.

_____
Executive Director
Texas Commission on Law Enforcement Officer Standards and Education

_____
Executive Director
Texas Commission on Jail Standards

_____
Executive Director
Texas Department of Criminal Justice

Figure: 37 TAC §159.19(a)

MEMORANDUM OF UNDERSTANDING

Between the Texas Department of Criminal Justice and the Department of Assistive and Rehabilitative Services, the Department of State Health Services, and the Department of Aging and Disability Services

For the purpose of establishing a continuity of care and service program for offenders with physical disabilities, the elderly, the significantly or terminally ill, and the mentally retarded involved in the criminal justice system, the Texas Department of Criminal Justice (TDCJ), the Department of Assistive and Rehabilitative Services (DARS), the Department of Aging and Disability Services (DADS), and the Department of State Health Services (DSHS), hereinafter the Entities, agree to the following:

1. AUTHORITY AND PURPOSE:

a) Texas Health and Safety Code, §§614.014 - 614.015 authorize TDCJ, DARS, DADS and DSHS to establish a Memorandum of Understanding (MOU) that identifies methods for:

• identifying offenders with physical disabilities, the elderly, the significantly or terminally ill, and those with mental retardation (hereinafter referred to as offenders with special needs);

• developing interagency rules, policies, procedures and standards for the coordination of care and services of and exchange of information on offenders with special needs; and

• identifying services needed by offenders with special needs to reenter the community successfully.

2. ALL ENTITIES AGREE TO:

a) Follow the statutory provisions in Chapter 614 of the Texas Health and Safety Code relating to the exchange of information (including electronic) about offenders with special needs for the purpose of providing or coordinating services among the Entities; and when appropriate, include such requirements in any relevant rules, policies or contract/grants.

b) Develop rules, policies, procedures, or standards that describe the agency's role and responsibility in the continuity of care process for offenders with special needs.

c) Develop procedures that provide for the preparation and sharing of assessments or diagnostics for offenders with special needs prior to the imposition of community supervision, incarceration, or parole, and the transfer of such diagnostics on offenders with special needs between local and state entities described in this agreement.

d) Participate in cross training or educational events targeted for improving each agency's knowledge and understanding of the criminal justice, DARS, DADS and DSHS systems' roles and responsibilities.

e) Inform each other of any proposed policy, procedure, standard or rule change which could affect the continuity of care system for offenders with special needs with each agency afforded thirty (30) days after receipt of proposed change(s) to respond to the recommendations prior to the adoption.

f) Provide information to Texas Correctional Office on Offenders With Medical or Mental Impairments (TCOOMMI) on the implementation of initiatives outlined in this MOU, as requested, and available to assist in the completion of their annual report.

g) Actively seek federal grants or funds to operate and expand the program.

h) Operate the continuity of care and service program for special needs offenders in the criminal justice system with funds appropriated for that purpose.

3. TDCJ THROUGH ITS DIVISIONS SHALL:

a) Cross-reference offender database and make information available to the DARS, DADS and DSHS as allowed by applicable statutes, rules or policies.

b) Develop a process to ensure that any medical, diagnostic or treatment information pertaining to offenders with special needs shall be provided to relevant local and state criminal justice agencies or other contract providers.

c) Ensure that offenders with special needs being released from institutional facilities have access to a ten-day supply of medications upon their release.

d) Contact the DARS Deaf and Hard of Hearing Services Regional Specialist 60 days prior to release of offenders with hearing impairments to ensure access to appropriate services and resources upon their release.

e) Establish an internal procedure in cooperation with TCOOMMI to review Motion to Revoke cases involving any offender with special needs. This review shall address interventions that have been made or should be made prior to final revocation action.

4. DARS SHALL:

a) Develop continuity of Services Procedures specific to offenders with special needs who are involved in the criminal justice system.

b) Provide a list of regional contacts that will coordinate connecting applicants to the appropriate field office that will accept appropriate referrals in the applicant community for offenders with special needs within 60 days prior to release and determine eligibility in accordance with federal and state laws and policies of the DARS.

c) Resources permitting, participate in any relevant research or studies specific to offenders with special needs.

d) Subject to time and fiscal constraints, provide and/or coordinate training and/or technical assistance to TCOOMMI and other participating agencies concerning issues related to persons served by the department.

5. DADS SHALL:

a) Develop continuity of care rules specific to offenders with special needs; and

b) Include in the performance contract requirements for local aging, mental retardation and long term care centers to adhere to and implement the activities outlined in the MOU, including statutory provisions specific to sharing of information, and cross-referencing data with local and state correctional and criminal justice entities.

6. DSHS SHALL:

a) Develop continuity of care policies specific to offenders with special needs who are involved in the criminal justice system;

b) Accept appropriate referrals in the applicant community within 30 days prior to release for offenders with special needs and determine eligibility in accordance with federal and state laws and policies of DSHS;

c) Resources permitting, participate in relevant research or studies specific to offenders with special needs with the approval of the DSHS Institutional Review Board;

d) Respond to TDCJ's data requests to cross-reference offender data against relevant DSHS information on offenders with special needs; and

e) Subject to time and fiscal constraints, provide and/or coordinate training and/or technical assistance to TCOOMMMI and other participating agencies concerning issues related to offenders with special needs.

7. REVIEW AND MONITORING:

a) This MOU shall be adopted by the Departments of Assistive and Rehabilitative Services, Aging and Disability Services and State Health Services and the Texas Department of Criminal Justice. Subsequent to adoption, all parties shall provide status reports to TCOOMMI. Amendments to this MOU may be made at any time by mutual agreement of the parties.

b) TCOOMMI shall serve as the dispute resolution mechanism for conflicts concerning this MOU at both the local and statewide level.

TCOOMMI, in coordination with each state agency or department identified, shall develop a standardized process for collecting and reporting the MOU implementation outcomes. The findings of these reports shall be submitted to the Texas Board of Criminal Justice and the Legislature by

September 1 of each even-numbered year and shall be included in recommendations in TCOOMMI's biennium report.

8. RENEWAL: This agreement shall be renewed every four years by mutual agreement of all the parties.

Certification

This Memorandum of Understanding is adopted to be effective_____2007.

_____
Executive Director
Texas Department of Criminal Justice

_____
Commissioner
Department of Assistive and Rehabilitative Services

_____
Commissioner
Department of Aging and Disability Services

_____
Commissioner
Department of State Health Services

Tab H

CORRECTIONAL MANAGED HEALTH CARE
POLICY & PROCEDURE
2007 ANNUAL REVIEW COMMITTEE

Allen Sapp (Co-Chair)	Assistant Director for Administrative Services (CMHC)
Mike Kelley, M.D. (Co-Chair)	Director of Preventive Medicine (TDCJ)
Jim Montross, PhD	Director of Mental Health Services, Monitoring and Liaison (TDCJ)
George Crippen, RN, MSN	Director, Clinical Administration (TDCJ)
Linda Cooper, RN, MSN	Director, Clinical Services (TDCJ)
Myra Walker, RN	Chief, Office of Professional Standards (TDCJ)
Phyllis McWhorter, RN	Health Services Liaison (TDCJ)
Denise DeShields, MD	Medical Director (TTHSC)
Sheri Talley, MD	Southern Region Medical Director (TTHSC)
Nancy Hurt-Spain, RN	Administrator, Standards & Compliance (TTHSC)
Brian Tucker, DDS	Director of Dental Services (TTHSC)
Dana Butler, MD	Director of Mental Health Services (TTHSC)
Glenda Adams, MD	Huntsville Cluster Medical Director (UTMB-CMC)
Sonny Wells, DDS	Director of Dental Services (UTMB-CMC)
Leslie Dupuy, MA	Associate Director, Mental Health (UTMB-CMC)
Lisa D'Cunha, RHIA	Manager Health Information Mgt. (UTMB-CMC)
Stephanie Zepeda, R.Ph.D	Assistant Director, Pharmacy Services (UTMB-CMC)
Rebecca Rudd	Policy & Procedure Coordinator (UTMB-CMC)

