CORRECTIONAL MANAGED HEALTH CARE

COMMITTEE

AGENDA

March 25, 2008

9:00 a.m.

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

CORRECTIONAL MANAGED HEALTH CARE COMMITTEE
March 25, 2008
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. Consent Items

1. Approval of Minutes, December 4, 2007

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

V. Executive Director's Report

VI. Performance and Financial Status Dashboard

VII. Summary of Critical Correctional Health Care Personnel Vacancies

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

EACH ITEM ABOVE INCLUDES DISCUSSION AND ACTION AS NECESSARY

VIII. Medical Director's Updates

1. Texas Department of Criminal Justice

2. Texas Tech University Health Sciences Center
   - Recruiting and Retentive

3. The University of Texas Medical Branch
   - CMC Update

IX. Updates to Hepatitis Policy

1. B-14.13: Hepatitis Policy
2. B-14.13TR: Technical Reference for Hepatitis Policy

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

XI. System Leadership Council – Selection of New Chair

XII. Presentation from Joint Work Group Committee: Joint Mortality Review Committee

XIII. Financial Reports

1. FY 2008 First Quarter Financial Report
2. Financial Monitoring Update

XIV. Public Comment

XV. Date / Location of Next CMHCC Meeting

XVI. Adjourn

Consent Item 1

Approval of Minutes, December 4, 2007

MINUTES

CORRECTIONAL MANAGED HEALTH CARE COMMITTEE
December 4, 2007

Chairperson: James D. Griffin, M.D.

CMHCC Members Present: Elmo Cavin, Bryan Collier, Jeannie Frazier, Cynthia Jumper, M.D., Ben G. Raimer, M.D. , Larry Revill, Desmar Walkes, M.D.

CMHCC Members Absent: Lannette Linthicum, M.D.

Partner Agency Staff Present: John Allen, Troy Sybert, M.D., Leslie Dupuy, Bryan Schneider, Dr. William Winslade, Bernadette McKinney, JD., Ph.D., Tonya Allyn, Steve Smock, Gary Eubank, The University of Texas Medical Branch; Denise DeShields, Gary Tonniges, Larry Elkins, Jerry Hoover, Texas Tech University Health Sciences Center; Dee Wilson, Jerry McGinty, Michael Kelley, M.D. George Crippen, R.N., Cathy Martinez, Rebecca Berner, Charma Blount, Texas Department of Criminal Justice; Allen Hightower, David McNutt, Lynn Webb, Tati Buentello, CMHCC Staff and Allen Sapp (Retired CMHCC Staff)

Others Present: The Honorable Jerry Madden, Chairman, House Corrections Committee; Helga Dill, Mina Gayton, Texas Cure; Martha Ann Dafft, Allison Garret, Representing Self

Location: 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 9:00 a.m. in accordance with Chapter 551 of the Texas Government Code, the Open Meetings Act. He noted that a quorum was present then thanked everyone for attending.		
II. Recognitions and Introductions **- James D. Griffin, M.D.**	Dr. Griffin stated that it was an honor to introduce and welcome Representative Jerry Madden, Chairman, House Corrections Committee and the lead House member on the Legislative Oversight Committee for Criminal Justice. Dr. Griffin then introduced and welcomed Mr. Bryan Collier, Deputy Executive Director who was appointed in July to be the non-physician member representing TDCJ replacing Mr. Ed Owens who recently retired. Mr. Collier's career began in 1985 and during those years held many distinguished positions, most recently serving as the Director of the Parole Division. Mr. Collier was also named as one of the Best of Business by the American Correctional Association in 2005.	Dr. Griffin on behalf of the committee welcomed Mr. Collier in his new role as a member of the CMHCC.	

Agenda Topic / Presenter	Presentation	Discussion	Action
II. Recognitions and Introductions (Cont.)	Dr. Griffin next introduced Mr. David McNutt who has been selected to serve as the CMHCC Assistant Director of Administrative Services replacing Mr. Allen Sapp who retired in November. Dr. Griffin noted that Mr. McNutt brings with him over 30 years of correctional management and administration experience, including extensive legislative and appropriations expertise. He most recently served as the Director of Administrative and Business Services for the Windham School System. Prior to that, Mr. McNutt served in a number of key management and leadership positions within the Texas Department of Criminal Justice, including having served as the Assistant Director for Budget, the Deputy Director for Administrative Services and the Director of the Financial Services Division. Dr. Griffin then asked Dr. Cynthia Jumper to introduce the newest TTUHSC staff member.	Dr. Griffin on behalf of the committee then welcomed Mr. McNutt to the staff.	
	Dr. Jumper stated that it was a pleasure to introduce Mr. Larry Elkins who was selected to serve as the Executive Director for TTUHSC Correctional Managed Health Care. Dr. Jumper further stated that Mr. Elkins has been with TTUHSC for thirteen years to include some experience with correctional health care at the Sanchez Unit in El Paso. Mr. Elkins recently served as both the TTUHSC Assistant Dean for Finance and Administration and Assistant Vice-President for Fiscal Affairs, School of Medicine in El Paso. Dr. Jumper then noted that Mr. Elkins moved to Lubbock where his office will be located as he takes on his new position.	Dr. Griffin thanked Dr. Jumper for the introduction and on behalf of the committee welcomed Mr. Elkin to the staff.	
	Dr. Griffin next noted that after over 28 years of dedicated state service, Mr. Allen Sapp, CMHCC Assistant Director, retired at the end of November to take on new challenges. Dr. Griffin stated that on behalf of the committee he wanted to officially recognize Mr. Sapp for his outstanding leadership role.	Dr. Griffin then read and asked that the committee adopt the Resolution of Appreciation being presented to Mr. Sapp. (copy provided at Attachment 1)	Mr. Cavin moved that the committee adopt the Resolution of Appreciation as presented by Dr. Griffin. Dr. Raimer seconded the motion which prevailed by a unanimous vote.

Agenda Topic / Presenter	Presentation	Discussion	Action
	Dr. Griffin then asked Ms. Jeannie Frazier to make the next presentation and further asked Chairman Madden if he would stand in for Representative Lois Kolkhorst in presenting Mr. Sapp with the Texas flag that was recently flown over the Capitol.	Ms. Frazier presented a gavel to Mr. Sapp on behalf of the committee members and thanked him for his outstanding leadership and dedicated service to the CMHCC and congratulated him on his retirement. Chairman Madden next presented the Texas flag and certificate signed by Representative Lois Kolkhorst which read, "In appreciation to Allen D. Sapp for over 28 years of dedicated service to the State of Texas", then also congratulated Mr. Sapp on his retirement. Mr. Sapp thanked everyone in the room for the gifts, the recognition, and the support provided by the staff of all three partner agencies. He further stated how proud he was of the committee and its staff on the accomplishments achieved throughout the years and wished the committee well on its future endeavors.	
III. Approval of Excused Absence - **James D. Griffin, M.D.**	Dr. Griffin next noted that Mr. Bryan Collier, Ms. Jeannie Frazier, Mr. Larry Revill and Dr. Desmar Walkes were absent from the September 25, 2007 CMHCC meeting due to scheduling conflicts then stated that he would entertain a motion to excuse their absence.		Dr. Raimer moved to approve Mr. Collier, Ms. Frazier, Mr. Revill and Dr. Walkes absence from the September 25, 2007 CMHCC meeting. Mr. Cavin seconded the motion. Motion passed by unanimous vote.
IV. Consent Items - **James D. Griffin, M.D.**	Dr. Griffin then stated next on the agenda was the approval of the consent items to include approval of the Minutes from the September 25, 2007 CMHCC meeting; the TDCJ Health Services Monitoring Report; both UTMB and TTUHSC Medical Director's report and the Summary of Joint Committee Activities. He asked if any of the members had any specific consent item(s) to pull for separate discussion?		

Agenda Topic / Presenter	Presentation	Discussion	Action
IV. Consent Items (Cont.)	Hearing no further discussions, Dr. Griffin stated that he would entertain a motion.		Ms. Frazier moved to approve the consent items as presented in the agenda packet. Dr. Raimer seconded the motion. Motion passed by unanimous vote.
V. Executive Director's Report	Dr. Griffin next called on Mr. Hightower to present the Executive Director's Report.		
- **Allen Hightower**	Mr. Hightower stated that he was unable to attend the September 25, 2007 CMHCC meeting due to medical reasons.		
- LBB Tour of Hospital Galveston and Carole Young Facility	He then reported that UTMB hosted a tour of the Hospital Galveston and the Carole Young Facility at the request of Mr. Wayne Pulver, Assistant Director and Susan Dow, Budget Analyst of the Legislative Budget Board. Mr. Hightower expressed his appreciation to Dr. Ben Raimer, Dr. Owen Murray, John Allen and the other UTMB staff for coordinating and assisting with the tour. Also participating in the tour from TDCJ was Mr. Jerry McGinty, Deputy Chief Financial Officer; Mr. McNutt, Mr. Webb and himself representing the committee staff.		
- Staff Transitions	Mr. Hightower again noted the staff transitions and stated while Mr. Sapp will be missed as a member of the CMHCC staff, the committee is pleased to have Mr. David McNutt join the team as of November 5, 2007. Mr. Hightower also recalled that at the September 25th CMHCC meeting, Mr. Lynn Webb was introduced as the newly selected Finance Manager then noted that Mr. Webb formally joined the staff on October 10, 2007.		
- LBB Uniform Cost Project	Mr. Hightower next reported that the FY 2007 cost data by facility was obtained from both UTMB and TTUHSC. The data was then submitted to TDCJ in preparation for the LBB Uniform Cost Project.		

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- CMHC Limitation of Expenditure	Mr. Hightower then noted that a total of $35,601.16 was refunded to TDCJ in accordance with Rider 69, TDCJ Appropriations, Article V, Senate Bill 1, 79th Legislature. He further clarified that the Rider reads, that "any funds appropriated for CMHCC remaining unexpended or unobligated on August 31st of each fiscal year shall lapse to the General Revenue Fund".		
- Annual Financial Reporting Requirements	Mr. Hightower concluded by stating that for the first time, the CMHCC submitted an Annual Financial Report for FY 2007 as required by the State Comptroller's Office. He then stated that he would entertain any questions.	Dr. Griffin noted that it was also a part of the Sunset recommendation to have more information readily accessible to the public and asked Mr. Hightower to provide an update on the status of the CMHCC website. Mr. Hightower responded that the CMHCC website now links directly with TDCJ, UTMB and TTUHSC and can be accessed at www.cmhc@state.tx.us. Information on the functions of the committee, the financial reports, the agenda and minutes and other resource data are readily available on the committee and its partnership. He further stated that as noted by Mr. Sapp at prior meetings, this website is a working progress and will continue to be updated periodically.	
VI. Performance and Financial Status Update - David McNutt	Dr. Griffin thanked Mr. Hightower for the Executive Director's report and next called on Mr. McNutt to provide the performance and financial status update. Mr. McNutt reported that the average service population for the current fiscal year was 151,813 which was slightly above the anticipated average service population of 151,717. Mr. McNutt then noted that the aging offenders continue to increase for the biennium. In May 2007, for the first time in TDCJ history, the number of offenders aged 55+ and older topped 10,000 as reported by Mr. Sapp at the last two meetings, but that number had leveled off in June, then went slightly above that mark in July and August.		

Agenda Topic / Presenter	Presentation	Discussion	Action
- Performance and Financial Status Update (Cont.)	The psychiatric inpatient census are averaging close to 2,000 which is slightly above the budgeted level of 1,915 and is pretty consistent throughout the biennium. For the psychiatric outpatient census at the first of the biennium it was down at the 17,000 mark but is now up to 21,000. Mr. McNutt then reported that the medical access to care remained consistent staying within the 96% compliance rate which again is indicative of the staff vacancy issues being addressed. The mental health access to care indicator have remained in the 98% -99% for most of the biennium. The dental access to care indicator 1 and 2 remained in the 99% - 100% while indicator 3 dropped back down in the month of June to 98% then went back up to 99.5% in August. The UTMB vacancy rates on page 97 provides the eight quarters of the biennium which ranges from 10-15% across the provider categories except the dental vacancy rate which is below the 5% range. The TTUHSC vacancy rate provided on page 98 shows the range dropping slightly below the 15% range for nursing and the dental vacancy dropped down to 5% range for the last quarter. Mr. McNutt again cautioned that the psychiatric vacancy number looks higher because of the lower number of the total psychiatric positions.	Chairman Madden asked what the budget level was for the outpatient census. Mr. McNutt responded that the budgeted number for the outpatient census was 17,400 for medical access to care. Chairman Madden then asked for the budgeted level for the health plan. Mr. McNutt responded that it was the same at 17,400.	

Agenda Topic / Presenter	Presentation	Discussion	Action
- Performance and Financial Status Update (Cont.)	The timeliness for the Medically Recommended Intensive Supervision Program (MRIS) medical summaries remained pretty consistent. He did note however, that it dropped down in June but came back up to the 95% range in July. Mr. McNutt next noted that the reason for the increased spike in August for the statewide revenue and expense chart and for the statewide loss / gain by month is due to $6,207,630 received in supplemental appropriations. In conclusion, Mr. McNutt reported that for the biennium, both TTUHSC and UTMB experienced substantial loss but was brought back up closer to breaking even due to the supplemental appropriation funding. Hearing no further discussions, Dr. Griffin thanked Mr. McNutt for the update.	Chairman Madden asked what constitutes as being within the timeframe for the MRIS medical summaries. Ms. Dee Wilson responded that timely manner is calculated as the number of medical referral summaries completed and submitted to TCOOMMI within five days of receiving the request.	
VII. Summary of Critical Correctional Health Care Personnel Vacancies	Dr. Griffin stated that the next agenda item was the Summary of Critical Correctional Health Care Personnel Vacancies to be provided by each of the partner agencies. He then called on Dr. Kelley to provide the TDCJ report.		
- Mike Kelley, M.D.	Dr. Kelley first noted that an updated TDCJ personnel vacancy list was provided as a separate handout (Attachment 2). He then reported that the positions listed as of September 1, 2007 were created to accommodate the quality of care monitoring positions as mandated by the Sunset legislation. The rest of the positions have been vacant for some time as they are having difficulties getting them filled. He again noted that retaining and hiring nurses were the biggest challenges and that they were requesting an across-the-board salary be in-place to better compete with the market in recruiting qualified applicants.	Dr. Griffin asked if there were other factors involved other than salaries that impacts the ability of recruiting and retaining qualified applicants? Dr. Kelley responded that they were not able to compete in the market due to the salary differentials.	

Agenda Topic / Presenter	Presentation	Discussion	Action
- Summary of Critical Personnel Vacancies (Cont.)	Dr. Griffin thanked Dr. Kelley then called on Dr. DeShields to provide the TTUHSC update. Dr. DeShields reported that TTUHSC also face the same difficulties recruiting and retaining nurses, PA's, and noted that the PAMIO Mental Health Director position had been vacant for quite some time. She further stated that Tech utilized the recruitment agencies, the National Correctional and Psychiatric Publication advertisements, increased the salary to try and recruit for the PAMIO Mental Health Director. She agreed that not being more competitive in the salary market with the local community hospitals have been challenging especially in West Texas and they are looking at alternative recruiting methods.	Dr. Griffin further asked if these positions required traveling? Dr. Kelley responded that these positions require some travel to the various units but the main issue still remains to be the salary differentials. Dr. Raimer added that it is harder to recruit in certain locales such as Huntsville or other similarly remote sites. The Huntsville Hospital also offers both a sign-on bonuses and higher salaries. He further added that since Huntsville is part of the UTMB sector, they have had to raise salaries to keep up with the local economy but stated UTMB still can not compete with the $5,000 - $10,000 sign-on bonuses. There is also the issue of specialized nurses being paid an even higher salary. Dr. Raimer added that they recently made major adjustments for both nursing and PA positions as the salaries were about $15,000 below market and it is impossible to recruit or retain those positions with that type of salary differentials.	

Agenda Topic / Presenter	Presentation	Discussion	Action
- Summary of Personnel Vacancies (UTMB) - John Allen	Dr. Griffin thanked Dr. DeShields for the update then called on Mr. John Allen to provide the UTMB vacancy update. Mr. Allen stated that his presentation is provided as a separate handout titled, "UTMB Prison Healthcare Staffing Update" (Attachment 3). He noted on page 2 of his presentation is a chart that compares the average UTMB salaries to the national average on the key position categories. Mr. Allen then stated that the MD and DO salary of $156,551 is over-stated as it includes physicians who also provides oversight management to include Medical Directors who is over four to five facilities and the district providers who oversees between six to eight facilities. Mr. Allen also noted that the average MD and DO provider salary is more in the range between $142,000 - $146,000 compared to the national average of $157,400. He then reported that the increase in offender population outpaced provider staffing. The number of MD provider groups have remained relatively constant between 70 and 77 total positions for the past several years. Of the 77 total positions, there were 63 filled positions and 14 vacant positions or an 18% vacancy rate. The average age of the providers is 57 years old, then in 5 years, 46% of the current MD group will be past retirement age of 65. The mid-level positions salaries he noted are slightly higher than the national average. He then stated that the psychiatric providers have remained relatively constant with a total of 18 positions. Out of those 18 positions, 13 of those are filled with 5 or a 28% vacancy rate. The average age of psychiatric providers being age 56. Mr. Allen then reported that the psychiatric case loads have increased 53% from FY2000 – 2007 as shown on page 5. The nursing staffing versus encounters chart on page 7 includes both RN's and LVN's. Mr. Allen reported a 50% increase in encounters between the years 2003 – 2007 with a 10% decline in nursing staff. He recalled that the drop in nursing staff in 2003 was due to the reduction in force (RIF's). He further noted that the vacancy rate for RN's are currently at 11% with the average age being 51 and the LVN's currently show a 14% vacancy rate with the average age being 46.		