April 2006

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SECTION H - HEALTH RECORDS

SECTION I - MEDICAL-LEGAL ISSUES

Tab I

UTMB CMC Market Adjustments

Position Type	Turnover Rate	Vacancy Rate	Total Positions
RN Managers	25%	10%	95
RN Staff	30%	19%	292
LVN Staff	37%	16%	720
Mid-Level Providers	29%	13%	127
Dental Assistants	17%	10%	107
Dental Hygienists	4%	7%	27
Clinical Associates	18%	10%	471
Patient Care Assistants	28%	14%	395
Phlebotomists	27%	15%	52
Mental Health Liaisons	31%	7%	70
Staff Psychotherapists	19%	6%	112
		Total Positions	2468

UTMB CMC Market Adjustments

Nursing:	Medical market demands, high turnover rates & vacancy rates
Mid-Levels:	Medical market demands, high turnover rates & vacancy rates
Hyg. & Asst:	Market factors (new licenses for Asst) and salary compression with other non-clinical groups
Clinical Asst:	High turnover & internal equity issues
Patient Asst:	High turnover
Phlebotomist:	High turnover & high vacancy rates
MHL:	High turnover
Psych:	High turnover

Tab J

Hepatitis B Vaccine - Cost Estimate

	UTMB	TX TECH	**TOTAL**	
Cost Per Dose (340b UTMB / Novations TT)	$24.57	$36.59		
Total Current Patients	119,290	31,710	**151,000**	
80% Acceptance Rate	95,432	25,368	**120,800**	First Dose Hep B Vaccine
92% Acceptance Rate for 2nd Dose of the orginal 80% group	87,797	23,339	**111,136**	Second Dose Hep B Vaccine
76% Acceptance Rate for 3nd Dose of the orginal 80% group	72,528	19,280	**91,808**	Third Dose Hep B Vaccine
TOTAL HEP B VACCINE - Current Patients	255,758	67,986	**323,744**	
Cost Current Patients	$ 6,283,968	$ 2,487,617	**$ 8,771,585**	

Annual Intakes	55,300	14,700	**70,000**	
80% Acceptance Rate	44,240	11,760	**56,000**	First Dose Hep B Vaccine
92% Acceptance Rate for 2nd Dose of the orginal 80% group	40,701	10,819	**51,520**	Second Dose Hep B Vaccine
76% Acceptance Rate for 3nd Dose of the orginal 80% group	33,622	8,938	**42,560**	Third Dose Hep B Vaccine
TOTAL HEP B VACCINE - Annual Intakes	118,563	31,517	**150,080**	
Cost Annual Intake	$ 2,913,098	$ 1,153,200	**$ 4,066,298**	
TOTAL COST CURRENT PATIENTS PLUS ANNUAL INTAKE	$ 9,197,066	$ 3,640,816	**$ 12,837,882**	

Assumptions For Cost Projections:

1. Historical acceptance rate of 80% for first dose offered.
2. Historical acceptance rate of 92% for second dose offered.
3. Historical acceptance rate of 76% for third dose offered.
4. No serological testing performed to confirm prior immunity and no need for vaccination - Seroprevalence study may be warranted to determine if serological testing would be more cost effective approach.
5. Points 1-3 were obtained from Dr. Mike Kelley, TDCJ Director of Preventive Medicine

6. Cost estimates using 2/14/07 pricing available (340b for UTMB & Novations for TX Tech)
Should program be funded would be subject to bidding and possible that final pricing may differ

Tab K

Correctional Managed Health Care

Quarterly Report
FY 2007 First Quarter

September 2006 – November 2006

Summary

This report is submitted in accordance with Rider 46, page V-20, Senate Bill 1, 79th Legislature, Regular Session 2005. The report summarizes activity through the first quarter of FY 2007. Following this summary are individual data tables and charts supporting this report.

Background

During Fiscal Year 2007, approximately $375.8 million within the TDCJ appropriation has been allocated for funding correctional health care services. This funding included:

- $313.2M in general revenue appropriations in strategy C.1.8 (Managed Health Care, medical services)
- $17.5M in supplemental appropriations from HB10
- $43.1M in general revenue appropriations in strategy C.1.3. (Psychiatric Care).
- $2.0M in general revenue funding from C.3.1 (Contract Prisons/Private State Jails) provided by TDCJ for the addition of health services for the privately-operated facilities to the CMHCC service population. This transfer of responsibility from the private prison operators to the CMHCC resulted in a net savings to the TDCJ appropriations.

Of this funding, $375.2M (99.8%) was allocated for health care services provided by UTMB and TTUHSC and $584.9K (0.2%) for the operation of the Correctional Managed Health Care Committee.

UTMB and TTUHSC receive partial reimbursement for certain benefit payments through other appropriations made for that purpose. These payments are made directly to the university providers. Benefit reimbursement amounts and expenditures are included in the reported totals provided by the universities.

Report Highlights

Population Indicators

- Through the first quarter of this fiscal year, the correctional health care program remained essentially stable in the overall offender population served by the program. The average daily population served through the first quarter of FY 2007 was

151,838. Through this same quarter a year ago (FY 2006), the average daily population was 151,293, an increase of 545 (0.4%). While overall growth was relatively stable, the number of offenders age 55 and over has continued to steadily increase.

- Consistent with the trend for the last several years, the number of offenders in the service population aged 55 or older has continued to rise at a faster rate than the overall population. Through the first quarter of FY 2007, the average number of older offenders in the service population was 9488. Through this same quarter a year ago (FY 2006), the average number of offenders age 55 and over was 8655. This represents an increase of 833 or about 9.6% more older offenders than a year ago.
- The overall HIV+ population has remained relatively stable throughout the last two years and continued to remain so through this quarter, averaging 2,688 (or about 1.8% of the population served).
- Two mental health caseload measures have also remained relatively stable:
    - The average number of psychiatric inpatients within the system was 2002 through the first quarter of FY 2007, as compared to 1958 through the same quarter a year ago (FY 2006). The inpatient caseload is limited by the number of available inpatient beds in the system.
    - Through the first quarter of FY 2007, the average number of mental health outpatients was 20,475 representing 13.5% of the service population.

Health Care Costs

- Overall health costs through the first quarter of FY 2007 totaled $105.4M. This amount exceeded overall revenues earned by the university providers by $1.7M or 1.6%.
    - UTMB's total revenue through the quarter was $83.5M. Their expenditures totaled $83.7M, resulting in a net loss of $0.2M. On a per offender per day basis, UTMB earned $7.63 in revenue, but expended $7.65 resulting in a shortfall of $0.02 per offender per day.
    - TTUHSC's total revenue through the first quarter was $20.2M. Expenditures totaled $21.7M, resulting in a net loss of $1.5M. On a per offender per day basis, TTUHSC earned $7.03 in revenue, but expended $7.55 resulting in a shortfall of $0.52 per offender per day.

- Examining the health care costs in further detail indicates that of the $105.4M in expenses reported through the first quarter of the year:
  - Onsite services (those medical services provided at the prison units) comprised $49.1M representing about 46.6% of the total health care expenses:
    - Of this amount, 77.1% was for salaries and benefits and 22.9% for operating costs.
  - Pharmacy services totaled $10.0M representing approximately 9.5% of the total expenses:
    - Of this amount 15.1% was for related salaries and benefits, 7.0% for operating costs and 77.9% for drug purchases.
  - Offsite services (services including hospitalization and specialty clinic care) accounted for $33.2M or 31.5% of total expenses:
    - Of this amount 77.2% was for estimated university provider hospital, physician and professional services; and 22.8% for Freeworld (non-university) hospital, specialty and emergency care.
  - Mental health services totaled $9.5M or 9.0% of the total costs:
    - Of this amount, 97.3% was for mental health staff salaries and benefits, with the remaining 2.7% for operating costs.
  - Indirect support expenses accounted for $3.6M and represented 3.4% of the total costs.

- The total cost per offender per day for all health care services statewide through the first quarter of FY 2007 was $7.63. The average cost per offender per day for the prior four fiscal years was $7.53.
  - For UTMB, the cost per offender per day was $7.65. This is slightly lower than the average cost per offender per day for the last four fiscal years of $7.66.
  - For TTUHSC, the cost per offender per day was $7.55, significantly higher than the average cost per offender per day for the last four fiscal years of $7.05.
  - Differences in cost between UTMB and TTUHSC relate to the differences in mission, population assigned and the acuity level of the offender patients served.

Aging Offenders

- As consistently noted in prior reports, the aging of the offender population has a demonstrated impact on the resources of the health care system. Offenders age 55 and older access the health care delivery system at a much higher level and frequency than younger offenders:
    - Encounter data through the first quarter of FY 2007 indicates that offenders aged 55 and over had a documented encounter with medical staff about three times as often as those under age 55.
    - An examination of hospital admissions by age category found that through this quarter of the fiscal year, hospital costs received to date for charges incurred this fiscal year for offenders over age 55 totaled approximately $886 per offender. The same calculation for offenders under age 55 totaled about $142. In terms of hospitalization, the older offenders were utilizing health care resources at a rate approximately five times higher than the younger offenders. While comprising about 6.2% of the overall service population, offenders age 55 and over account for more than 29% of the hospitalization costs received to date.
    - A third examination of dialysis costs found that, proportionately, older offenders are represented more than four times more often in the dialysis population than younger offenders. Dialysis costs continue to be significant, averaging about $19K per patient per year. Providing medically necessary dialysis treatment for an average of 188 patients through the first quarter of FY2007 cost $0.9M.

Drug Costs

- Total drug costs through the first quarter of FY 2007 totaled $8.0M.
    - Pharmaceutical costs related to HIV care continue to be the largest single component of pharmacy expenses.
        - Through this quarter, $3.7M in costs (or just over $1.2M per month) for HIV antiretroviral medication costs were experienced. This represents 46.4% of the total drug cost during this time period.
        - Expenses for psychiatric drugs are also being tracked, with approximately $0.6M being expended for psychiatric medications through the first quarter, representing 6.9% of the overall drug cost.
        - Another pharmacy indicator being tracked is the cost related to Hepatitis C therapies. These costs were $0.3M and represented about 4.0% of the total drug cost.

Reporting of Fund Balances

- In accordance with Rider 46, page V-20, Senate Bill 1, 79th Legislature, Regular Session 2005, both the University of Texas Medical Branch and Texas Tech University Health Sciences Center are required to report if they hold any monies in reserve for correctional managed health care. UTMB reports that they hold no such reserves and report a total shortfall of $155,253 through this quarter. TTUHSC reports that they hold no such reserves and report a total shortfall of $1,495,288.

- A summary analysis of the ending balances, revenue and payments through the first quarter for all CMHCC accounts is included in this report. That summary indicates that the net unencumbered balance on all CMHCC accounts on November 30, 2006 was $376,158.33.

- The FY 2006 unencumbered ending fund balance, as of August 31, 2006, was $1,340,637.58. The total amount of the FY 2006 fund balance was lapsed back to the State General Revenue Fund in November 2006, as required by Rider 69.

- UTMB has experienced difficulties with the October implementation of a new Payroll system. This payroll conversion has resulted in a significant amount of payroll expense being expensed to a default university suspense account rather than the employees' assigned account/class. This issue has affected all areas of UTMB, including Correctional Managed Care. Per discussion with UTMB representatives, this problem was expected to be resolved in early February and an adjustment made to the general ledger to correctly reflect employees' payroll expenses to date.

- Due to delays resulting from changes to the budgeting process and decisions to be made as a result of the Navigant study, the financial statements contain estimated financial information for Hospital Galveston. The estimated amounts were calculated using FY 2006 fiscal year end cost totals, inflated by 3%, pro-rated on a monthly basis. Per correspondence with UTMB representatives, the 1st quarter cost data should be available by late February, 2007. Reported financial information received after February 2007 should reflect actual cost data for Hospital Galveston.

Financial Monitoring

Detailed transaction level data from both providers is being tested on a monthly basis to verify reasonableness, accuracy, and compliance with policies, procedures, and contractual requirements. Due to a delay in receiving UTMB's financial reports, review and testing of the first Quarter financial information is currently in process and final results are not yet available. UTMB reported that this delay resulted from end of year close out processes and transition issues related to changes to the accounting systems and the cost allocation methodologies. Upon completion of the reviews for the first Quarter, the results will be reported in the December monthly report.

The testing of detail transactions performed on TTUHSC's financial information for September, 2006, resulted in no discrepancies requiring correction or adjustment.

The preliminary testing of detail transactions performed on UTMB's financial information for September, 2006, resulted in two possible issues needing additional information or correction/adjustment. The additional information has been requested from UTMB and is pending.

Concluding Notes

The combined operating loss for the university providers through the first quarter of FY 2007 is $1.7M. The university providers are continuing to monitor their expenditures closely, while seeking additional opportunities to reduce costs in order to minimize their operating losses.

Listing of Supporting Tables and Charts

Table 1

Correctional Managed Health Care

FY 2007 Budget Allocations

Distribution of Funds

Allocated to	FY 2007
University Providers	
The University of Texas Medical Branch	
Medical Services	$273,775,733
Mental Health Services	$25,619,350
Subtotal UTMB	$299,395,083
Texas Tech University Health Sciences Center	
Medical Services	$63,433,828
Mental Health Services	$12,337,000
Subtotal TTUHSC	$75,770,828
SUBTOTAL UNIVERSITY PROVIDERS	$375,165,911
Correctional Managed Health Care Committee	$584,909
TOTAL DISTRIBUTION	**$375,750,820**

Source of Funds

Source	FY 2007
Legislative Appropriations	
SB 1, Article V, TDCJ Appropriations	
Strategy C.1.8. Managed Health Care	$313,174,719
Strategy C.1.3 Psychiatric Care	$43,094,589
Strategy C.3.1. Contract Prisons/Private St. Jails*	$1,981,512
HB 10 Supplemental Appropriations	$17,500,000
TOTAL	**$375,750,820**

Note: In addition to the amounts received and allocated by the CMHCC, the university providers receive partial reimbursement for employee benefit costs directly from other appropriations made for that purpose.