Agenda Topic / Presenter	Presentation	Discussion	Action
- Summary of Critical Personnel Vacancies (Cont.) - UTMB – John Allen	Mr. Allen next stated that the pharmacy is an area that have made improvements with the addition of new technology. The graph on page 10 shows the number of prescriptions that each pharmacists reviews in an eight-hour period. The workload number have steadily increased to the 700 range since FY2001 as compared to the industry average being 550. In FY2007, three more pharmacist positions were added which dropped down the workload from a high of 937 back in FY 2005 down to 800 in FY 2007. The chart on page 11 shows the interventions per 10,000 Rx. Pharmacy interventions. This is where the pharmacists take an active roll in reviewing a prescription that is questionable. There are currently 30 pharmacist positions and 28 of those are currently filled. Mr. Allen stated that the plan is to create ten additional pharmacist positions. Mr. Allen next reported that even though there is an 18% vacancy rate for the mid-level providers, there has been some success in retaining those positions. Mr. Allen further noted some of the key challenges facing the staffing vacancy issues to include the difficulties recruiting applicants in rural areas; salaries not up to market levels; and the correctional environment not being seen as a desirable place to work. He added that correctional health care environment does not usually attract new graduates but are looked at more by the mid-to-late career health care professionals. Mr. Allen concluded by stating that the last page of his presentation list samples of the type of tools needed to better recruit and retain professional health care staff to include increase in salaries to remain competitive; sign-on bonuses; incentive pay for hard-to-fill locations; financially meaningful retention plan; medical buy-out programs; and moving expenses for new hires.		

Agenda Topic / Presenter	Presentation	Discussion	Action
- Summary of Critical Personnel Vacancies (Cont.) - UTMB – John Allen	Dr. Griffin then asked if there were any other comments or questions and hearing none, thanked Mr. Allen for the update.	Ms. Frazier asked which one of those recruitment tools listed does not require approval from an external body prior to implementation by the committee? Mr. Allen responded that the salary increases is the only one allowable to a point as there are restrictions with UTMB being classified under the General Revenue Funds. Mr. Hightower added that the State Auditor's Office recommended and the Sunset Bill states that the monies TDCJ pays to the committee, then out to the universities are to be treated as general revenue funds as opposed to funding under higher education. Dr. Jumper asked what can be done to let the state leadership aware of the problems with staffing shortages? Mr. Hightower responded that it would the committee staff's responsibility to address this issue with the state leadership. Mr. Revill added that he wanted to also note the benefits of being a state employee such as retirement plans, insurance benefits and the staff benefit reimbursement plans. After some further discussions, Dr. Griffin asked that the committee staff continue to provide both a pre-session and in-session updates on critical personnel vacancies.	

Agenda Topic / Presenter	Presentation	Discussion	Action
VIII. 24-Hour Staffing Review - Bryan Schneider	Dr. Griffin next called on Mr. Bryan Schneider, Director of Support Services, UTMB-CMC, to provide the update on the 24-hour staffing review. Mr. Schneider stated that his presentation is a separate handout (Attachment 4) titled "Correctional Healthcare Joint Staffing Study". He then noted that the CMHCC, its university providers and the TDCJ Health Services Division conducted a joint staffing review on the process related to providing medical coverage for each correctional health care facility. The purpose of this review was to examine options for extending medical staff coverage and to determine the feasibility of extending hours at facilities identified in the review. Mr. Schneider reported there are 57 facilities operated by UTMB that have never had 24-hour medical coverage or any infirmary beds. He further noted that TTUHSC operates 19 facilities and of those, eight facilities operated with 24-hour medical coverage prior to 2003 and had no infirmary beds. Mr. Schneider continued by noting that even though the facilities do not have 24-hour coverage; on-call coverage is provided by medical and nursing staff. In addition to that, UTMB has ten HUB sites or pre-admission triage centers that have additional diagnostic equipment available to serve the local facilities in that geographical area. A list of those facilities without 24-hour medical coverage and the list of the ten UTMB - HUB sites are provided in the presentation packet. He then stated that the joint committee reviewed both clinical and fiscal data; the top offsite diagnostic related groups (DRG); the offsite expense patterns; population trends; analysis of death rates from 24 –hour facilities compared to non 24-hour facilities; nursing on-call data, nursing vacancy rates; and the number of encounters and admissions. Mr. Schneider also noted that the majority of the top UTMB DRG's by number of admission were cardiac related such as chest pains, heart failure, cardiac arrhythmia. Of those patients requiring offsite care, the data showed that the level of care	Chairman Madden asked how many total units are covered by UTMB and TTUHSC? Mr. Bryan Collier responded that there are currently 109 facilities.	

Agenda Topic / Presenter	Presentation	Discussion	Action
- 24-Hour Staffing Review (Cont.)	needed were beyond the capabilities of what the correctional health care can provide regardless of how that unit is staffed. Looking at the total offsite costs per offender per month, there is a downward trend over the last few years which are attributed to focusing on the care provided by the medical staff and nursing training being provided. Also seen are the decrease in the number of admittance, the number of ER's and outpatient cases between 2001 and 2007. For TTUHSC, the majority of the top ten DRG's include diseases or disorders related to circulatory system and a similar comparison of the offsite events are included in the presentation. Mr. Schneider then stated that the UTMB population trends for those facilities that do not operate 24-hours have consistently increased from 2000 to 2007. He further noted the downward trend line for the Texas offender death analysis between 1999 through 2007 except for an increase in 2006. Mr. Schneider continued by reporting that the majority of the deaths occurred at the Michael Unit which is the hospice facility, then at the Estelle Unit which is the geriatric facility and the facility for dialysis patients; the Stiles Unit which houses the HIV population and the Carol Young facility that houses a large number of cancer patients.	Dr. Griffin asked if the deaths were due to co-morbid diseases or jut total deaths? Mr. Schneider responded that these were for total deaths. Dr. Griffin asked if the death analysis included the entire offender population? Mr. Schneider responded that this was just the list of the top ten facilities with the most occurrences of offender deaths. This was listed to note the significance of the types of patients that are housed at these facilities. Ms. Frazier noted that this data shows the death rates did not increase or decrease due to the facility having 24-hour coverage.	

Agenda Topic / Presenter	Presentation	Discussion	Action
- 24-Hour Staffing Review(Cont.)		Chairman Madden asked if there were any other indicators in the past that lead to housing specific types of offenders at these facilities? Mr. Hightower responded that the TDCJ Classifications Department together with Health Services will assign offenders according to the needs of that particular individual such as those requiring more extensive health care. Dr. Kelley agreed that the offenders are matched to the unit that provides the necessary medical care. Dr. Raimer added that this is no different than an individual having a heart attack at home and call EMS who responds accordingly.	
	Mr. Schneider then reported, for the UTMB on-call nursing hours in comparison to the dollar amount, there was a 158% growth of dollars and hours in FY 2004 as it was related to cut backs that occurred in FY 2003. On-call hours and dollars from FY2004 to FY 2005 was 2% and an increase in FY 2006 to 2007 of 7%- 8%. He further noted that the overall increase is also attributable to the increase in units from 34 in FY 2003 up to 48 in FY 2007.	Dr. Griffin then asked if the conclusion is that those dollars saved had no negative patient outcome. Mr. Schneider responded that the committee did not make the comparison of the net gain or loss between the staff that was cut and what was ultimately spent on staff that were on-call. Chairman Madden asked if the review should go beyond FY2003 to see about those numbers prior to the budget cuts? Dr. Raimer responded that it was approximately 35 to 40 patients offsite in local hospitals which then affected TDCJ because of the number of correctional officers needed for security.	
	Mr. Schneider stated that the committee continues to analyze the total cost of making the non-24 hour facilities to function 24 /7 with the appropriate mix of staff that is required for operation.		

Agenda Topic / Presenter	Presentation	Discussion	Action
- 24-Hour Staffing Review (Cont.)	Mr. Schneider then stated that an alternative may be is to add three LVN's to each of the non 24-hour facility at approximately $40K in salary which is being calculated without any differential pay. The other is the EMT option with similar staffing expense. The operational difference would be that the EMT according to the Board of Nursing Examiners must function as a non-licensed personnel therefore can not independently make medical interventions and are required to work under the supervision of a physician.	Dr. Raimer added that it was his understanding that LVN's can no longer make an assessment on a patient as in the past without supervision and that he would ask Mr. Gary Eubanks, Director of Nursing to relay what was discussed at the last meeting of the Board of Nursing Examiners. Mr. Eubanks stated that four years ago, the LVN's had their own rules. With the merging of both RN's and LVN's into one single Board of Nursing Guidelines, the LVN's now can only collect the information, then relay that information collected to an RN or a physician provider. He further stated that they are in the process of re-designing the delivery system as the LVN's can not be independently on-call and require an RN to make the initial call. Chairman Madden asked how big of an impact did this change have on the system? Dr. Raimer responded that currently UTMB have approximately 1700 nurses and only 400 of those are registered nurses. Dr. DeShields responded that the Tech sector currently have approximately 500 nurses and only 165 of those are registered nurses. Dr. Walkes then asked if this report was an recommendation being made or just an informational update? Mr. Schneider concluded by responding that this was being presented as an update of what has been looked at so far before a recommendation is made on the study.	
IX. Medical Director's Update - TDCJ **- Mike Kelley, M.D.**	Hearing no further discussions, Dr. Griffin thanked Mr. Schneider for the update then called on Dr. Kelley to provide the TDCJ Medical Director's Report. Dr. Kelley stated that he would be presenting the TDCJ Medical Director's Report found at Tab E of the agenda packet on behalf of Dr. Linthicum who had a scheduling conflict.		

Agenda Topic / Presenter	Presentation	Discussion	Action
- TDCJ Medical Directors Report (Cont.)	During the fourth quarter of FY 2007, Dr. Kelley reported that 15 operational review audits were conducted. The Patient Liaison Program and the Step II Grievance Program received a total of 3,053 correspondences and of those total number, 182 or 5.96% action requests were generated. The Quality Improvement Quality / Quality Monitoring staff performed 40 access to care audits this quarter. Of the 40 facilities representing a total of 360 indicators reviewed, 37 of them fell below the 80% threshold which represents 10.3% which is a decrease from the previous quarters. The Capital Assets Contract Monitoring Office audited 13 units and those audits are conducted to determine compliance with the Health Services Policy and State Property Accounting Inventory procedures. Dr. Kelley next reported that the Office of Preventive Medicine monitors the incidence of infectious diseases for TDCJ. For this fourth quarter, there was 169 reports of suspected syphilis compared with 171 in the previous quarter; 1,285 Methicillin-Resistant Staphylococcus cases were reported compared to 1,560 during the same quarter of FY 2006. There was an average of 21 Tuberculosis cases under management per month during this quarter which is the same average as the same quarter of the previous fiscal year. Dr. Kelley noted that the Office of Preventive Medicine also began reporting the activities of the Sexual Assault Nurse Examiner Coordinator which is funded through the Safe Prisons Program. He further reported that 33 training sessions have been held on 28 units as of this date with 184 medical staff receiving training. Dr. Kelley recalled that this position provides in-service training to unit providers in the performance of medical examination, evidence collection and documentation, and the use of the sexual assault kits. The number of peer educators decreased from last year because those who are inactive or who have been released were removed from the roster. There are currently programs on 94 of the 111 units.		

Agenda Topic / Presenter	Presentation	Discussion	Action
- TDCJ Medical Director's Report (Cont.)	The Mortality and Morbidity Committee reviewed 100 deaths. Of these, 10 were referred to peer review committees. Dr. Kelley next reported that the Office of Mental Health Monitoring and Liaison made 81 contacts with county jails who identified 200 offenders with immediate mental health needs prior to TDCJ intake. The mental health / mental retardation history were reviewed on 19,267 offenders brought in to TDCJ and intake facilities were provided with critical mental health data not otherwise available for 1,194 offenders. He further reported they visited 17 administrative segregation facilities where 4,160 offenders observed and 1,728 interviewed and 6 referred for further evaluation. Dr. Kelley continued by stating that during the fourth quarter of FY 2007, 10% of the combined UTMB and TTUHSC hospital (2,196) and infirmary (472) discharges were audited. The chart on page 110 of the agenda book provides the breakout information. Also during this quarter, 8 units were presented to the panel of commissioners for initial accreditation and Dr. Kelley reported that the agency now has a total of 72 accredited units. Dr. Kelley concluded his report by stating that the summary of current and pending research projects is found under the consent items.	Chairman Madden asked for clarification on whether the 1,728 offenders interviewed was for the total offender population? Dr. Kelley clarified that he was referring only to the Ad Seg facilities that were visited.	
- **Medical Directors Report TTUHSC** **- D. DeShields, M.D.**	Hearing no further questions, Dr. Griffin thanked Dr. Kelley for the update. He then asked Dr. DeShields if she had anything to report for the TTUHSC sector to which she responded that she did not.		
- **Medical Directors Report UTMB** **- Troy Sybert, M.D.**	Dr. Griffin next called on Dr. Troy Sybert to provide the UTMB Medical Director's Report. Dr. Sybert stated that he would present the UTMB Medical Director's report on behalf of Dr. Murray who		

Agenda Topic / Presenter	Presentation	Discussion	Action
- Medical Director's Report UTMB (Cont.)	was unable to attend due to scheduling conflict. Dr. Sybert stated that he and his colleague, Dr. Clemens were hired back in July 2006 to start a hospitalist group at Hospital Galveston. He then stated that he would be providing a brief update on the progress of these initiatives. He reported that the opening of the skilled nursing facility in February is working quite well in the hospital with the CMC nursing staff and physicians. In May 2007, approval was given to move ahead with the expansions in the areas that were not being utilized to the fullest capacity. Implementation of the final phases of that expansion will continue over the next 6 to 8 weeks. Dr. Sybert then reported that there are 96 beds at the Hospital Galveston Acute Care that operates within a 5 to 10% margin of vacancy. He further noted that there are 425 CMC infirmary beds that operate at 5 to 10% margin of vacancy and the newest expansion plan will have an additional 110 beds whereas offsite offers <10. Dr. Sybert next reported on the comparison of the major acute diagnosis between November 2006 through May 2007 which include chest pains that have gone down as it is one case that can be diagnosed. He further noted that heart failures increased; chronic obstructive pulmonary disease (COP) remained constant; and saw a tremendous increase in celllulitis (277) with complication during that particular time frame. Dr. Sybert then noted that the average length of hospital stays as sourced by CDC's National Hospital Discharge Survey shows that those 65+ stayed longer than those below 44 years of age. The length of stay at community hospitals between 1981 and 2005 averaged between 5.6 to 6 days as sourced by the American Hospital Association Annual Survey. The break-out of the average daily census in FY 2006 was 428 at John Sealy which is a teaching hospital compared to 408 in FY2007 at TDCJ hospital. The average length of stay at John	Dr. Griffin clarified that cellulites is an infection of the skin and underlying tissue, which can result after problems with circulation, diabetes, etc.	

Agenda Topic / Presenter	Presentation	Discussion	Action
- Medical Director's Report UTMB (Cont.)	Sealy for both FY 2006 and 2007 was at 5.1 days compared to 6.5 in FY 2006 at the TDCJ hospital and 6.3 in FY 2007. The case mix index is an indication for resources being used to take care of a patient and noted that the farther the number is from 1, the sicker the patient. John Sealy's case mix ranged from 1.17 in FY 2006 to 1.15 in FY 2007 compared to TDCJ Hospital at 1.26 in FY 2006 and 1.32 in FY 2007. Dr. Sybert further noted that the goals of the new Hospital Galveston efforts include focusing on the understanding and facilitating of patient flow; optimize system-based perspective to include reducing the length of stay in acute care beds; characterize infirmary patient population and improve patient care. Dr. Griffin thanked Dr. Sybert for the report. He then asked Dr. Raimer to introduce Dr. Winslade who will be reporting on Organ Transplants in Correctional Health Care System.		
X. Organ Transplants In Correctional Health Care System **- W. Winslade, Ph.D.**	Dr. Raimer introduced Dr. William Winslade, Professor of the School of Medicine at UTMB then stated that Dr. Winslade's committee looked at organ transplant issues from a national perspective. Dr. Raimer next introduced Dr. Bernadette McKinney, J.D., Ph.D., Post Doctoral Fellow, UTMB Institute for Medical Humanities who assisted in this study. Dr. Winslade reported that in 2002, a Federal Court in California not only authorized organ transplant but awarded $35,000 for deliberate indifference that led to a heart transplant for an individual in prison. This brought into question the legal duties to offenders. Dr. Winslade noted that the 8th and 14th Amendment by interpretation of the US Supreme Court states that when caring for offenders, you can not be deliberately indifferent to a serious medical need. Dr. Winslade then referred to two cases in particular, Barron v. Keohane and Clark v. Hendrick which addressed prison policies that precludes offenders who might be eligible for organ transplants as being looked at unfavorably by the courts. Dr. Winslade stated as noted by reports being presented today, there are numerous offenders diagnosed with cirrhosis which is one of the major indicators of liver failures. The other cause of liver failure he stated is Hepatitis C.	The presentation titled "Organ Transplants for Offenders, Law Ethic, and Economics" is provided at Attachment 5.	

Agenda Topic / Presenter	Presentation	Discussion	Action
- Organ Transplants in Correctional Health Care System (Cont.)	Dr. Winslade further reported that the Federal Bureau of Prison have now adopted policy that state that if an individual has been identified by a physician as being in need of a transplant, the individual should then be evaluated for eligibility by the transplant center. It is the responsibility of the institution to diagnose and recommend treatment for their patients. He further reported that with the aging population, the cost of providing health care to those 55+ are three times higher than the younger population. Kidney transplants in the long run may be less costly than dialysis or the costs associated with the end-of-life care or hospice care. Dr. Winsldate recommended updating policies by looking more closely at the law and ethics as it relates to organ transplants; further studies be done on cost effectiveness as it relates to long term care and drug costs. He concluded by stating that his committee has put together a report that will be available upon request. Hearing no further discussions, Dr. Griffin thanked Dr.Winslade for the report.	Dr. Kelley clarified that the current policies does not say "no organ transplants". It instead looks at other different options such as hospice care or recommendations for MRIS as the patient's health deteriorates.	
XI. Updates to Hepatitis Policies **- Mike Kelley, M.D.**	Dr. Griffin then stated that he was going to change the order of the agenda and called on Dr. Kelley next to provide the updates to the Hepatitis Policies. Dr. Kelley noted that there are major changes to the Hepatitis policy. It is now separated into two documents, one containing the policy requirements and the other containing the technical reference that provided background information and serves as a resource for clinical decision making. He further noted that due to a recent change in guidelines from the Advisory Council on Immunization Practices, he would like to propose a modification to I.D.2 that is currently in the agenda packet at Tab H to recommending the use of Hepatitis A vaccine for prevention of contacts who are anti-HAV antibody negative, younger than 40, and has no evidence of chronic underlying liver disease instead of the use of the immune globulin.		