Chart 1

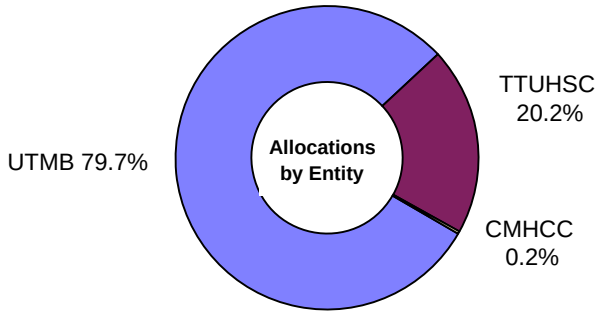


Table 2
FY 2007
Key Population Indicators
Correctional Health Care Program

Indicator	Sep-06	Oct-06	Nov-06	Population Year to Date Avg.
Avg. Population Served by CMHC:				
UTMB State-Operated Population	108,444	108,358	108,500	108,434
UTMB Private Prison Population*	11,802	11,817	11,807	11,809
UTMB Total Service Population	120,246	120,174	120,307	120,242
TTUHSC Total Service Population	31,520	31,568	31,700	31,596
CMHC Service Population Total	**151,766**	**151,742**	**152,007**	**151,838**
Population Age 55 and Over				
UTMB Service Population Average	7,704	7,760	7,832	7,765
TTUHSC Service Population Average	1,704	1,721	1,743	1,723
CMHC Service Population Average	**9,408**	**9,481**	**9,575**	**9,488**
HIV+ Population	**2,679**	**2,706**	**2,679**	**2,688**
Mental Health Inpatient Census				
UTMB Psychiatric Inpatient Average	1,037	1,034	1,039	1,037
TTUHSC Psychiatric Inpatient Average	960	971	964	965
CMHC Psychiatric Inpatient Average	**1,997**	**2,005**	**2,003**	**2,002**
Mental Health Outpatient Census				
UTMB Psychiatric Outpatient Average	15,648	16,654	15,426	15,909
TTUHSC Psychiatric Outpatient Average	4,557	4,807	4,333	4,566
CMHC Psychiatric Outpatient Average	**20,205**	**21,461**	**19,759**	**20,475**

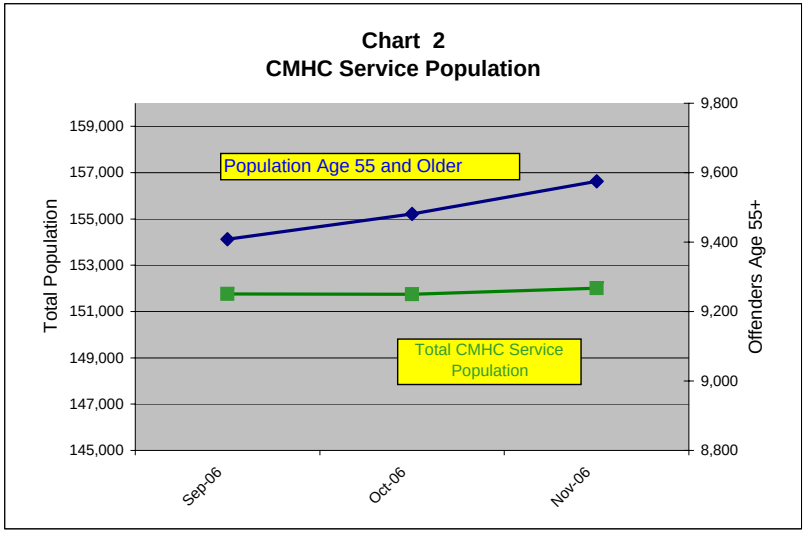


Chart 2
CMHC Service Population
Total Population
Offenders Age 55+
159,000
157,000
155,000
153,000
151,000
149,000
147,000
145,000
9,800
9,600
9,400
9,200
9,000
8,800
Population Age 55 and Older
Total CMHC Service Population
Sep-06
Oct-06
Nov-06

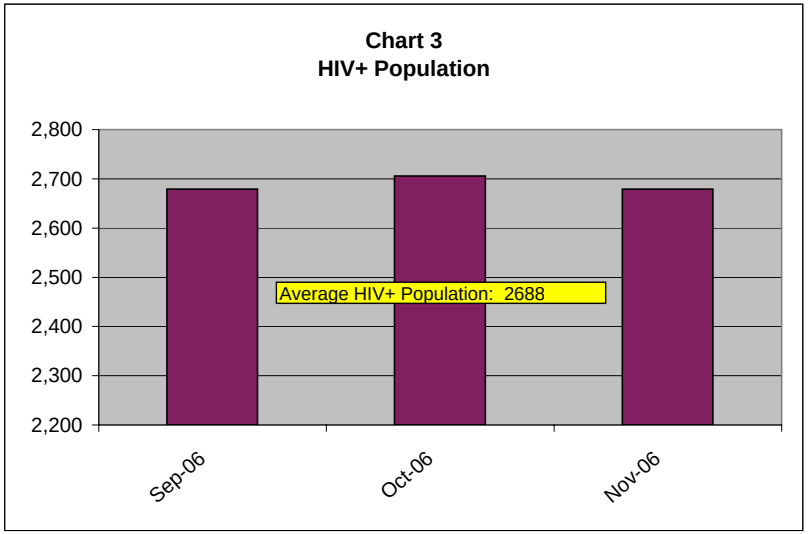


Chart 3
HIV+ Population
2,800
2,700
2,600
2,500
2,400
2,300
2,200
Average HIV+ Population: 2688
Sep-06
Oct-06
Nov-06

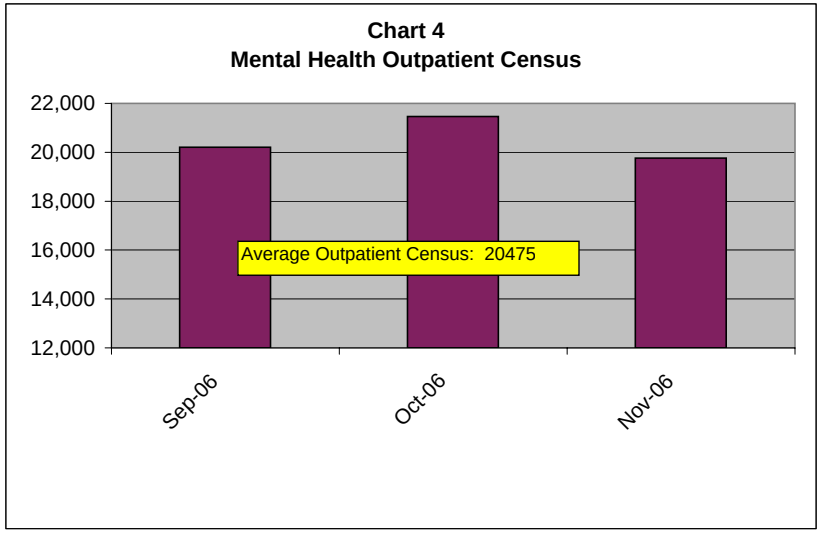


Chart 4
Mental Health Outpatient Census
22,000
20,000
18,000
16,000
14,000
12,000
Average Outpatient Census: 20475
Sep-06
Oct-06
Nov-06