Agenda / Presenter	Presentation	Discussion	Action
- Updates to Hepatitis Policy (Cont.)	Dr. Kelley then stated that the changes added requirements for baseline testing, chronic care follow-up, and criteria to consider antiviral treatment for Hepatitis B that are distinct from Hepatitis C. He further noted that this would follow the American Association for the Study of Liver Disease Guidelines. He further noted that the criteria for considering an offender with Hepatitis C for antiviral treatment has also changed considerably. Dr. Kelley reported that the basic criterion is the new indicator, AST Platelet Ration Index (APRI) which correlates with fibrosis in the liver. APRI scores below 0.42 will generally not be considered for treatment. Those with scores over 1.2 will be considered for treatment without liver biopsy. Those with scores in between will have a liver biopsy and be treated according to the findings. He continued by noting that re-treatment for Hepatitis C may now be considered if an offender relapsed after treatment with standard interferon with or without ribaviron or for those who do not respond to standard interferon alone. Dr. Kelley then stated that a new section has been added for management of advanced liver disease which include screening for hepatocellular carcinoma by ultrasound every six months; considering referral for liver transplant evaluation; instruction to obtain an advance directive; consider for hospice placement; and, referral for Medically Recommended Intensive Supervision (MRIS). The other two items mentioned in the advanced liver disease section would require further development. Dr. Kelley stated that the first of which is sheltered housing for patients with end-state liver disease; and the second is the Extraordinary Care Review Panel that would review cases being considered for liver transplant evaluation. Dr. Griffin asked if there were any comments or questions before he entertained a motion.	Dr. Jumper asked how many biopsies are being considered as the budget for the biennium have already been set. Dr. Kelley responded that he did not have the exact numbers at this time. Dr. Griffin added there will be considerations in terms of how to step up the treatment based on available funding. Mr. Cavin recommended that the committee get more cost data associated with these policy changes before any action is taken.	.

Agenda / Presenter	Presentation	Discussion	Action
- Updates on Hepatitis Policies (Cont.)		Dr. Raimer agreed with Mr. Cavin that the committee be provided with the fiscal impact notes prior to taking a vote. Ms. Frazier asked if there were any external pressures associated with having to implement the policy changes at this meeting? Dr. Kelley responded that he did not, and will ask for a special research project to do a fiscal report on these changes. Chairman Madden asked how many offenders in the system have any form of Hepatitis? Dr. Griffin responded that a seroprevalance study was done a few years back and it was approximately 28.8%. Chairman Madden then asked if that number was for offenders coming in and then diagnosed? Dr. Kelley responded the number was for those coming in and the diagnosed are just over a half of that number.	After further discussion, Dr. Griffin stated that the Update on Hepatitis Policy Changes will be tabled at this time, then asked Dr. Kelley to provide the fiscal analysis on these changes being requested at the next CMHCC meeting.
XII. TCOOMMI Update - **James Griffin, M.D**.	Dr. Grffin noted that due to the number of special reports being presented combined with time constraints; the TCOOMMI Update will be presented at the next CMHCC meeting. He then stated that there will be a short five minute recess.		
XIII. System Leadership Council Update **- Denise DeShields, M.D.**	After the five minute recess, Dr. Griffin reconvened the meeting under Chapter 551, Texas Government Code then called on Dr. DeShields to provide the Joint Committee Update on the System Leadership Council. Dr. DeShields noted that the Overview of the System Leadership Council (SLC) is provided at Tab G of the agenda packet.		

Agenda / Presenter	Presentation	Discussion	Action
- System Leadership Council (Cont.)	Dr. DeShields reported that the System Leadership Council (SLC) is charged with the routine oversight of the CMHCC Quality Improvement Plan including the monitoring of statewide access to care and quality of care indicators. The SLC is a multidisciplinary committee composed of both clinical and administrative discipline directors of all three partner agencies and the chairperson is appointed annually by the presiding chair of the CMHCC. She noted that a list of the membership is provided on pages 130 – 131 of the agenda packet. Dr. DeShields further noted that the SLC meets quarterly in Huntsville. Included in the agenda are reports presented by the discipline directors on the nine access to care indicators; reports on continuity of care indicators; monthly grievance exception reports and safe prisons updates provided by the TDCJ Health Services; and updates from the CMHCC committee staff. Additional pertinent issues related to the provision and monitoring of offender health care are also presented. She further stated that other SLC functions include providing direction and support to the Quality Improvement Plan; using data collected to identify aspects of care for systemwide improvement; facilitate information flow to the unit medical facilities; receive and evaluate reports, and recommend corrective actions. The nine access to care indicators of which three are medical, three are mental health, three are dental indicators and the types of indicators and the facility compliance rates are provided at page 79 of the agenda book at Tab A under the consent items. Dr. DeShields further noted that the continuity of care indicators are developed annually by the SLC. The SLC members submit indicators for consideration and these indicators are voted upon at the end of each fiscal year for the ensuing year. On page 137 of the agenda packet lists the indicators monitored by the SLC for the last two fiscal years then noted that the majority of the access to care indicators addressed compliance issues due to staffing shortages. For FY 2008, the committee will continue to monitor the nine access to care indicators and four new indicators have been developed which are also listed on page 139 of the agenda packet. She concluded by stating that adequate level of trained nursing and provider staff is needed to maintain appropriate access to care.		

Agenda / Presenter	Presentation	Discussion	Action
XIV. Financial Reports **- Lynn Webb**	Dr. Griffin thanked Dr. DeShields for the update. Hearing no further discussions, called on Mr.Webb to provide the financial report. Mr. Webb noted that the July 2007 Monthly Financial Report is provided at Tab I and the FY 2007 Fourth Quarter Financial Report is provided at Tab J of the agenda packet. He further noted that he will be focusing on the FY 2007 year end report as compared to FY 2006. The average population served through the fourth quarter FY 2007 as noted by Mr. McNutt earlier was 151,813 compared to 151,284 the same quarter in FY 2006. The older offender population age 55+ continues to rise from FY 2006 at a rate of 9.5% for FY 2007. The HIV+ offender population remains steady at about 2,573 for FY 2007 as compared to FY 2006 of 2,498 or 1.7% increase. Through August 2007, FY 2007, the health care costs totaled $432.6M compared to $420.4M in FY 2006 or a 2.9% increase. Onsite services comprised of $207.8M representing about 48.0% of the total health care expenses. Pharmacy services totaled $41.9M representing approximately 9.7% of the total expenses. Mr. Webb further noted that this was an increase of 8.3% as compared to the amount of $38.6M reported in FY 2006. Of this amount, drugs purchased went up 8.9% from $29.8M to 32.6M or $2.7M per month. Offsite services for this quarter accounted for $129.2M or 29.9% of the total expenses. This amount decreased by 0.7% as compared to $130.2M for FY 2006. Mental Health Services totaled $39.3M or 9.1% of the total costs and indirect support expenses accounted for $14.4M which represented 3.3% of the total costs. Mr. Webb then stated as noted on Table 5 on page 204 of the agenda packet, the total cost per offender per day for all health care services statewide through August 2007 was $7.81. When benchmarked against the average cost per offender per day for the prior four fiscal years of $7.53, the cost has increased about 3.7%. For UTMB, the cost per offender per day was $7.87, slightly higher than the average cost per day for the last four fiscal years of $7.66. For TTUHSC, the cost per offender per day was $7.56, significantly higher than the average cost per day for the last four fiscal years of $7.05.		

Agenda / Presenter	Presentation	Discussion	Action
- Financial Reports (Cont.)	Mr. Webb next reported that the aging offenders continue to reflect their increased demand on health care resources as they access three times as many encounters with health care staff; hospitalization utilization rates of four times that of younger offenders while only making up 6.4% of the population. The aging offenders account for more than 27% of hospital costs. HIV continues to be the single largest component at almost $1.2M per month comprising 45.7% of the total drug costs. Psychiatric drugs accounted for 5.6% of the drug costs and Hepatitis C therapies accounted for 4% of the drug costs. In terms of fund balances, both universities report that they hold no such reserves for correctional health care. Mr. Webb then stated that a correction was needed to report a loss for UTMB through the end of August 2007 of $1.8M and a correction noted to the TTUHSC as a reported gain of $1.9M. He further stated that both of these balances were partially off-set by FY 2006 losses of $0.8M for UTMB and $2.0M for TTUHSC. For the biennium, UTMB had a net fund balance loss of $2,622,126 and TTUHSC had a net fund balance loss of $96,249. At the end of August FY 2007, the CMHCC accounts had a total balance on hand of $35,301 which lapsed back to the State Treasury as reported earlier by Mr. Hightower due to Rider 69. Mr. Webb then noted that this amount would have been larger except for the $230,000 spent on Pandemic Flu vaccines at the end of FY 2007	Dr. Griffin asked if there were any updates from the supplier of the Pandemic Flu vaccines on its 5 year shelf life? Dr. Kelley responded that Tamiflu still has a five year shelf life at this time, but they are developing some type of re-certification after testing samples to see about the possibility of extending that shelf life.	
	Hearing no further discussion, Dr. Griffin thanked Mr. Webb for the Financial Report.		
XV. Public Comments **- James Griffin, M.D.**	Dr. Griffin next noted that at each regular meeting of the CMHCC will include an opportunity for the Committee to receive public comments and noted that there were three registered speakers. He then requested that comments be limited to 3 minutes each and should refrain from discussing specifics of individual cases due to medical confidentiality provisions. Dr. Griffin first called on Ms. Helga Dill, Texas CURE.		

Agenda / Presenter	Presentation	Discussion	Action
- Public Comments (Cont.)	Ms. Dill stated that she was representing Texas CURE and hoped to be able to attend the CMHCC more regularly as she did in the past.		
- Ms. Helga Dill	Ms. Dill then noted that Dr. Lannette Linthicum and Dr. Owen Murray made it possible for Texas CURE to visit the Hospital in Galveston and the Michael Unit which provided a better understanding and oversight of how the system operates. She added that they met with staff who were very informative and was a great overall experience. Ms. Dill stated that she also wanted to thank Dr. Raimer and the committee members for allowing the public to address their concerns. Dr. Griffin next called on Ms. Marthann Dafft.	Dr. Raimer stated that it was a pleasure to host Ms. Dill and her colleagues. He also credited Ms. Dill and Ms. Carole Heine for providing the committee with their input and observations from their perspectives.	
- Ms. Marthann Dafft	Ms. Dafft stated that it is always rewarding to hear about the hard work the committee is doing. She reported that her son is doing well and even noticed that her son had gained weight when she last visited him. The only concern her son expressed at that time was his wanting to have a job. Ms. Dafft then stated that she just received a letter from him saying that he got a job cleaning a wing on third shift and seemed so much better. She again thanked the committee for stepping in to take care of her son's health care needs. She concluded by stating that if there was anything that she can do to assist the committee, to please let her know. Dr. Griffin thanked her for her comments then called on Ms. Allison Garrett.		
- Ms. Allison Garrett	Ms. Garrett stated that she also wanted to express her appreciation for what the committee is doing and the level of concern being expressed here at this meeting. She stated that she was representing herself and an individual who recently had a pace-maker put in. The individual had an incident in June and transported to Galveston by ambulance. Ms. Garrett stated that her main concern is the lack of communication between the physician providers at the Hospital in Galveston and the physicians on the facilities as to the health care needs of these individuals who are being transported back and forth between the various locations. She also expressed frustration that the staff after dealing with so many people day in and day out tend to become immune to the offender's health care needs and wanted the Committee to be aware of this lack of communication by the health care providers.	Dr. Griffin responded that the coordination of services in sub-specialization care in a correctional environment are as complex as they are in the free-world hospitals and hope to address those issues with the availability of the electronic medical records. He then thanked Ms. Garret for relaying her concerns to the committee.	

Agenda / Presenter	Presentation	Discussion	Action
XVI. Date and Location of Next Meeting **- James Griffin, M.D.**	Dr. Griffin then noted that the next meeting is scheduled for 9:00 a.m. on March 25, 2007 to be held at the Dallas Love Field Main Terminal Conference Room A. He further noted the following CMHCC meeting dates for CY 2008: Tuesday, March 25, 2008 Tuesday, June 10, 2008 Wednesday, September 17, 2008 Tuesday, December 9, 2008		
XVI. Adjournment **- James Griffin, M.D.**	Dr. Griffin hearing no further discussions thanked everyone for attending and thanked the committee staff for their hard work. Hearing no further discussions, Dr. Griffin adjourned the meeting at 12: 35 p.m.		

_____ _____

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

Date:

ATTACHMENT 1

ATTACHMENT 2

Attachment 1

Resolution of Appreciation
Allen D. Sapp, Jr.

WHEREAS, Allen D. Sapp began his employment with the Texas Department of Criminal Justice formerly known as the Texas Department of Corrections in the State of Texas in 1979, and has served admirably in a variety of professional and administrative capacities during his tenure; and,

WHEREAS, Mr. Sapp served as the Executive Assistant for Special Projects in the Executive Division of the Texas Department of Criminal Justice and has most recently served as the Assistant Director for Administrative Services, with the Correctional Managed Health Care Committee and,

WHEREAS, he has served on, actively participated in and chaired a wide variety of workgroups and standing committees to include the System Leadership Council, Policy and Procedures Committee, the Joint Committee on Information Services, TCOOMMI Advisory Committee; and,

WHEREAS, Mr. Sapp was instrumental in developing and managing the transition to the correctional health care program partnership between the Texas Department of Criminal Justice, the Texas Tech University Health Sciences Center and the University of Texas Medical Branch at Galveston that serves as a model for innovation, efficiency and cost-effectiveness, resulting in recognition at both the state and national level; and,

WHEREAS, the correctional health care program has greatly advanced and benefited from his demonstrated leadership, financial and legislative expertise, communication skills, professionalism, thoughtful and dedicated guidance through a period of unprecedented growth and achievement; and,

WHEREAS, Mr. Sapp is most recognized by the state leadership and by his peers as a person who exemplifies the highest ethical and moral standards both on a professional and personal basis, and is looked upon as the ideal role model in his profession for those most admirable attributes, and

WHEREAS, the Correctional Health Care Committee, its staff and its partner agencies wish to gratefully acknowledge the contributions, leadership and expertise of Mr. Sapp as he retires from state employment to accept new challenges;

THEREFORE BE IT RESOLVED, that the Committee adopt this resolution as an expression of our sincere appreciation for the professionalism, dedication and outstanding service of Allen D. Sapp, Jr. to the Texas correctional health care program and present to him a signed and framed copy of this resolution with our collective best wishes for success in future endeavors.

Adopted this 4th day of December in the Year 2007, by the Correctional Managed Health Care Committee.

James D. Griffin, M.D.
Chairman

Allen R. Hightower
Executive Director

Attachment 2

Summary of Critical Correctional Health Care Personnel Vacancies
Prepared for the Correctional Managed Health Care Committee

As of November 2007

Title of Position	CMHCC Partner Agency	Vacant Since (mm/yyyy)	Actions Taken to Fill Position
Director of Clinical Services – Physician III	TDCJ	9/1/07	An offer has been made to a physician who will start on December 11, 2007.
Physician II	TDCJ	9/1/07	Multiple postings and advertisement in journals and newspapers.
Nurse II – Contract and Quality Monitor	TDCJ	9/1/07	Posted 8/15/07, 9/11/07, 9/21/07, 10/1/07, and 10/17/07. No applicants. Division Director has requested an across the board salary increase for all RN II positions.
Nurse II – Contract and Quality Monitor	TDCJ	9/1/07	Posted 8/15/07, 9/11/07, 9/21/07, 10/1/07, and 10/17/07. No applicants. Division Director has requested an across the board salary increase for all RN II positions.
Nurse II – Contract and Quality Monitor	TDCJ	9/1/07	Posted 8/15/07, 9/11/07, 9/21/07, 10/1/07, and 10/17/07. No applicants. Division Director has requested an across the board salary increase for all RN II positions.
Nurse II – Contract and Quality Monitor	TDCJ	9/1/07	Posted 8/15/07, 9/11/07, 9/21/07, 10/1/07, and 10/17/07. No applicants. Division Director has requested an across the board salary increase for all RN II positions.
Nurse II – Contract and Quality Monitor	TDCJ	8/15/07	Posted 8/08/07, 8/24/07, 9/12/07, 9/21/07, 10/1/07, 10/17/07 and 10/26/07. No applicants. Division Director has requested an across the board salary increase for all RN II positions.
Nurse II – Contract and Quality Monitor	TDCJ	6/14/07	Posted 8/8/07, 8/24/07, 9/12/07, 10/1/07, and 10/17/07. No applicants. Division Director has requested an across the board salary increase for all RN II positions.
Public Health Technician II – HIV	TDCJ	11/1/07	The Division Director has requested an upgrade of this position to an LVN. Decision Memorandum is currently pending.

Attachment 3

UTMB Prison Healthcare Staffing Update

Major Positions In Review

- *Physicians*
- *Psychiatrist*
- *Registered Nurses*
- *Licensed Vocational Nurses*
- *Pharmacist*
- *Mid Level Providers*

Prison Healthcare Staffing

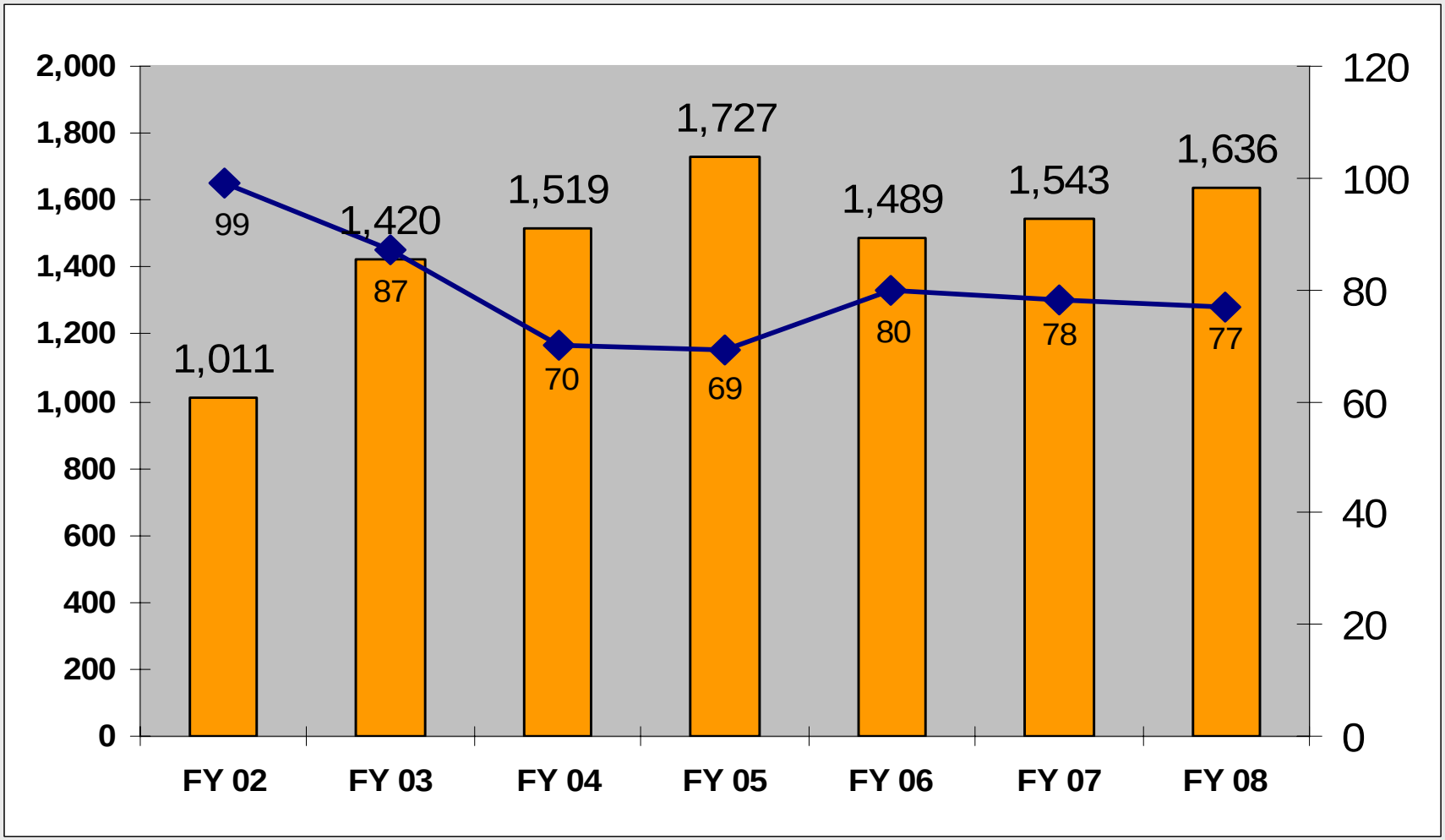
UTMB Average Salaries

Category	UTMB Avg.	*National Avg.
MD & DO	**$156,551**	**$157,400**
Psychiatrist	***$166,800***	**$178,069**
RN	**$59,300**	**$59,516**
LVN	***$37,815***	**$40,389**
Pharmacist	***$93,176***	**$98,932**
Mid-Level	**$90,657**	**$82,149**

As of 11/25/07

* Source – Salary.com HR Edition

Provider Workload



Inmate population increases outpace provider staffing.

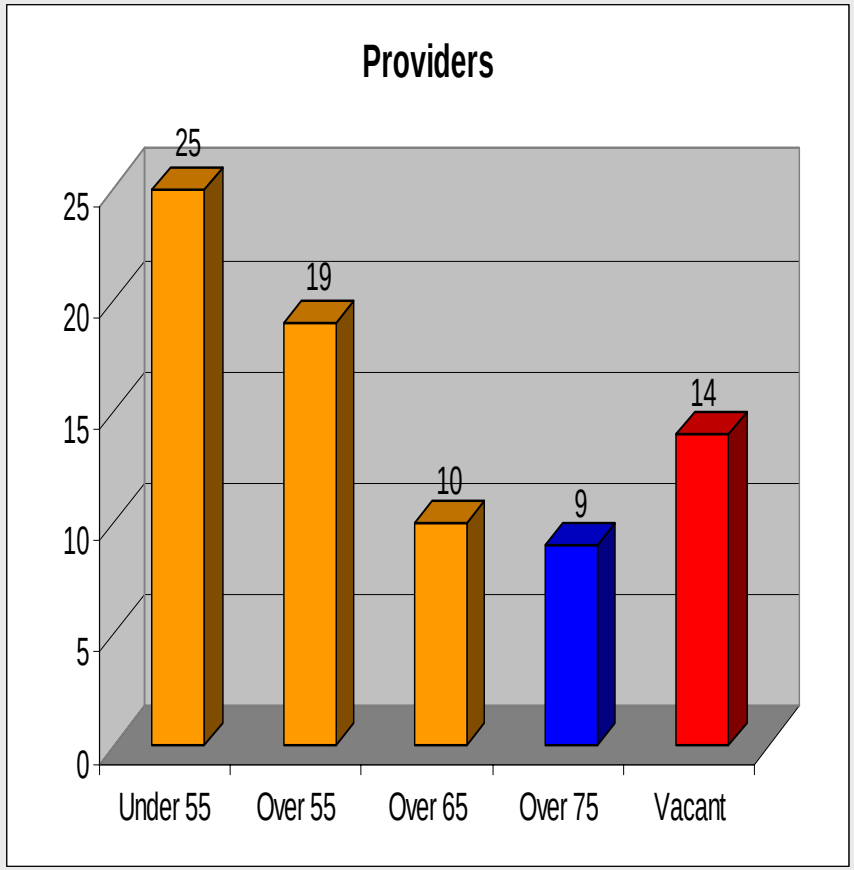
Providers

77 Total Positions

- 63 filled
- 14 vacant
- **18% vacancy rate**

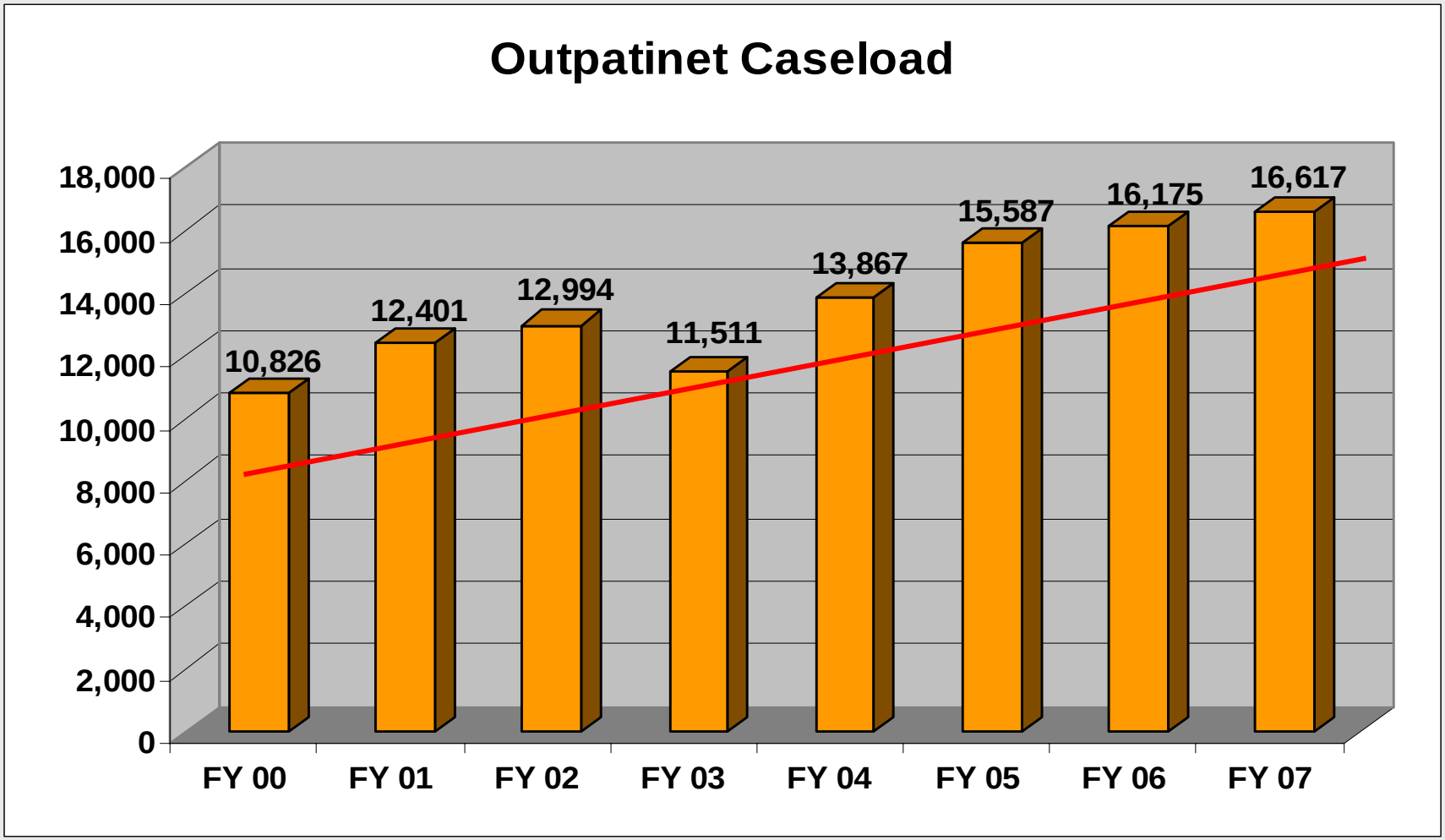
Average Age – 57

- 60% over age 55
- 31% over age 65
- 14% over age 75



In 5 years 46% of our current MD group will be past retirement age (65).

UTMB-CMC Mental Health Services
Outpatient Caseload 2000-2007



53% increase in caseload between 00 and 07

As of 11/25/07

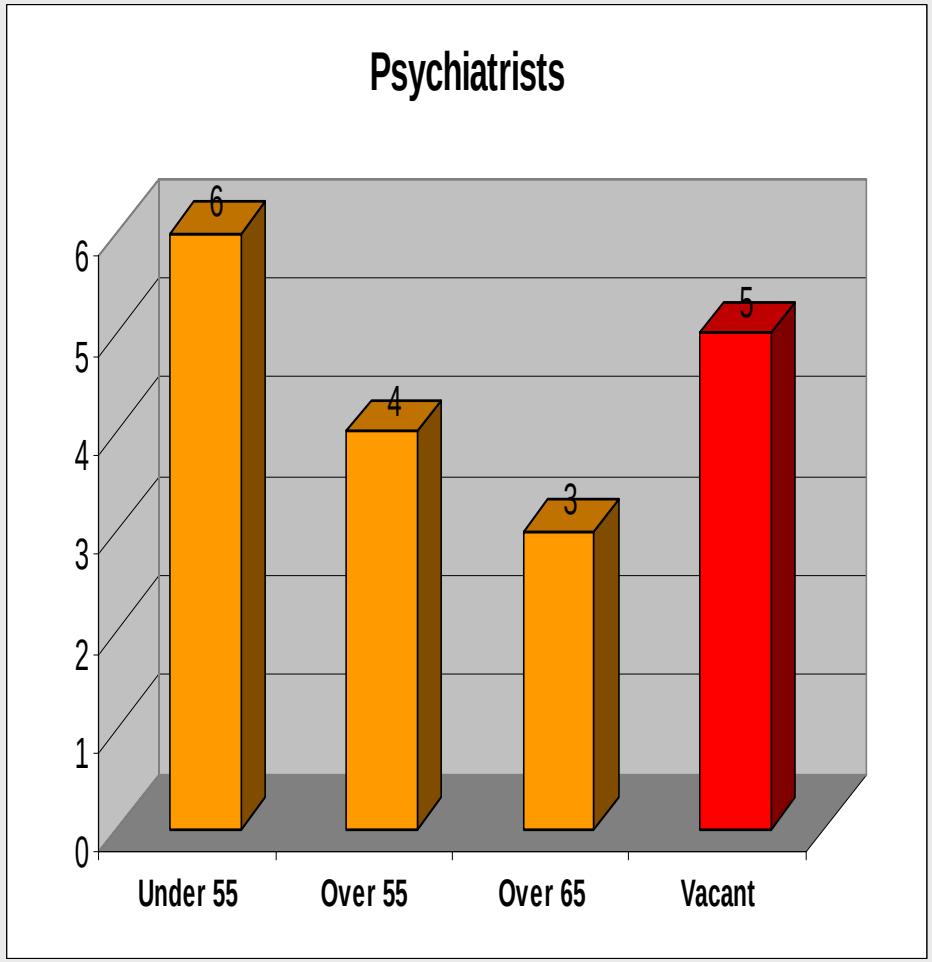
Psychiatrists

18 Total Positions

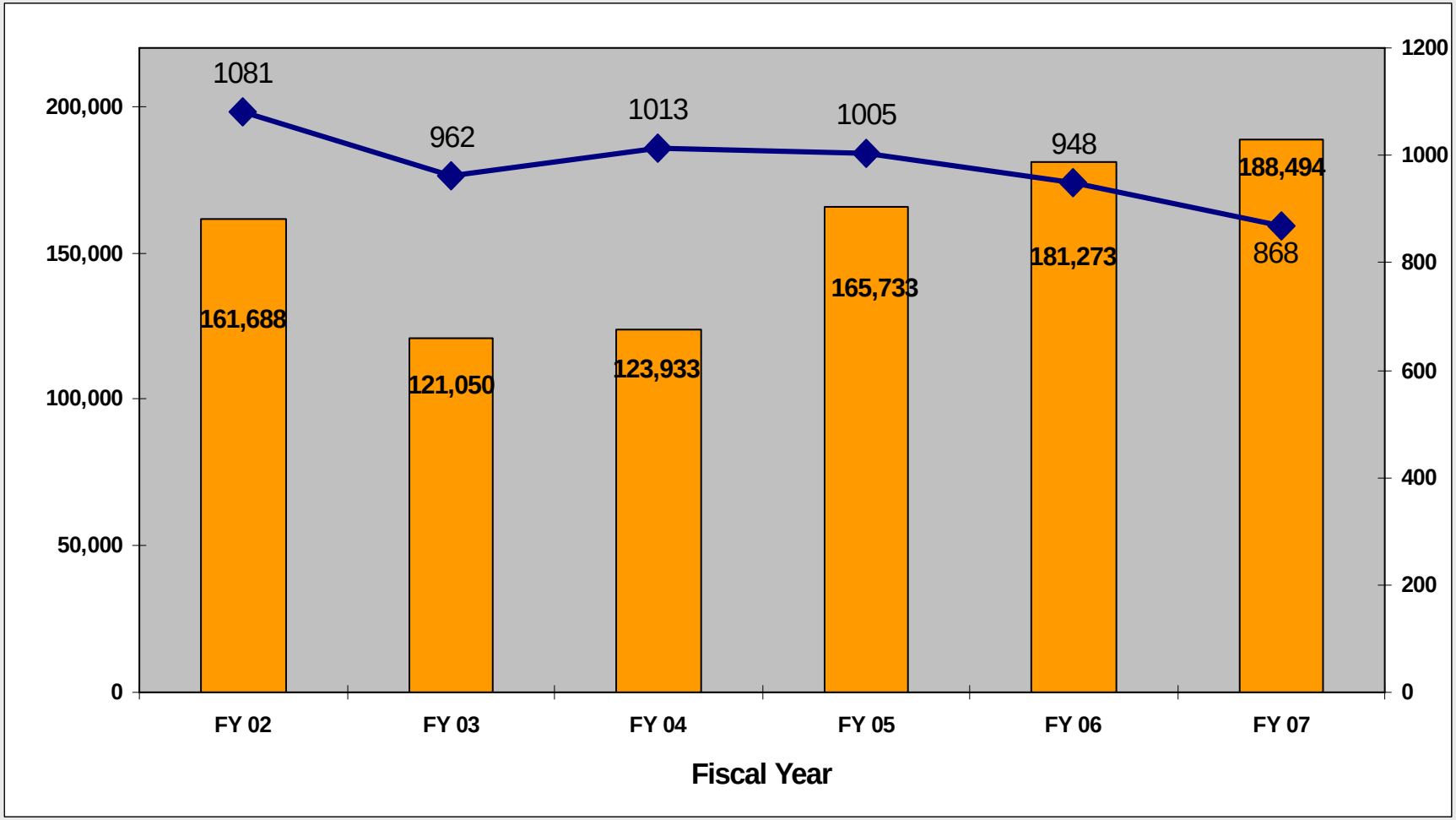
- 13 filled
- 5 vacant
- **28% vacancy rate**

Average Age – 56

- 53% over age 55
- 23% over age 65



Nursing Staffing Vs. Encounters



50% increase in encounter vs. 10% decline in staff (2003 to 2007)