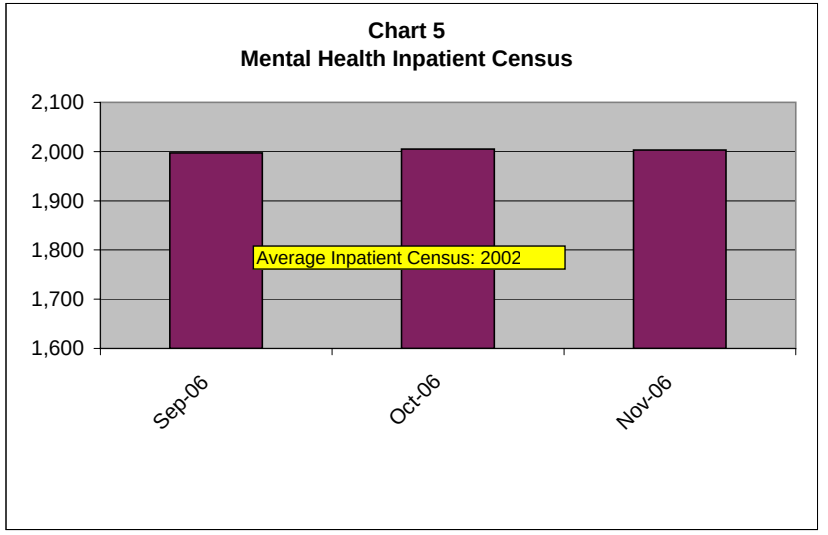


Chart 5
Mental Health Inpatient Census
2,100
2,000
1,900
1,800
1,700
1,600
Average Inpatient Census: 2002
Sep-06
Oct-06
Nov-06

Table 3
Summary Financial Report: Medical Costs
Fiscal Year 2007 through Quarter 1 (Sep 2006 - Nov 2006)

Days in Year: 91

	Medical Services Costs			Medical Cost Per Day Calculations		
	UTMB	**TTUHSC**	**TOTAL**	**UTMB**	**TTUHSC**	**TOTAL**
Population Served	**120,242**	**31,596**	**151,838**			
Revenue						
Capitation Payments	$68,256,415	$16,067,509	$84,323,924	$6.24	$5.59	$6.10
State Reimbursement Benefits	$7,707,048	$742,802	$8,449,850	$0.70	$0.26	$0.61
Non-Operating Revenue	$35,123	$0	$35,123	$0.00	$0.00	$0.00
Total Revenue	**$75,998,586**	**$16,810,311**	**$92,808,897**	**$6.95**	**$5.85**	**$6.72**
Expenses						
Onsite Services						
Salaries	$27,954,018	$2,297,179	$30,251,197	$2.55	$0.80	$2.19
Benefits	$7,066,751	$528,222	$7,594,973	$0.65	$0.18	$0.55
Operating (M&O)	$4,007,725	$328,172	$4,335,897	$0.37	$0.11	$0.31
Professional Services	$0	$837,189	$837,189	$0.00	$0.29	$0.06
Contracted Units/Services	$0	$5,159,550	$5,159,550	$0.00	$1.79	$0.37
Travel	$207,037	$26,276	$233,313	$0.02	$0.01	$0.02
Electronic Medicine	$0	$58,277	$58,277	$0.00	$0.02	$0.00
Capitalized Equipment	$644,564	$0	$644,564	$0.06	$0.00	$0.05
Subtotal Onsite Expenses	$39,880,095	$9,234,865	$49,114,960	$3.64	$3.21	$3.55
Pharmacy Services						
Salaries	$939,231	$277,111	$1,216,342	$0.09	$0.10	$0.09
Benefits	$288,096	$15,697	$303,793	$0.03	$0.01	$0.02
Operating (M&O)	$540,546	$153,483	$694,029	$0.05	$0.05	$0.05
Pharmaceutical Purchases	$6,132,665	$1,690,318	$7,822,983	$0.56	$0.59	$0.57
Professional Services	$0	$0	$0	$0.00	$0.00	$0.00
Travel	$3,477	$2,995	$6,472	$0.00	$0.00	$0.00
Subtotal Pharmacy Expenses	$7,904,015	$2,139,604	$10,043,619	$0.72	$0.74	$0.73
Offsite Services						
University Professional Services	$3,428,380	$256,136	$3,684,516	$0.31	$0.09	$0.27
Freeworld Provider Services	$2,650,388	$2,794,660	$5,445,048	$0.24	$0.97	$0.39
UTMB or TTUHSC Hospital Cost	$19,606,229	$2,323,144	$21,929,373	$1.79	$0.81	$1.59
Estimated IBNR	$1,446,346	$691,032	$2,137,378	$0.13	$0.24	$0.15
Subtotal Offsite Expenses	$27,131,343	$6,064,972	$33,196,315	$2.48	$2.11	$2.40
Indirect Expenses	$2,199,552	$988,610	$3,188,162	$0.20	$0.34	$0.23
Total Expenses	**$77,115,005**	**$18,428,051**	**$95,543,056**	**$7.05**	**$6.41**	**$6.91**
Operating Income (Loss)	**($1,116,419)**	**($1,617,740)**	**($2,734,159)**	**($0.10)**	**($0.56)**	**($0.20)**

Table 3 (Continued)
Summary Financial Report: Mental Health Costs
Fiscal Year 2007 through Quarter 1 (Sep 2006 - Nov 2006)

Days in Year: 91

	Mental Health Services Costs			Mental Health Cost Per Day Calculations		
	UTMB	TTUHSC	TOTAL	UTMB	TTUHSC	TOTAL
Population Served	**120,242**	**31,596**	**151,838**			
Revenue						
Capitation Payments	$6,387,290	$2,823,300	$9,210,590	$0.58	$0.98	$0.67
State Reimbursement Benefits	$1,150,433	$581,010	$1,731,443	$0.11	$0.20	$0.13
Other Misc Revenue	$0	$0	$0	$0.00	$0.00	$0.00
Total Revenue	**$7,537,723**	**$3,404,310**	**$10,942,033**	**$0.69**	**$1.18**	**$0.79**
Expenses						
Mental Health Services						
Salaries	$4,993,524	$2,388,497	$7,382,021	$0.46	$0.83	$0.53
Benefits	$1,203,122	$612,281	$1,815,403	$0.11	$0.21	$0.13
Operating (M&O)	$76,668	$39,381	$116,049	$0.01	$0.01	$0.01
Professional Services	$0	$51,316	$51,316	$0.00	$0.02	$0.00
Contracted Units/Services	$0	$0	$0	$0.00	$0.00	$0.00
Travel	$34,927	$5,835	$40,762	$0.00	$0.00	$0.00
Electronic Medicine	$0	$0	$0	$0.00	$0.00	$0.00
Capitalized Equipment	$47,149	$0	$47,149	$0.00	$0.00	$0.00
Subtotal Mental Health Expenses	$6,355,390	$3,097,310	$9,452,700	$0.58	$1.08	$0.68
Indirect Expenses	$221,167	$184,548	$405,715	$0.02	$0.06	$0.03
Total Expenses	**$6,576,557**	**$3,281,858**	**$9,858,415**	**$0.60**	**$1.14**	**$0.71**
Operating Income (Loss)	**$961,166**	**$122,452**	**$1,083,618**	**$0.09**	**$0.04**	**$0.08**

All Health Care Summary

	All Health Care Services			Cost Per Offender Per Day		
	UTMB	TTUHSC	TOTAL	UTMB	TTUHSC	TOTAL
Medical Services	$75,998,586	$16,810,311	$92,808,897	$6.95	$5.85	$6.72
Mental Health Services	$7,537,723	$3,404,310	$10,942,033	$0.69	$1.18	$0.79
Total Revenue	**$83,536,309**	**$20,214,621**	**$103,750,930**	**$7.63**	**$7.03**	**$7.51**
Medical Services	$77,115,005	$18,428,051	$95,543,056	$7.05	$6.41	$6.91
Mental Health Services	$6,576,557	$3,281,858	$9,858,415	$0.60	$1.14	$0.71
Total Expenses	**$83,691,562**	**$21,709,909**	**$105,401,471**	**$7.65**	**$7.55**	**$7.63**
Operating Income (Loss)	**($155,253)**	**($1,495,288)**	**($1,650,541)**	**($0.01)**	**($0.52)**	**($0.12)**