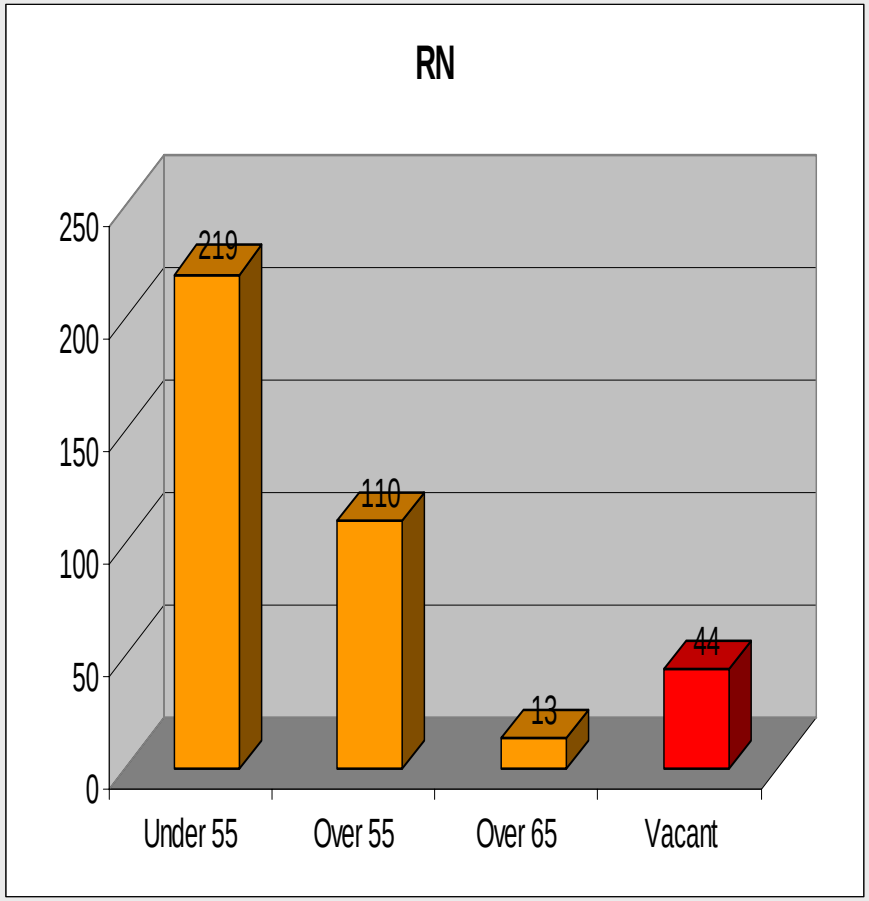
Registered Nurses

386 Total Positions

- 342 filled
- 44 vacant
- **11% vacancy rate**

Average Age – 51

- 36% over age 55
- 4% over age 65



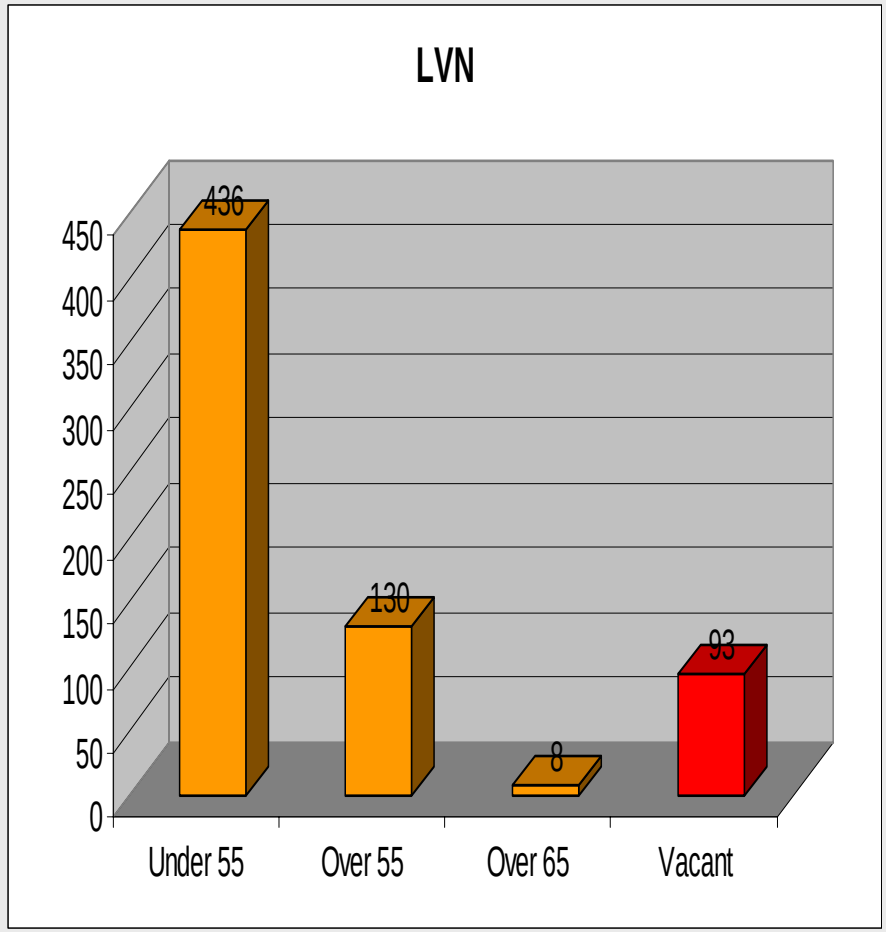
LVNs

667 Total Positions

- 574 filled
- 93 vacant
- **14% vacancy rate**

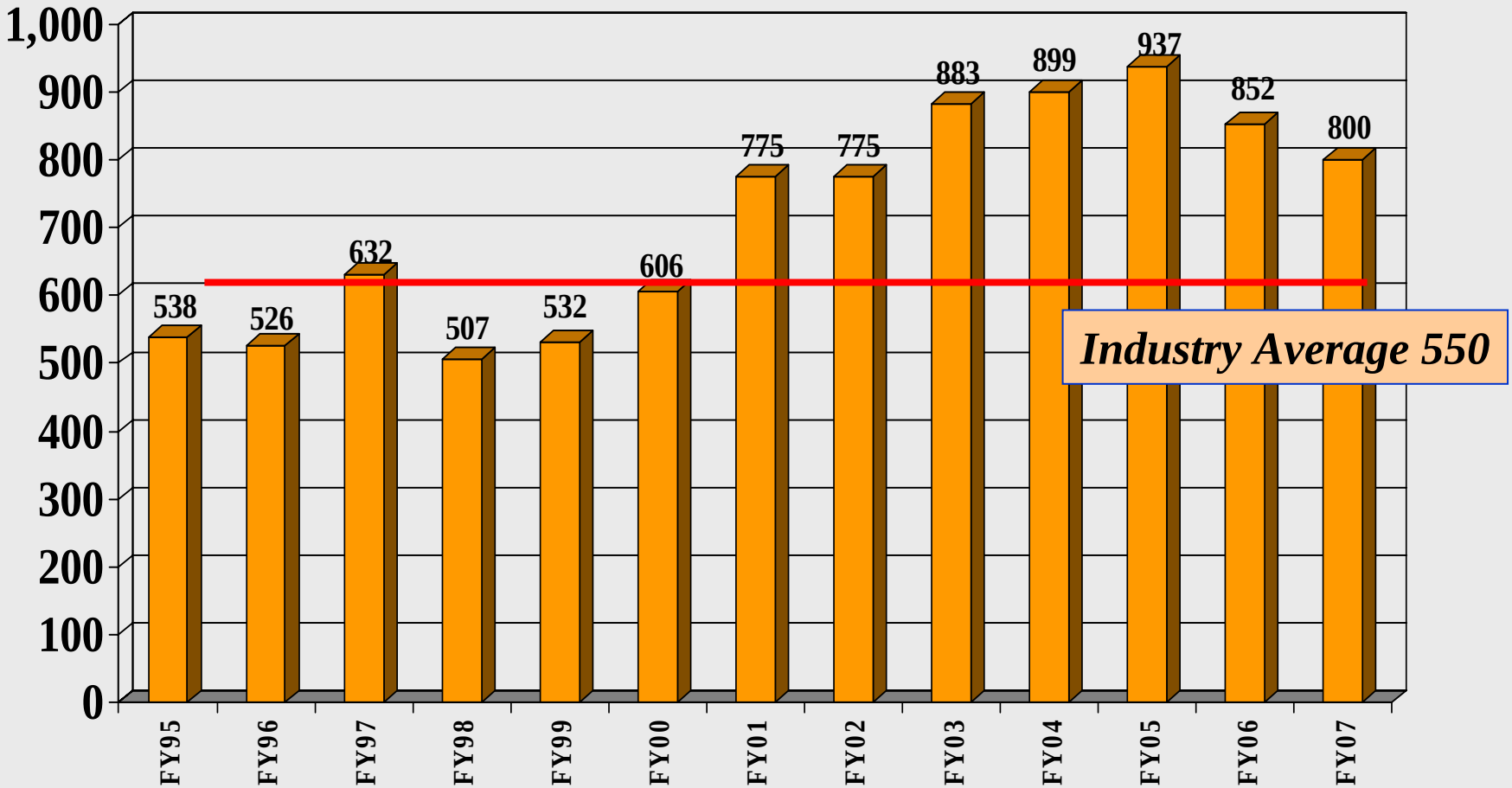
Average Age – 46

- 24% over age 55
- 1% over age 65



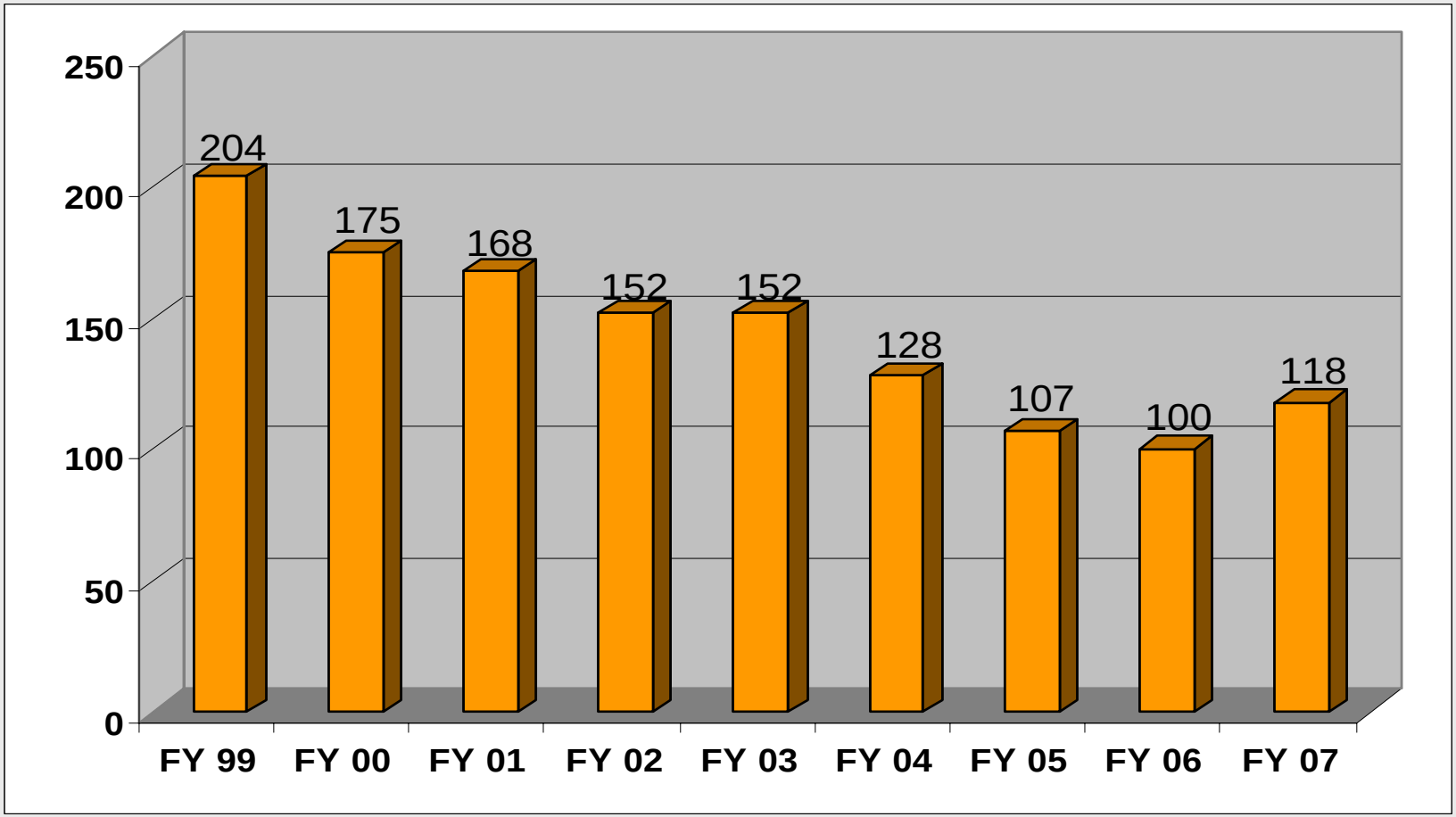
Pharmacist Workload

Rx/8hr RPh



Pharmacist Interventions

Interventions / 10,000 Rx



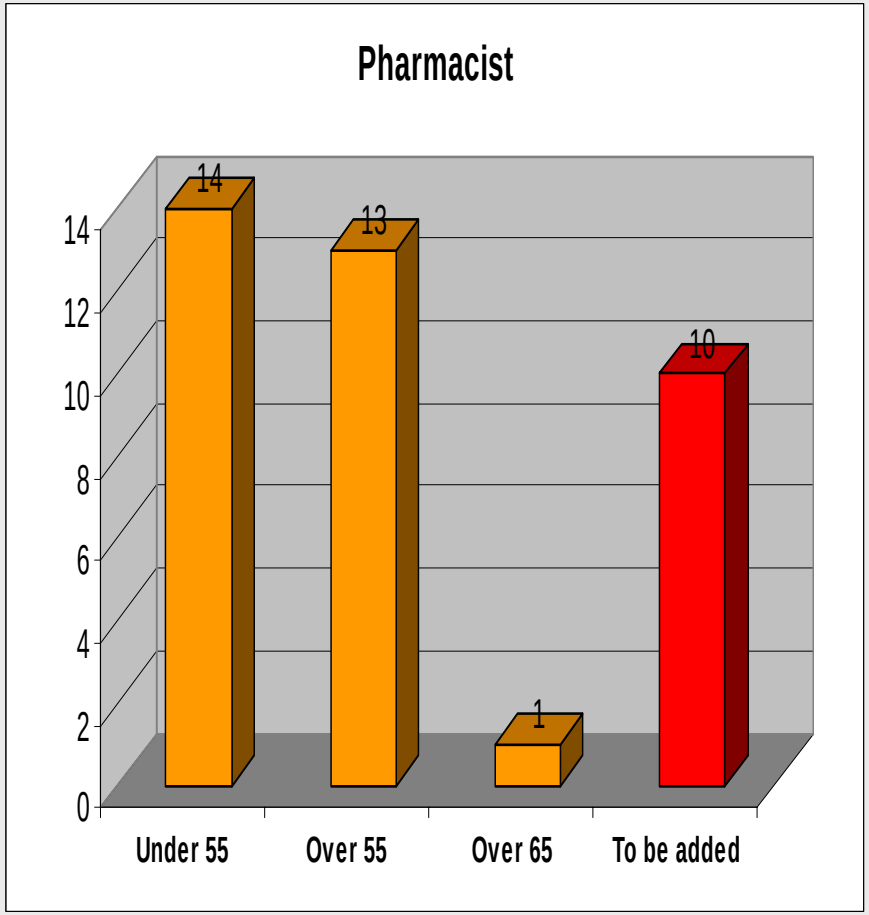
Pharmacists

30 Total Positions

- 28 filled
- **10 more need to be created**

Average Age – 51

- 50% over age 55
- 3% over age 65



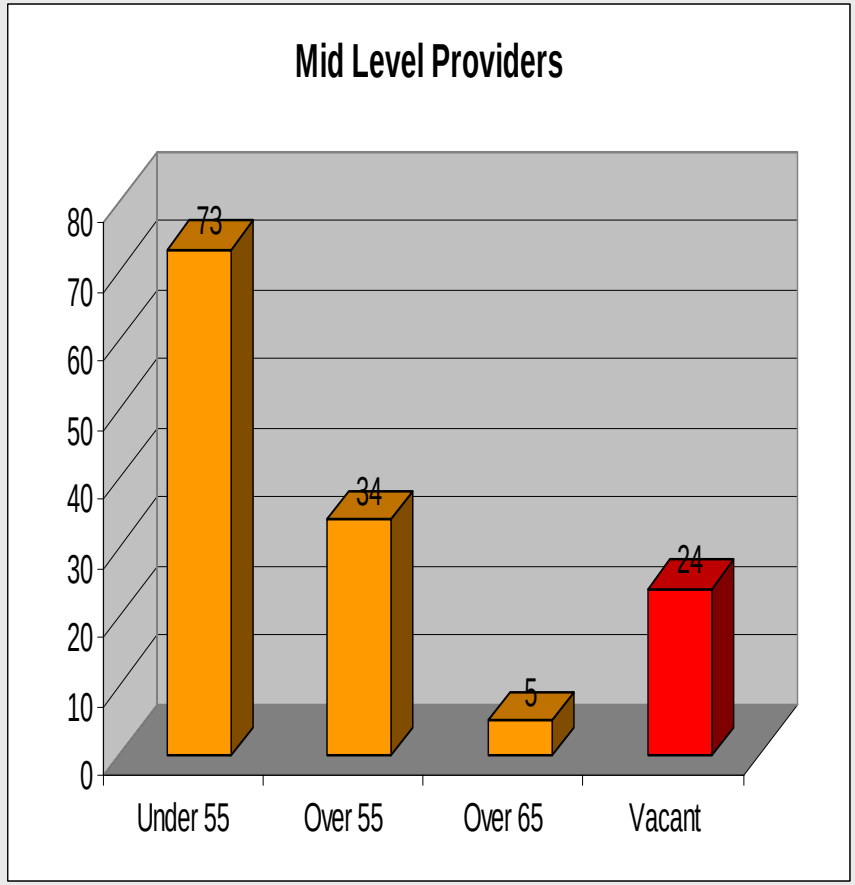
Mid Level Providers

136 Total Positions

- 112 filled
- 24 vacant
- **18% vacancy rate**

Average Age – 49

- 34% over age 55
- 4% over age 65



Issues Facing Prison Staffing

- **Rural Areas**- Reduced applicants due to location.
- Salary and Incentives- The State is not competitive with "for-profit" organizations (base salaries, sign on bonus, profit sharing, bonus pay)
- **Correctional Environment**- Prison is a dangerous and difficult place to practice medicine and typically not seen, within the profession, as a desirable place to work.
- **Aging of Correctional Work Force**- Correctional healthcare does not usually attract new graduates as a first career choice. Rather the more usual employee is the mid-to-late career healthcare professional. This creates a shorter career cycle within corrections and compounds the recruitment and retention problem.
- **Market Has Become Too Competitive**- The number of healthcare providers needed far exceeds the number in the market place. This has created a situation where salary alone will ***NOT*** solve the problem.

Tools Needed For Success

- Increased Salaries to Remain Competitive
- Loan Repayment Programs
- Medical Insurance Buyout Programs
- Sign-on Bonuses
- Incentive Pay For “Hard-to-Fill” locations
- Financially Meaningful Retention Plan
- Moving Expenses ~ For New Hires

Attachment 4

Correctional Healthcare

Joint Staffing Study

Executive Summary

- The CMHCC, its University Providers and the TDCJ Health Services Division have conducted a joint review of staffing plans and processes related to providing medical coverage for each correctional health care facility.

Purpose

- Examine options for extending medical staff coverage
- Determine feasibility of extending hours at facilities identified in the review

Scope of Review

- Focus On Facilities With Less Than 24 Hour Coverage
- Analyze Adding Staff
- Analyze Alternative Coverage Processes

Today's Situation

- Facilities operating < 24hrs.
  - 57 UTMB
    - Never operated 24 hrs.
    - No infirmary beds
  - 19 TTUHSC
    - 8 operated 24 hrs. prior to 2003
    - No infirmary beds
- Medicine and Nursing On - Call Coverage
- 10 Hub sites (Pre-Admission Triage Centers)

Facilities Operating < 24 Hours

B. Moore Unit
Baten ISF
Bartlett Unit
Boyd Unit
Bradshaw Unit
Bridgeport Unit
Briscoe Unit
C. Moore Unit
Central Unit
Clemens Unit
Cleveland
Cole St. Jail
Cotulla MUF
Dalhart Unit
Daniel Unit
Diboll Unit
Dominquez St. Jail
Duncan MUF
Eastham Unit
Ellis I Unit
Estes
Ferguson Unit
Formby St. Jail
Ft. Stockton MUF
Garza Unit - East & West
Gist State Jail
Glossbrenner Unit
Goodman Unit
Goree Unit
Gurney Unit
Halbert Unit
Hamilton Unit
Havins Unit
Henley Unit
Hightower Unit
Hilltop Unit
Hobby Unit
Holliday Unit
Huntsville Unit
Hutchins St. Jail
Jester I
Joe Kegans Unit
Johnston Unit
Jordan Unit
Kyle Unit
LeBlanc Unit
Lindsey Unit
Lockhart Unit
Lopez St. Jail
Lychner Unit
Lynaugh Unit
Middleton Transfer
Neal Unit
Ney Unit
Plane St. Jail
Ramsey I Unit
Roach Unit
Rudd Unit
Sanchez St. Jail
Sayle Unit
Scott Unit
Segovia Unit
Smith Unit
Stevenson Unit
Stringfellow Unit
Torres Unit
Travis County State Jail
Tulia MUF
Vance
Wallace Unit
Ware St. Jail 900
Wheeler Unit
Willacy Unit
Woodman St. Jail
Wynne Unit

Pre-Admission Triage Centers

UTMB Hub Sites

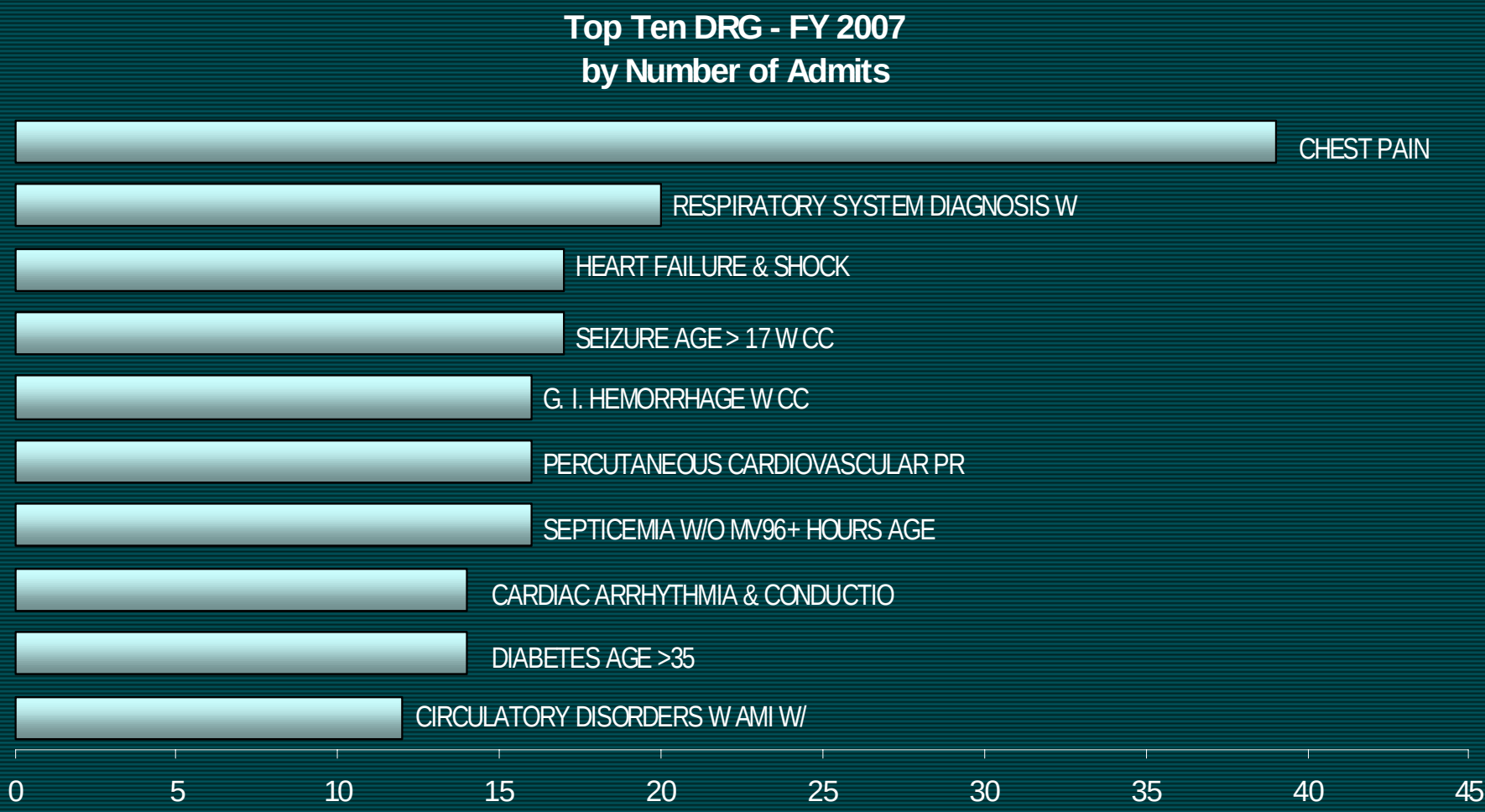
- A. Hughes Unit
- Beto I Unit
- C. Young RMF
- Estelle RMF
- Gatesville Unit
- Jester III Unit
- McConnell Unit
- Polunsky Unit
- Stiles Unit
- Terrell Unit

Data Analysis

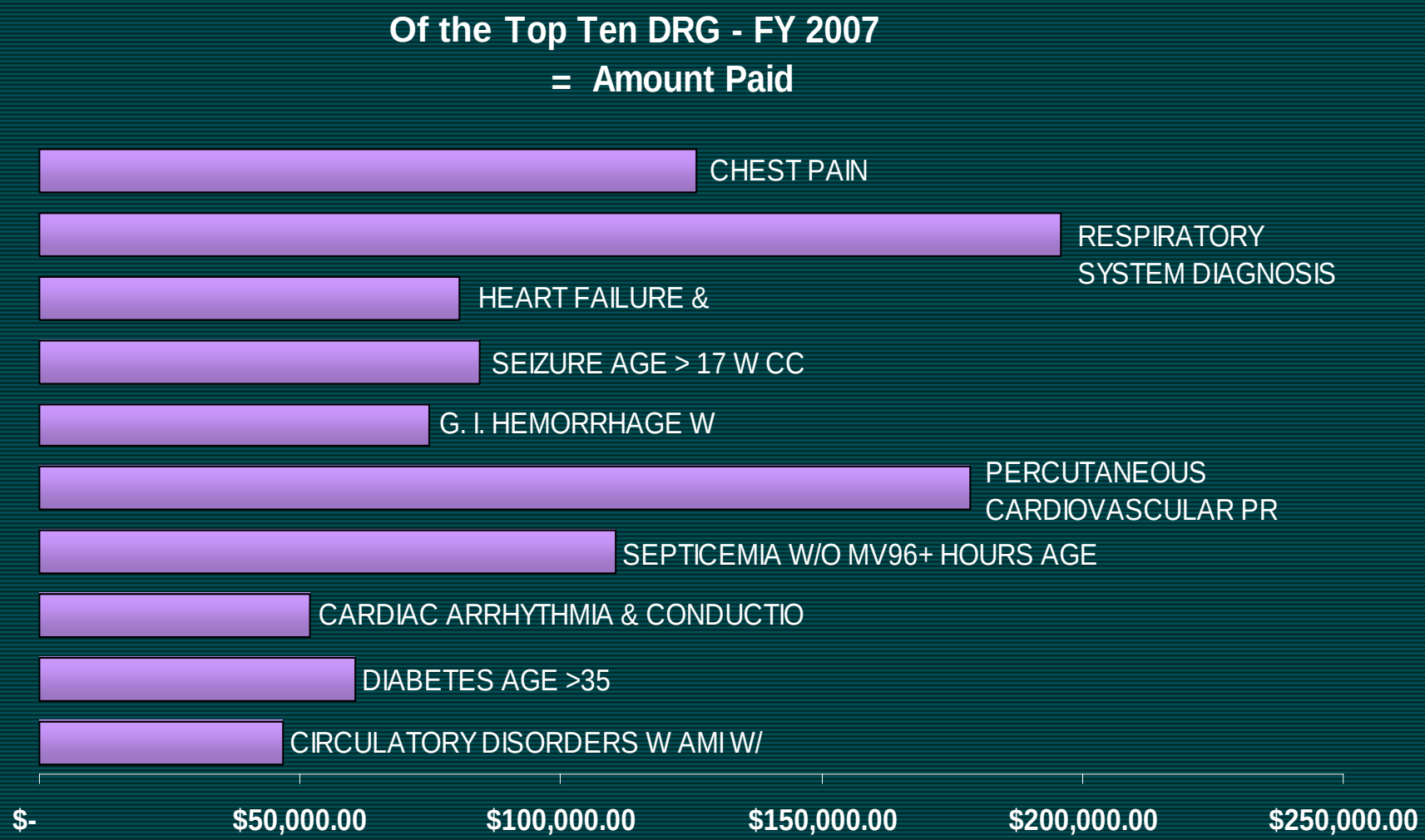
- Clinical And Fiscal
  - Top Offsite DRG's
  - Offsite Expense / Admits
  - Population Trends
- Death Rate
  - 24 / < 24 Hour Facility Comparison
- Nursing On - Call Data
- Nursing Vacancy Rate