Table 4
FY 2007 1st Quarter
UTMB/TTUHSC EXPENSE SUMMARY

Category	Expense	Percent of Total
Onsite Services	**$49,114,960**	**46.60%**
Salaries	$30,251,197	
Benefits	$7,594,973	
Operating	$11,268,790	
Pharmacy Services	**$10,043,619**	**9.53%**
Salaries	$1,216,342	
Benefits	$303,793	
Operating	$700,501	
Drug Purchases	$7,822,983	
Offsite Services	**$33,196,315**	**31.50%**
Univ. Professional Svcs.	$3,684,516	
Freeworld Provider Svcs.	$5,445,048	
Univ. Hospital Svcs.	$21,929,373	
Est. IBNR	$2,137,378	
Mental Health Services	**$9,452,700**	**8.97%**
Salaries	$7,382,021	
Benefits	$1,815,403	
Operating	$255,276	
Indirect Expense	**$3,593,877**	**3.41%**
Total Expenses	**$105,401,471**	**100.00%**

Chart 6: Total Health Care by Category

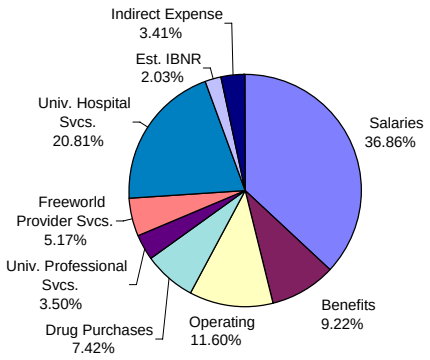


Chart 7: Onsite Services

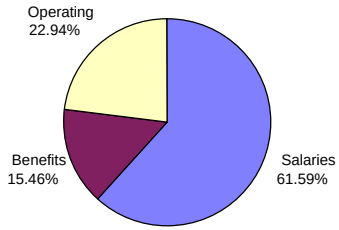


Chart 8: Pharmacy Services

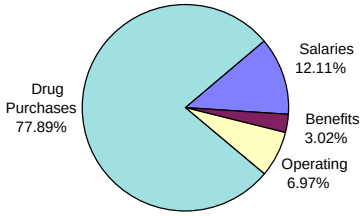


Chart 9: Offsite Services

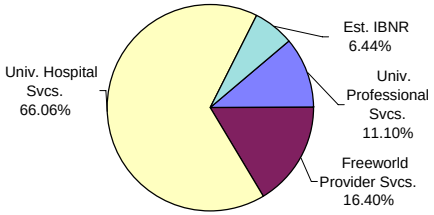


Chart 10: Mental Health Services

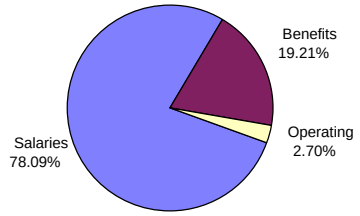
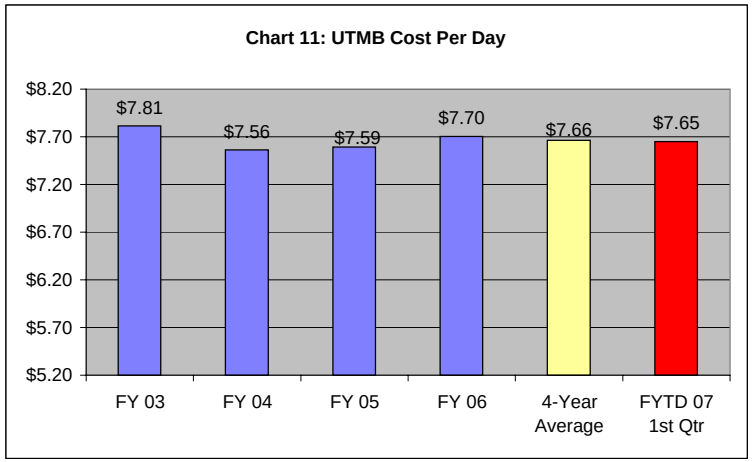
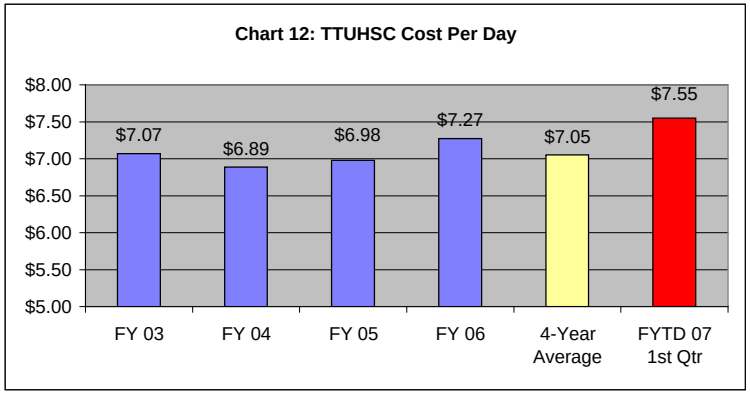


Table 5
Comparison of Total Health Care Costs

	FY 03	FY 04	FY 05	FY 06	4-Year Average	FYTD 07 1st Qtr
Population						
UTMB	105,525	113,729	119,322	119,835	114,603	120,242
TTUHSC	31,041	31,246	31,437	31,448	31,293	31,596
Total	136,566	144,975	150,759	151,283	145,896	151,838
Expenses						
UTMB	$300,912,092	$313,875,539	$330,672,773	$336,934,127	320,598,633	83,691,562
TTUHSC	$80,079,315	$78,548,146	$80,083,059	$83,467,550	80,544,518	21,709,909
Total	$380,991,407	$392,423,685	$410,755,832	$420,401,677	401,143,150	105,401,471
Cost/Day						
UTMB	$7.81	$7.56	$7.59	$7.70	$7.66	$7.65
TTUHSC	$7.07	$6.89	$6.98	$7.27	$7.05	$7.55
Total	**$7.64**	**$7.40**	**$7.46**	**$7.61**	**$7.53**	**$7.63**

* Expenses include all health care costs, including medical, mental health, and benefit costs.
NOTE: The FY04 calculation has been adjusted from previous reports to correctly account for leap year