Clinical & Fiscal Analysis

UTMB Offsite DRG



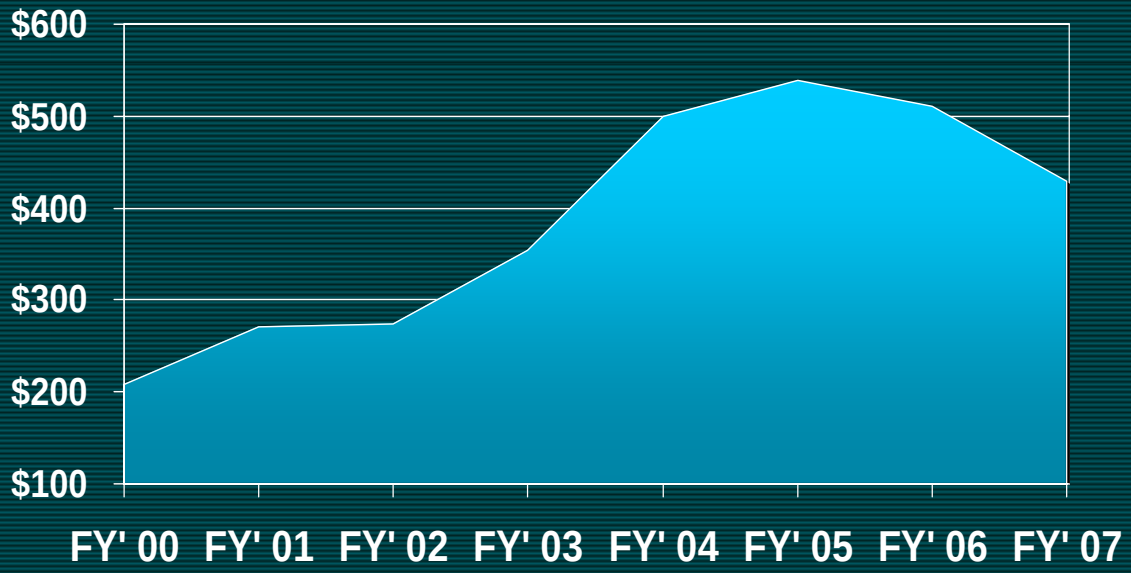
UTMB Offsite DRG

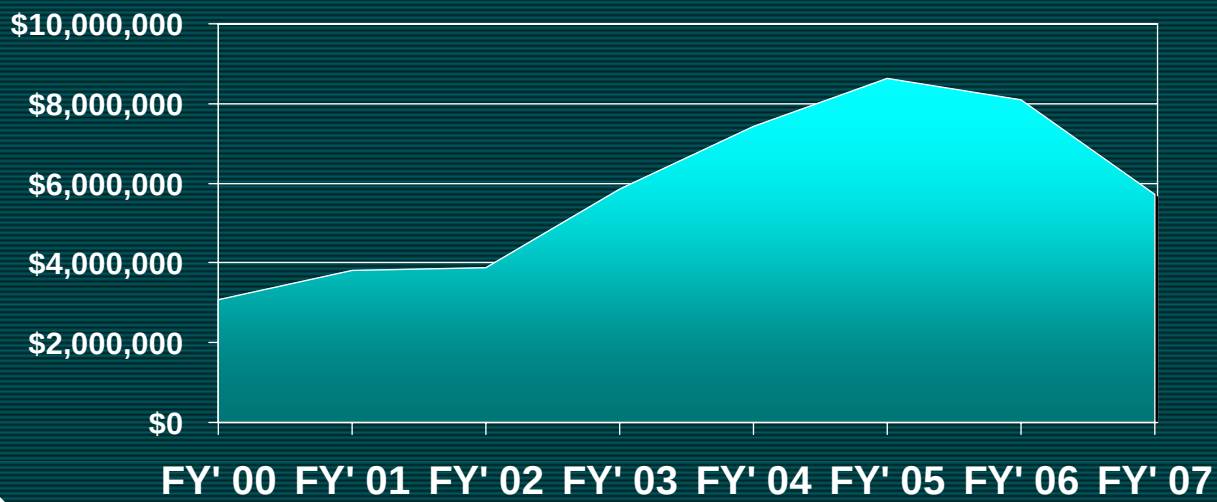


UTMB Offsite Costs

Offsite

Total Costs PMPM

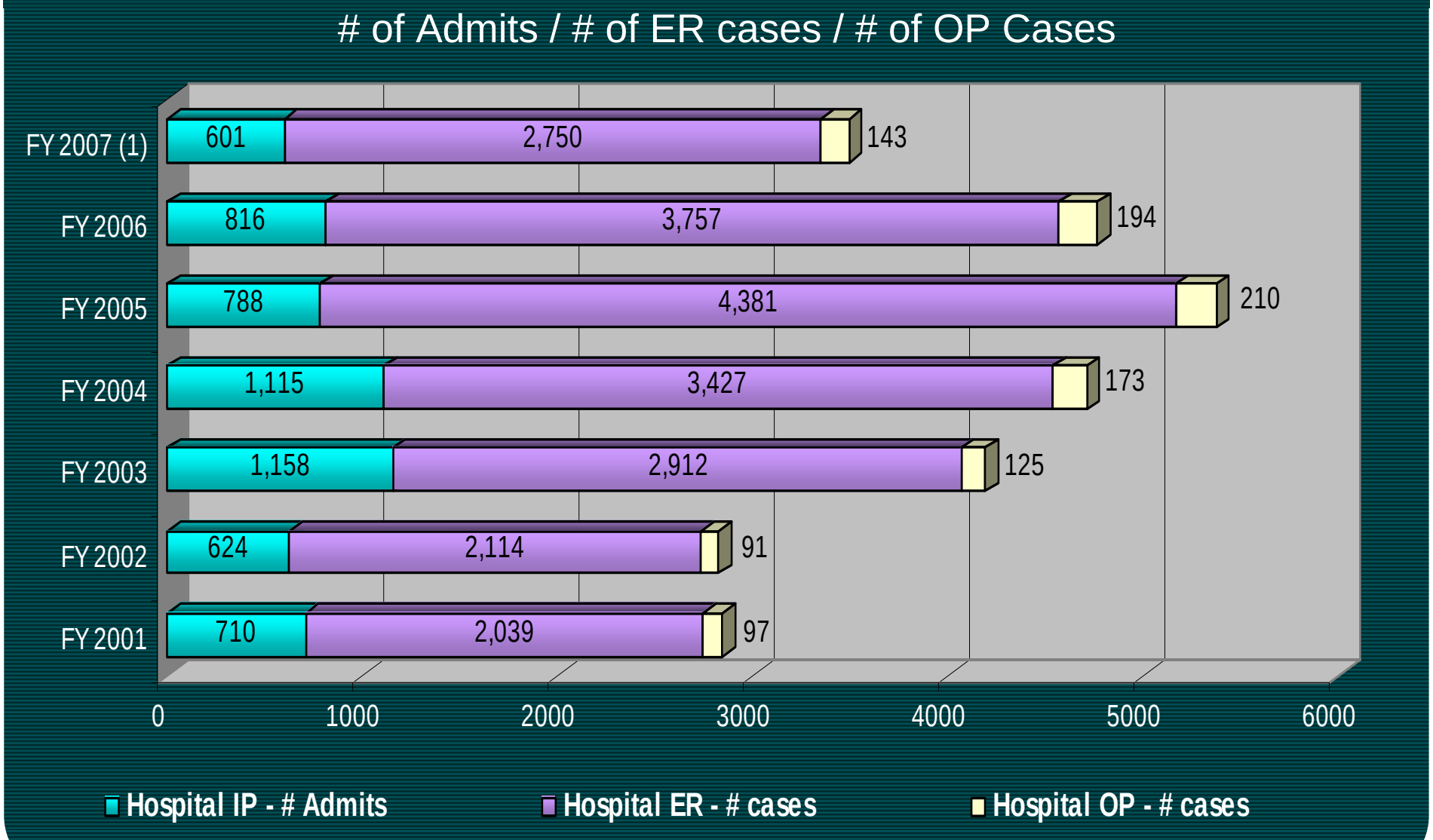




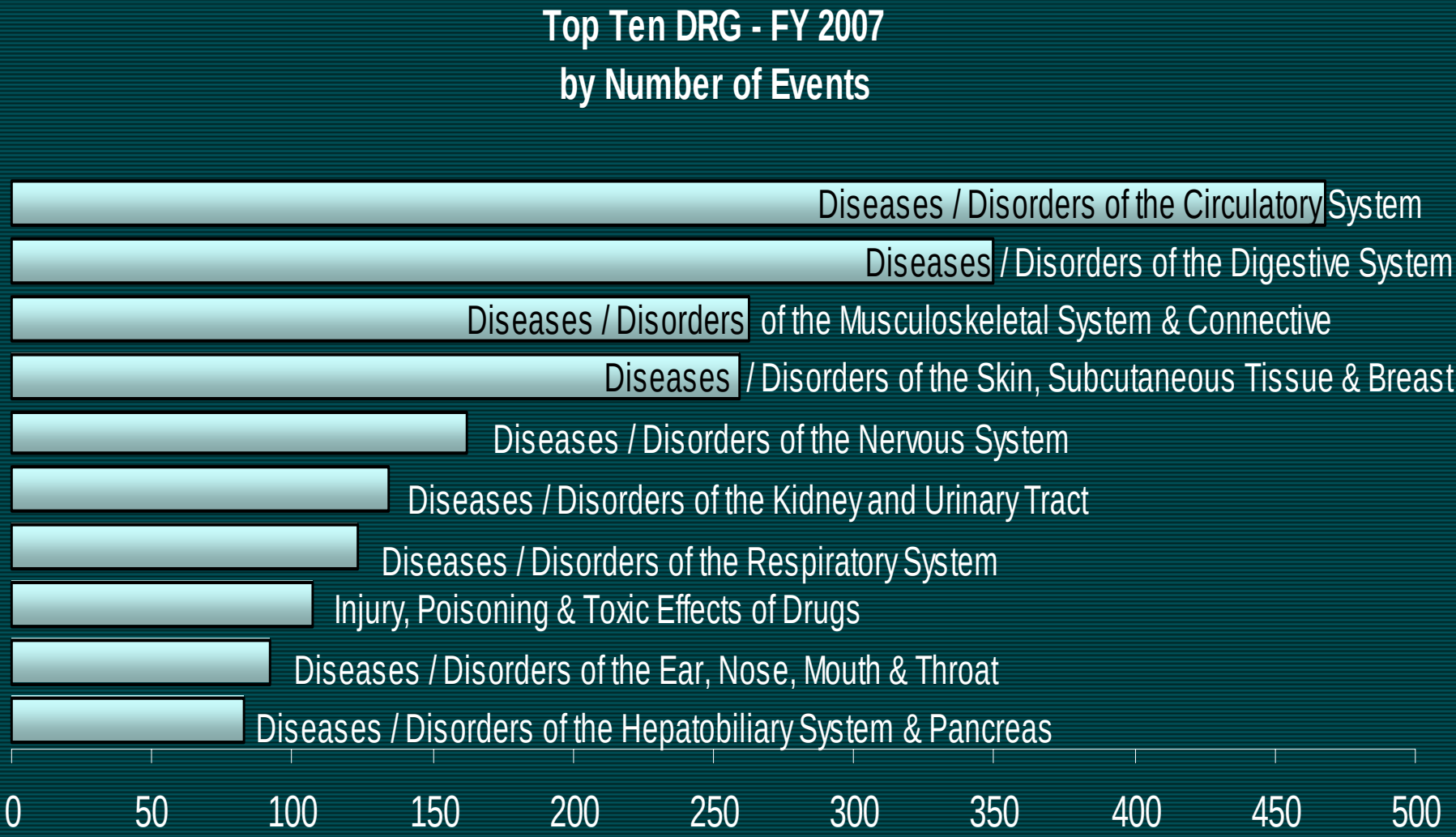
Offsite

Total Costs

UTMB Offsite DRG

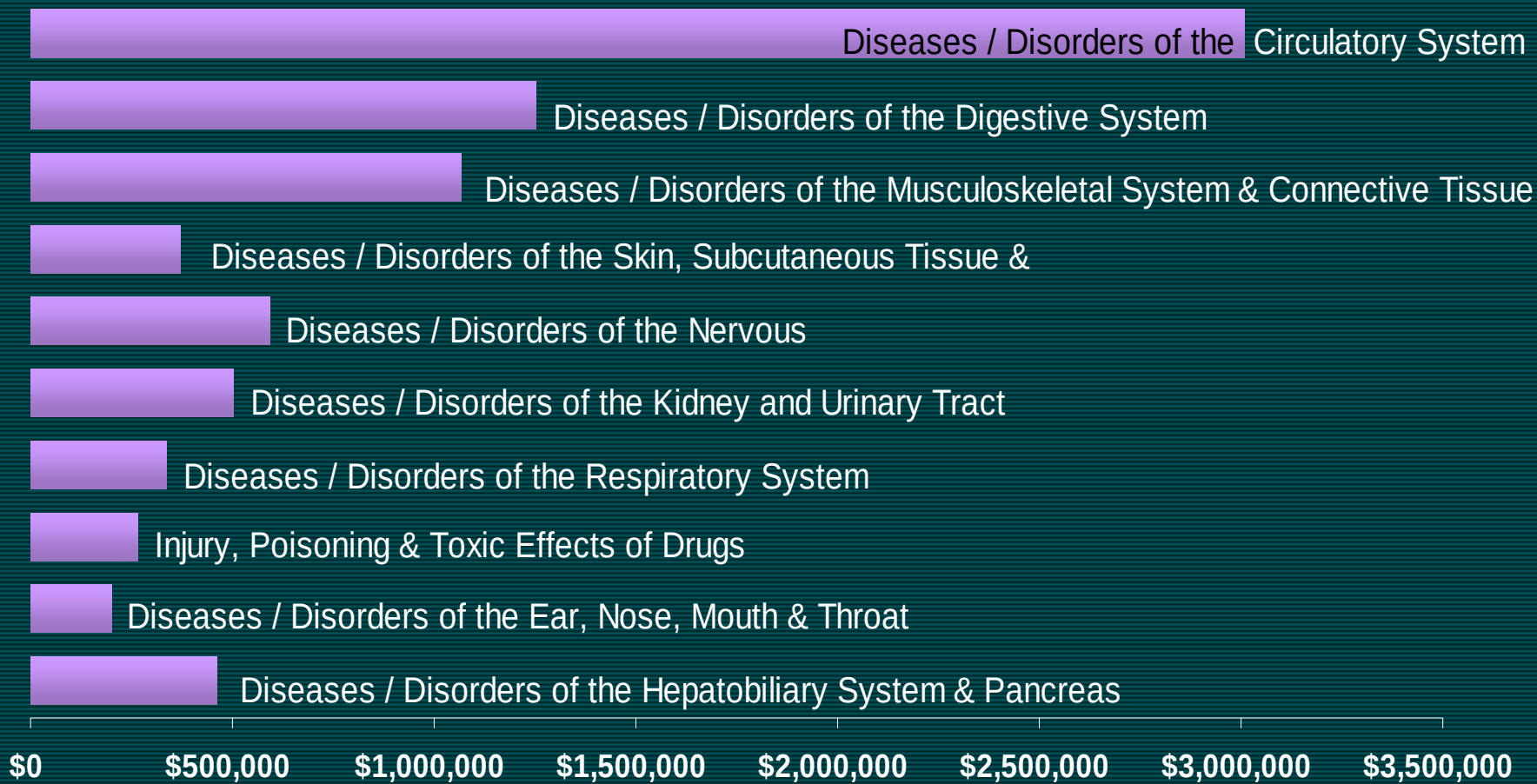


TTUHSC Offsite DRG

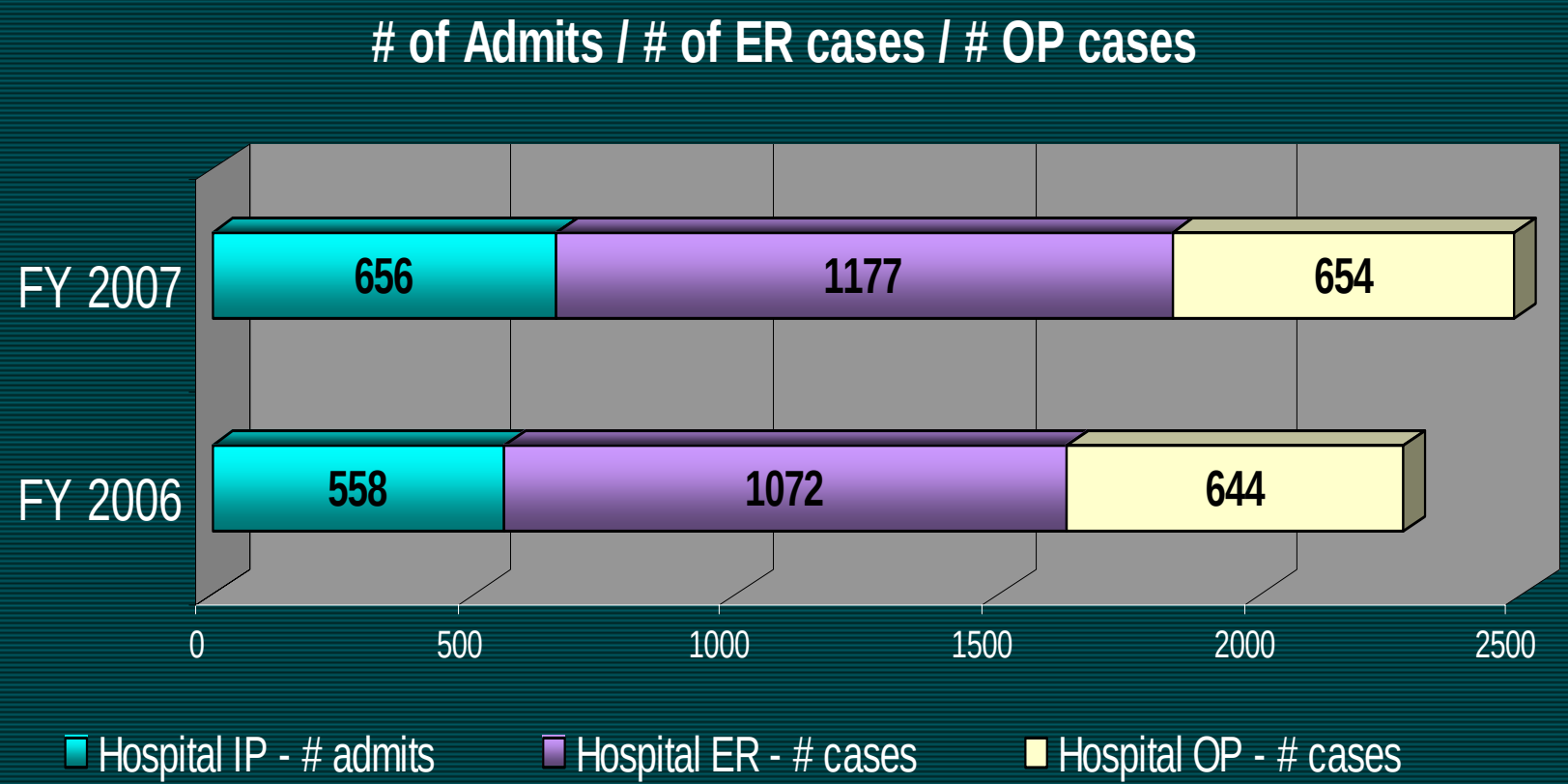


TTUHSC Offsite DRG

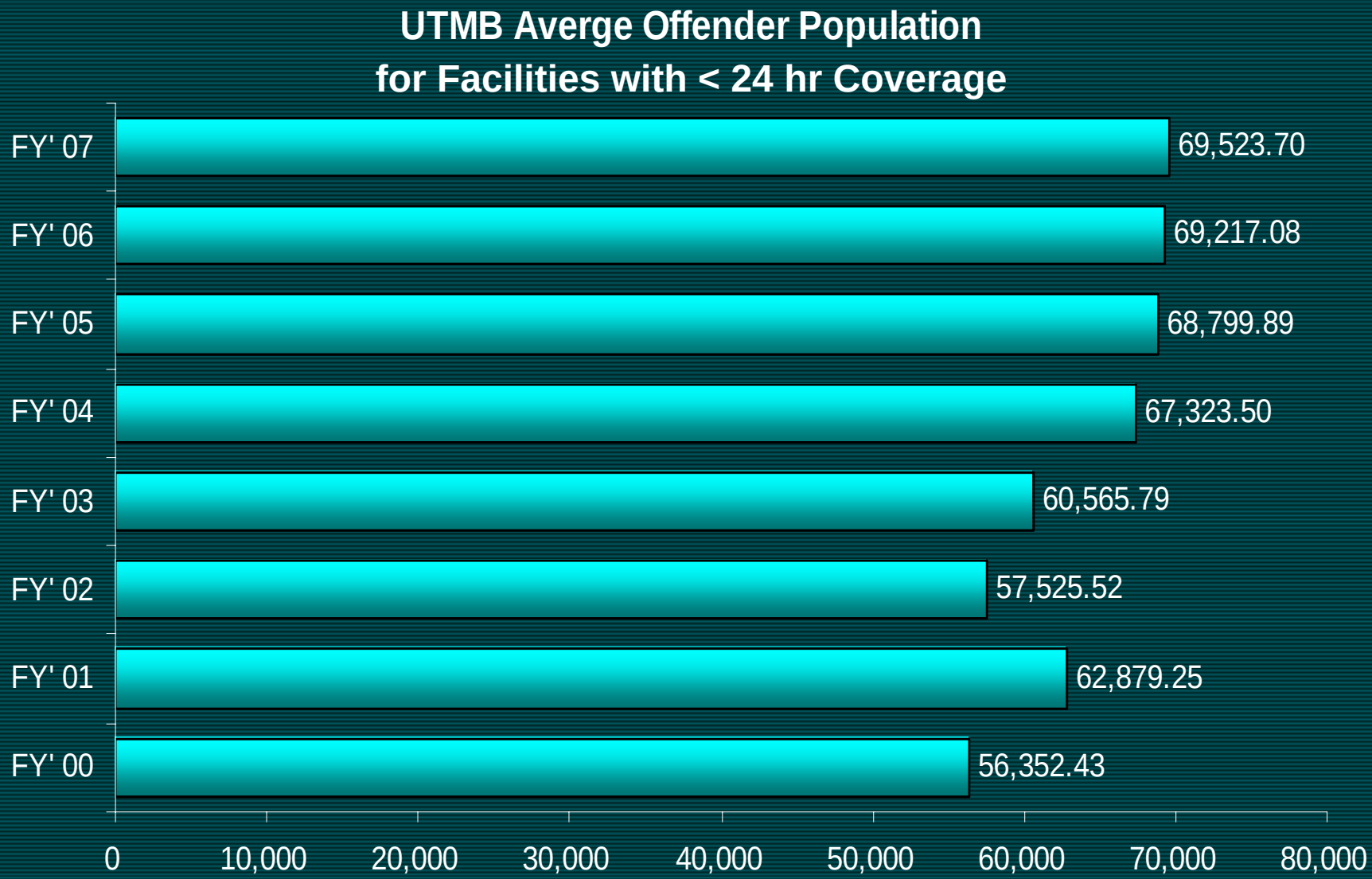
Of the Top Ten DRG – FY 2007
= Amount Paid