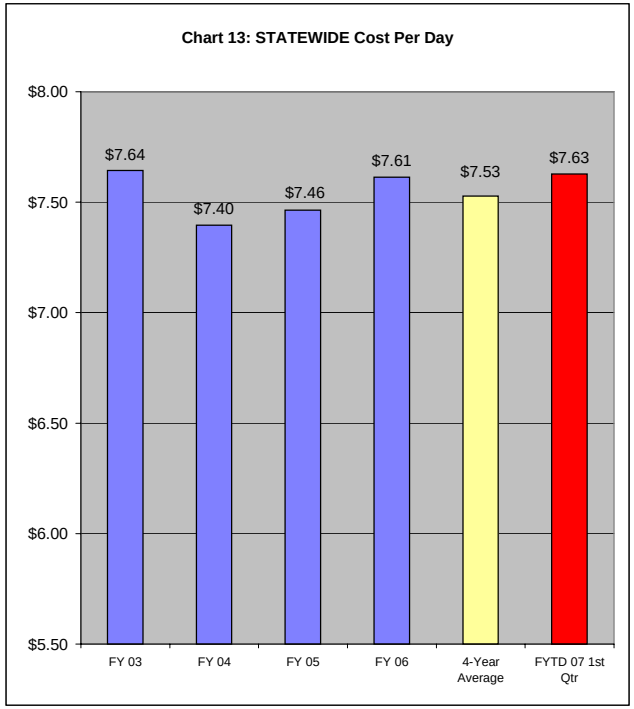


Table 6
Medical Encounter Statistics* by Age Grouping

3

Month	Encounters			Population			Encounters Per Offender		
	Age 55 and Over	Under Age 55	Total	Age 55 and Over	Under Age 55	Total	Age 55 and Over	Under Age 55	Total
Sep-06	35,447	164,845	200,292	7,704	112,542	120,246	4.60	1.46	1.67
Oct-06	37,291	175,609	212,900	7,760	112,414	120,174	4.81	1.56	1.77
Nov-06	36,321	163,865	200,186	7,832	112,475	120,307	4.64	1.46	1.66
Average	36,353	168,106	204,459	7,765	112,477	120,242	4.68	1.49	1.70

*Detailed data available for **UTMB** Sector only (representing approx. 79% of total population). Includes all medical and dental onsite visits. Excludes mental health visits.

Chart 14
Encounters Per Offender By Age Grouping

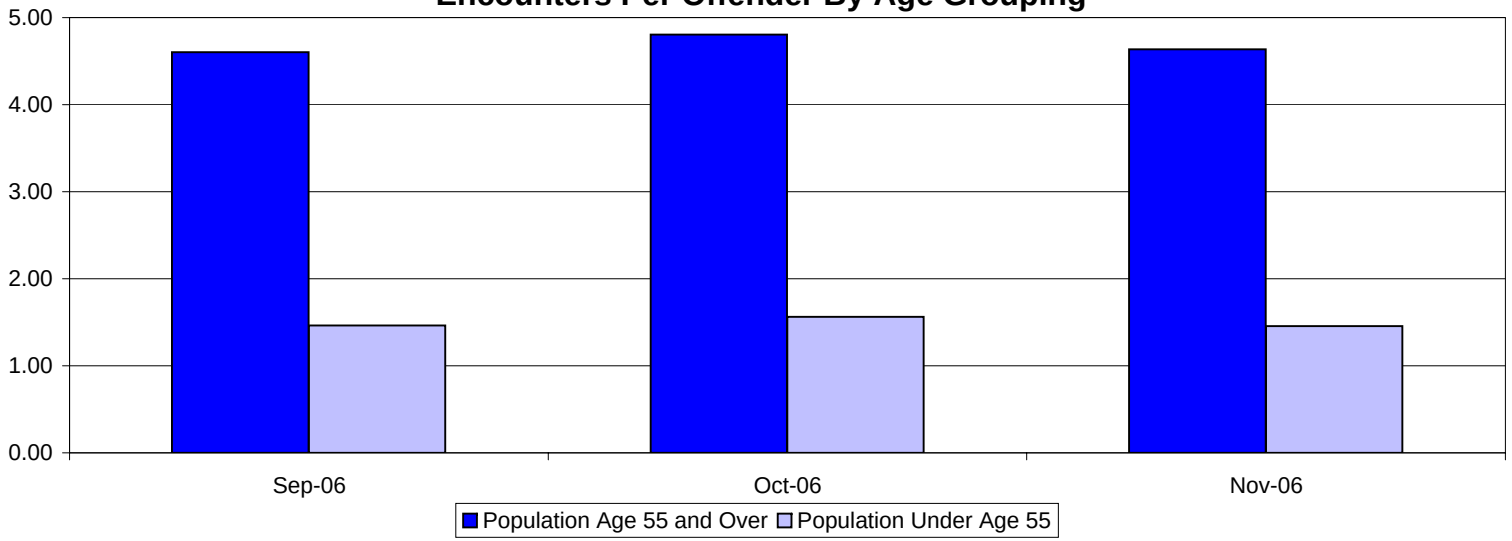


Table 7
FY 2007 1st Quarter
Offsite Costs* To Date by Age Grouping

Age Grouping	Cost Data	Total Population	Total Cost Per Offender
Age 55 and Over	$8,406,812	9,488	$886.05
Under Age 55	$20,281,329	142,350	$142.47
Total	**$28,688,141**	**151,838**	**$188.94**

**Figures represent repricing of customary billed charges received to date for services to institution's ac which includes any discounts and/or capitation arrangements. Repriced charges are compared agains population to illustrate and compare relative difference in utilization of offsite services. Billings have a 60-90 day time lag.*

Chart 15
Hospital Costs to Date Per Offender
by Age Grouping

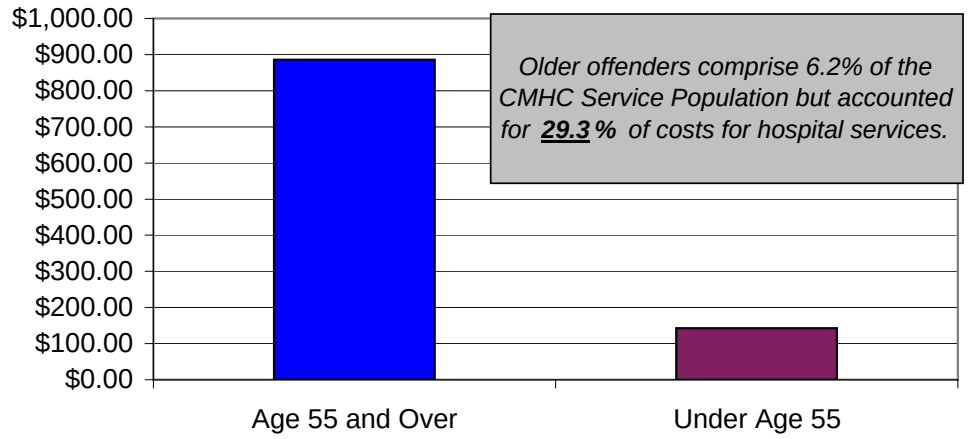
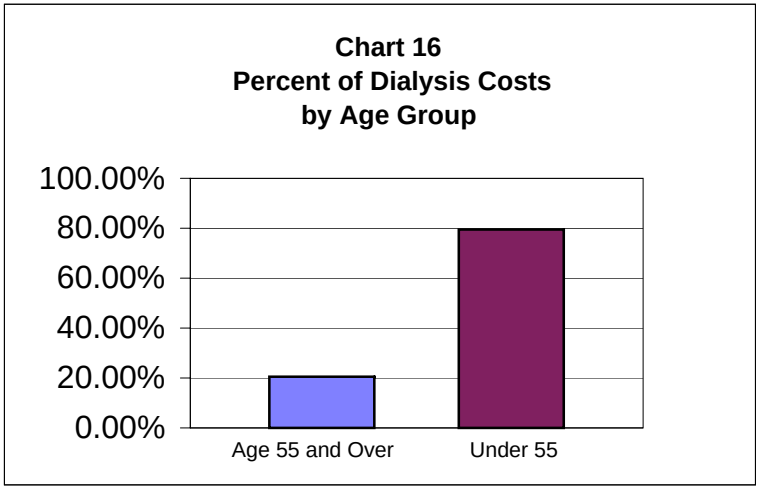


Table 8
Through FY 2007 1st Quarter
Dialysis Costs by Age Grouping

Age Group	Dialysis Costs	Percent of Costs	Average Population	Percent of Population	Avg Number of Dialysis Patients	Percent of Dialysis Patients in Population
Age 55 and Over	$182,554	20.54%	9,488	6.25%	40	0.42%
Under Age 55	$706,266	79.46%	142,350	93.75%	148	0.10%
Total	**$888,820**	**100.00%**	**151,838**	**100.00%**	**188**	**0.12%**

Projected Avg Cost Per Dialysis Patient Per Year: $18,944



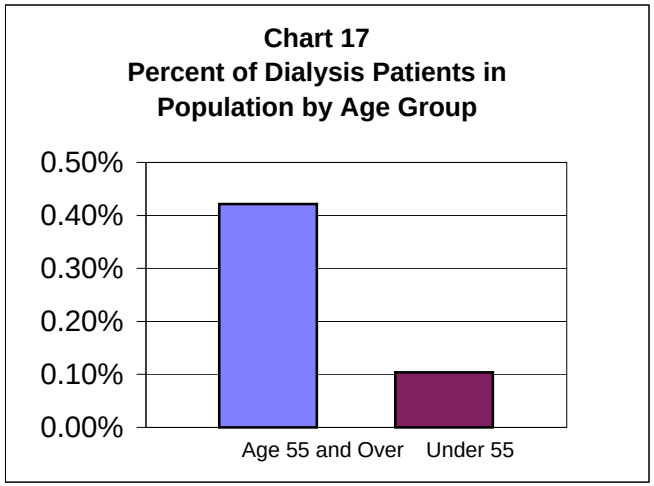


Table 9
Selected Drug Costs FY 2007

Category	Sep-06	Oct-06	Nov-06	Total Year-to-Date
Total Drug Costs	$2,958,564	$2,628,306	$2,459,070	$8,045,940
HIV Medications				
HIV Drug Cost	$1,578,626	$1,164,261	$991,471	$3,734,358
HIV Percent of Cost	53.36%	44.30%	40.32%	46.41%
Psychiatric Medications				
Psych Drug Cost	$224,093	$57,584	$276,291	$557,969
Psych Percent of Cost	7.57%	2.19%	11.24%	6.93%
Hepatitis C Medications				
Hep C Drug Cost	$99,021	$119,692	$107,789	$326,503
Hep C Percent of Cost	3.35%	4.55%	4.38%	4.06%
All Other Drug Costs	$1,056,822	$1,286,768	$1,083,519	$3,427,110

Chart 18
Drug Costs by Selected Categories

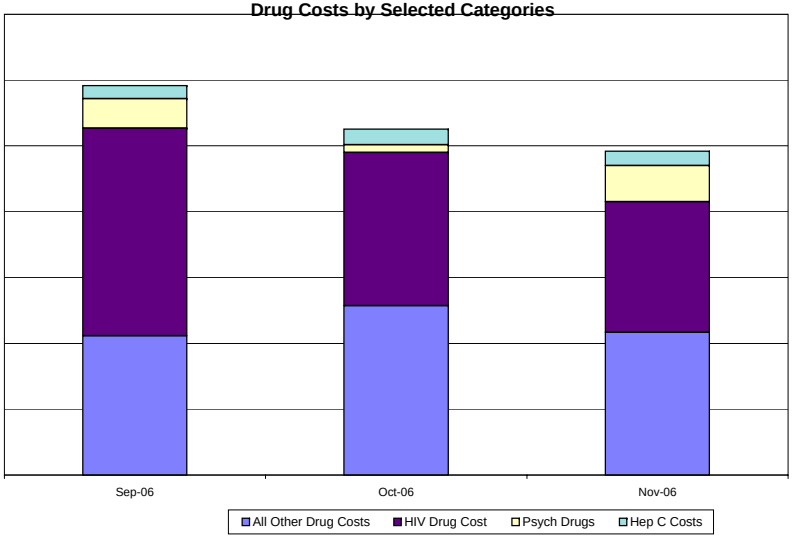


Table 10
Ending Balances 1st Qtr FY 2007

	Beginning Balance September 1, 2006	Net Activity FY 2007	Ending Balance November 30, 2006
CMHCC Operating Funds	$79,112.92	$130,036.53	$209,149.45
CMHCC Medical Services	$734,417.59	$16,342,898.88	$17,077,316.47
CMHCC Mental Health	$527,107.07	$2,676,845.34	$3,203,952.41
Ending Balance All Funds	**$1,340,637.58**	**$19,149,780.75**	**$20,490,418.33**
1st QTR Advance Payments			
From TDCJ - Medical			($84,302,390.25)
From TDCJ - Mental Health			($9,489,087.50)
To UTMB - Medical			$67,506,345.00
To UTMB - Mental Health			$6,317,100.00
From TDCJ - CMHCC			($146,227.25)
Total Unencumbered Fund Balance			$376,158.33

SUPPORTING DETAIL

CMHCC Operating Account	
Beginning Balance	$79,112.92
FY 2006 Funds Lapsed to State Treasury	($79,112.92)
Revenue Received	
1st Qtr Payment	$146,227.25
2nd Qtr Advance Payment	$146,227.25
Subtotal Revenue	$292,454.50
Expenses	
Salary & Benefits	($70,865.84)
Operating Expenses	($12,439.21)
Subtotal Expenses	**($83,305.05)**
Net Activity thru this Qtr	**$130,036.53**
Total Fund Balance CMHCC Operating	**$209,149.45**

RECONCILIATION:	
Less: 2nd Qtr Advance Payment from TDCJ	($146,227.25)
Total Unencumbered Fund Balance	$62,922.20

SUPPORTING DETAIL

CMHCC Capitation Accounts	**Medical Services**	**Mental Health**
Beginning Balance	$734,417.59	$527,107.07
FY 2006 Funds Lapsed to State Treasury	($734,417.59)	($527,107.07)
Revenue Detail		
1st Qtr Payment from TDCJ	$84,302,390.25	$9,489,087.50
2nd Qtr Advance Payment from TDCJ	$84,302,390.25	$9,489,087.50
Interest Earned	$50,305.68	$2,792.51
Revenue Received	**$168,655,086.18**	**$18,980,967.51**
Payments to UTMB		
1st Qtr Payment to UTMB	($68,256,415.50)	($6,384,115.10)
2nd Qtr Advance Payment to UTMB	($67,506,345.00)	($6,317,100.00)
Subtotal UTMB Payments	**($135,762,760.50)**	**($12,701,215.10)**
Payments to TTUHSC		
1st Qtr Payment to TTUHSC	($15,815,009.21)	($3,075,800.00)
Subtotal TTUHSC Payments	**($15,815,009.21)**	**($3,075,800.00)**
Total Payments Made thru this Qtr	**($151,577,769.71)**	**($15,777,015.10)**
Net ActivityThrough This Qtr	**$16,342,898.88**	**$2,676,845.34**
Total Fund Balance	**$17,077,316.47**	**$3,203,952.41**

RECONCILIATION:		
Less: 2nd Qtr Advance Payment from TDCJ	($84,302,390.25)	($9,489,087.50)
Add: 2nd Qtr Advance Payment to UTMB	$67,506,345.00	$6,317,100.00
Total Unencumbered Fund Balance	$281,271.22	$31,964.91