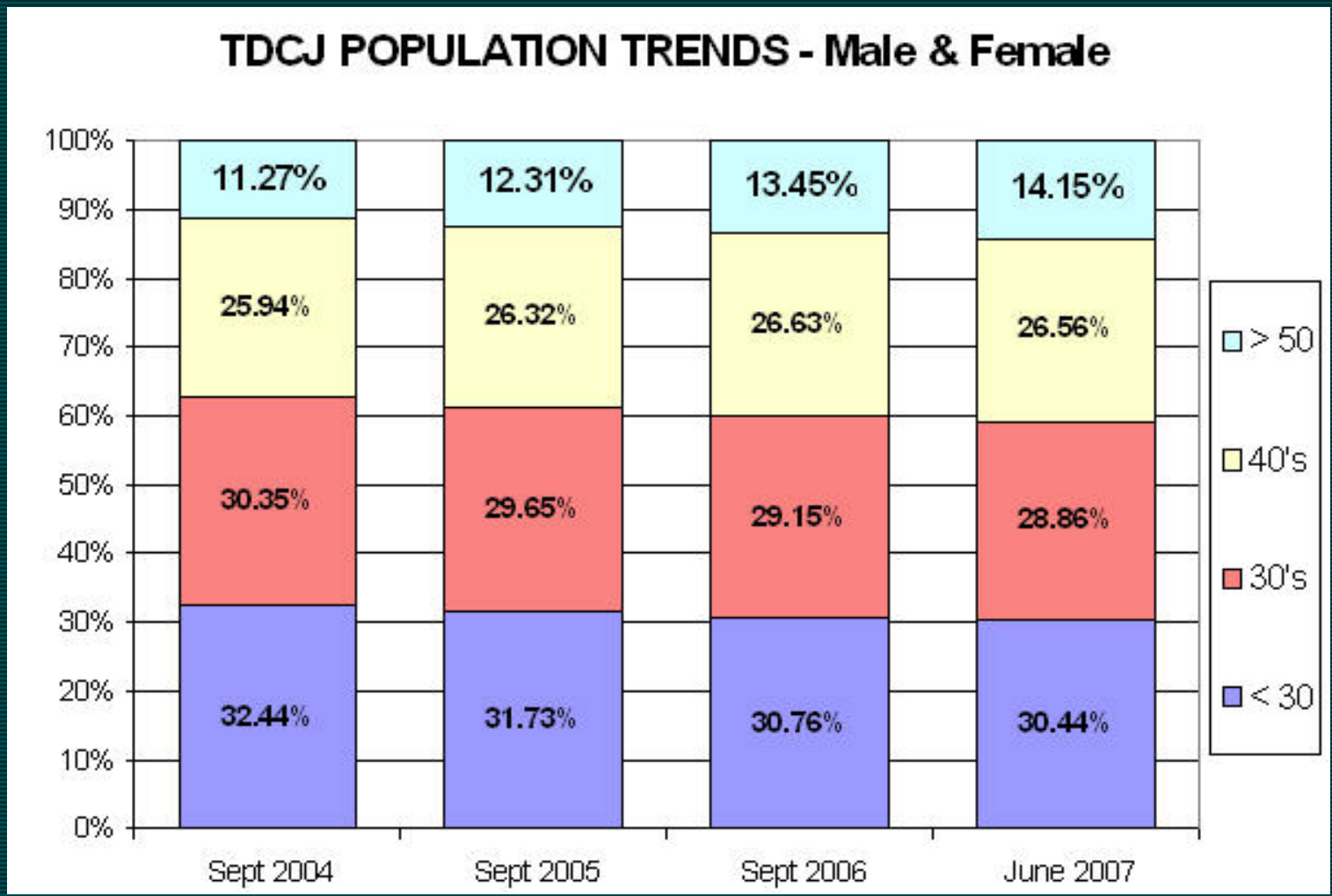
TTUHSC Offsite Events



UTMB Population Trends



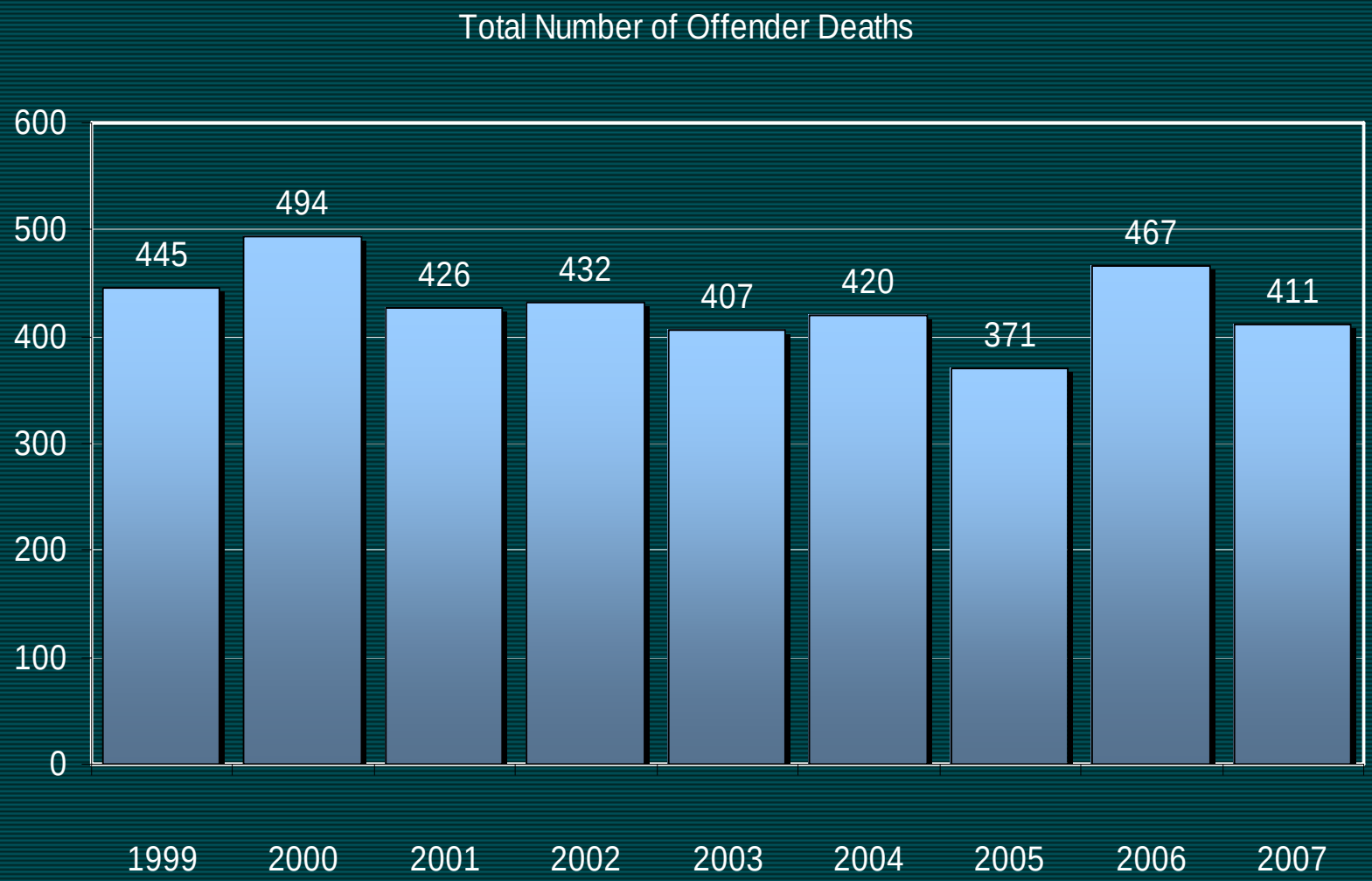
Population Trends



Offender Death Analysis

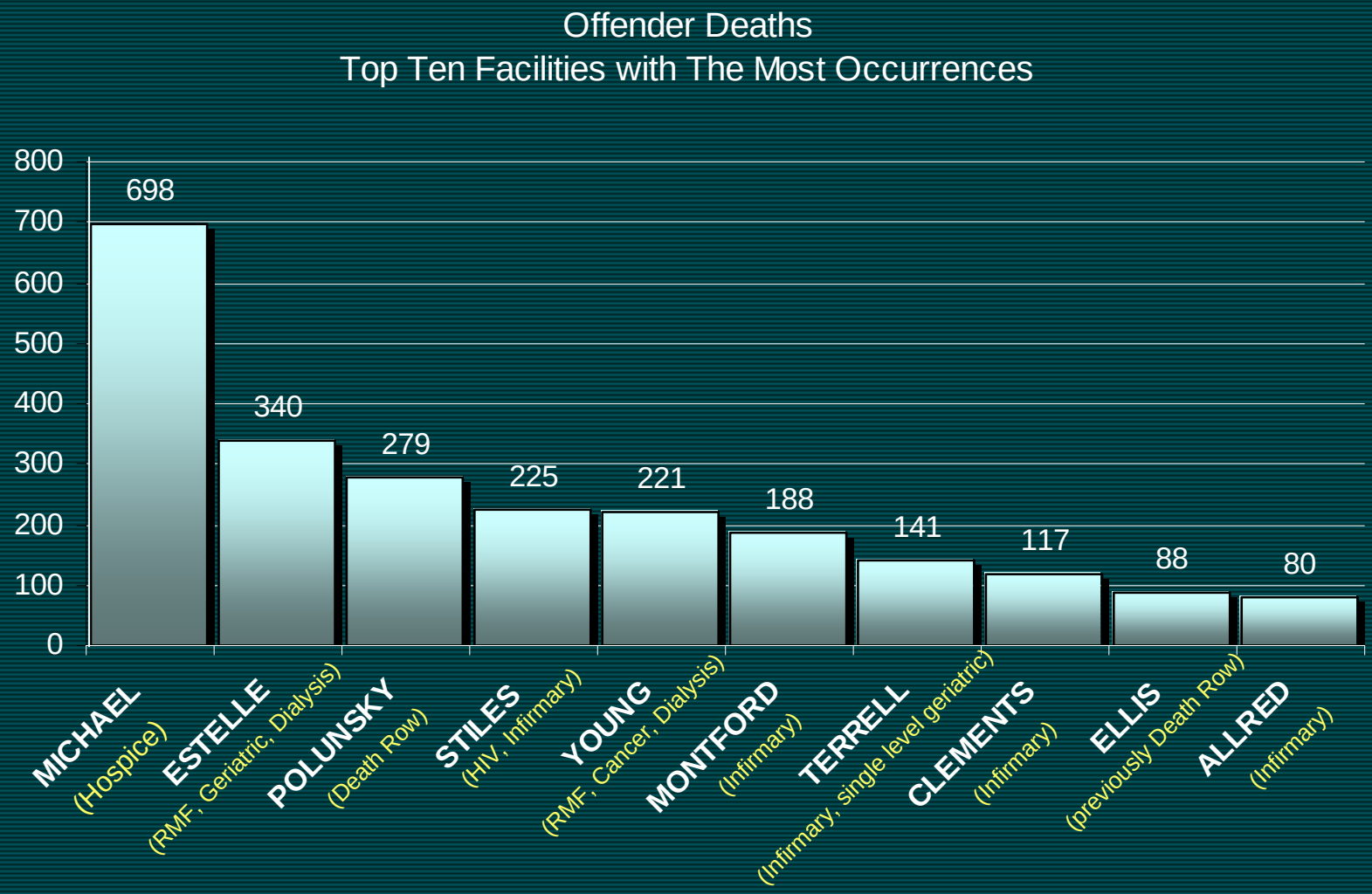
Texas Offender Death Analysis

FY 1999 – FY 2007



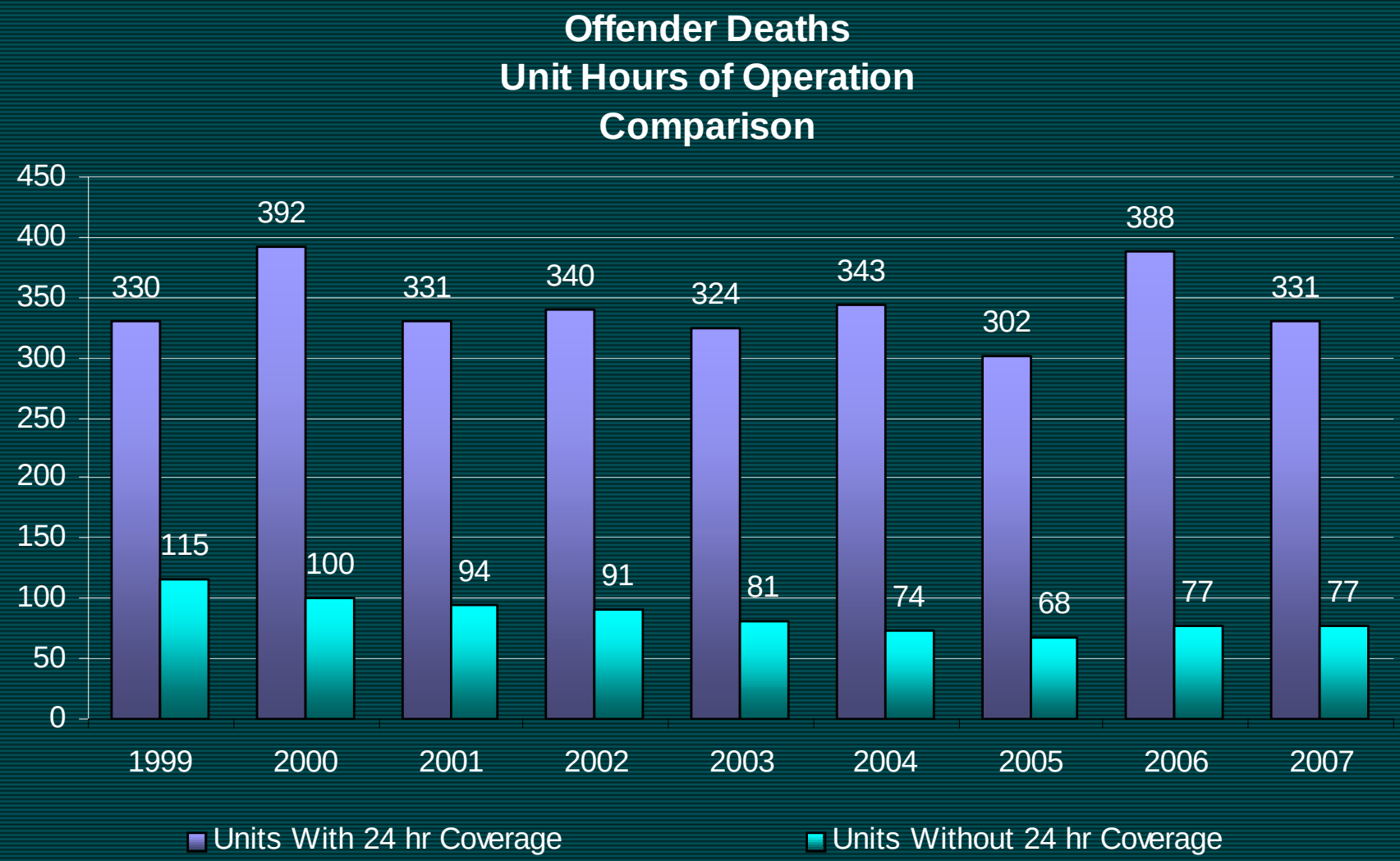
Texas Offender Death Analysis

FY 1999 – FY 2007



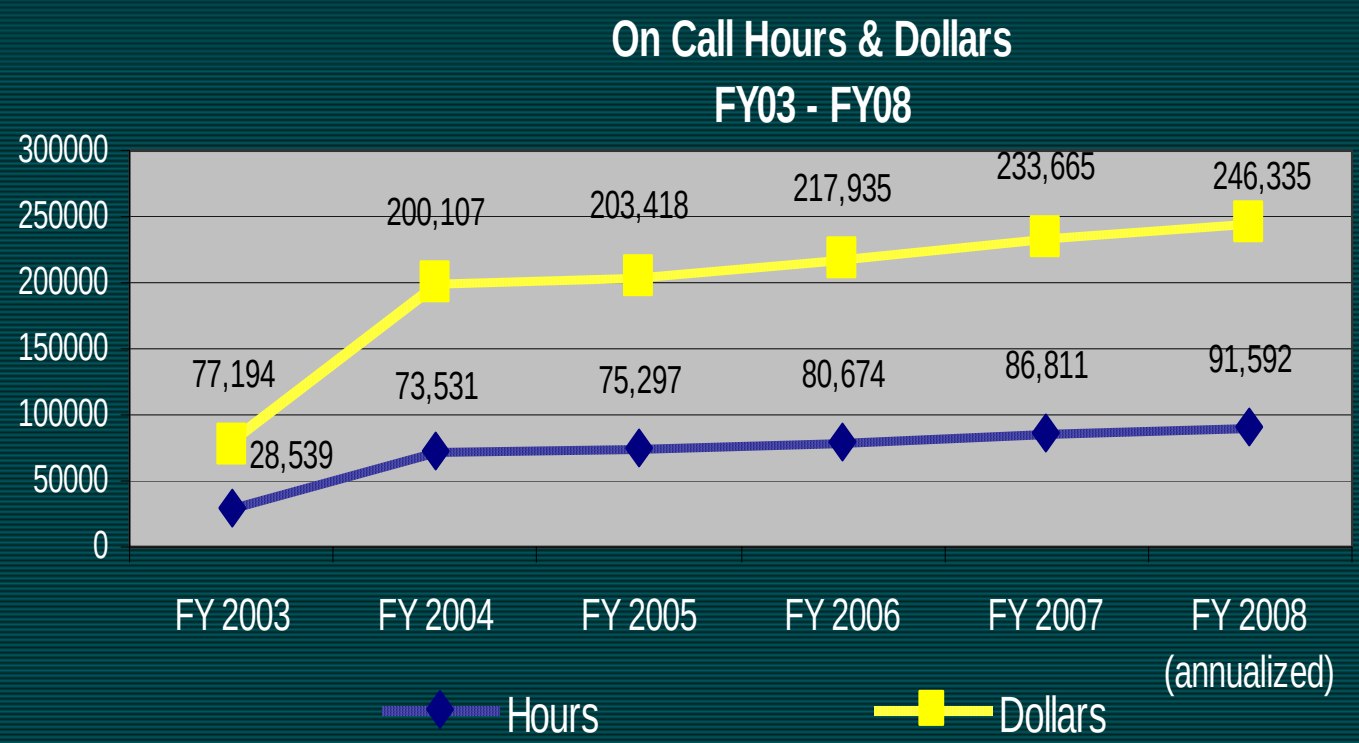
Texas Offender Death Analysis

FY 1999 – FY 2007



Nursing On-Call Analysis

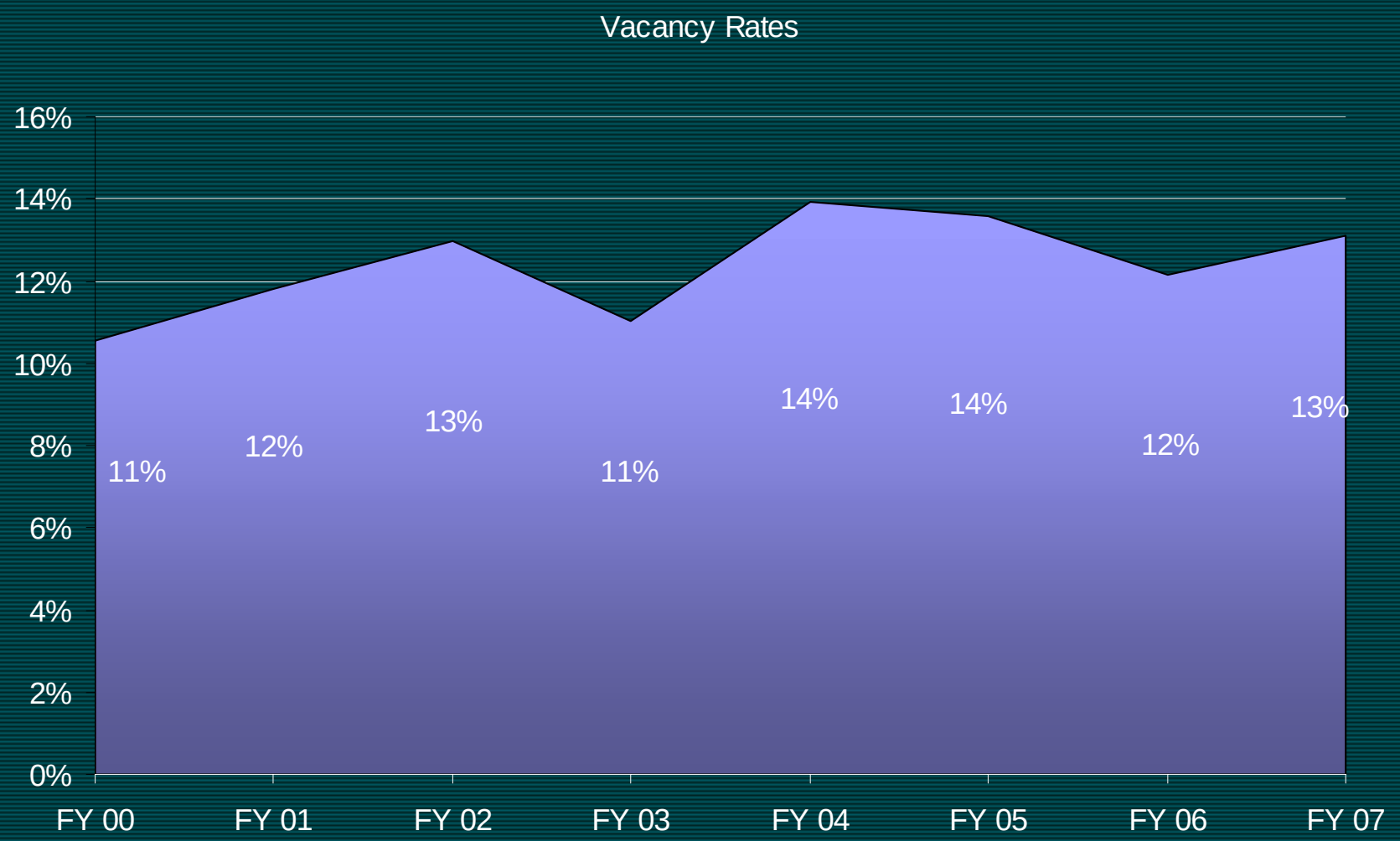
UTMB On-Call Nursing



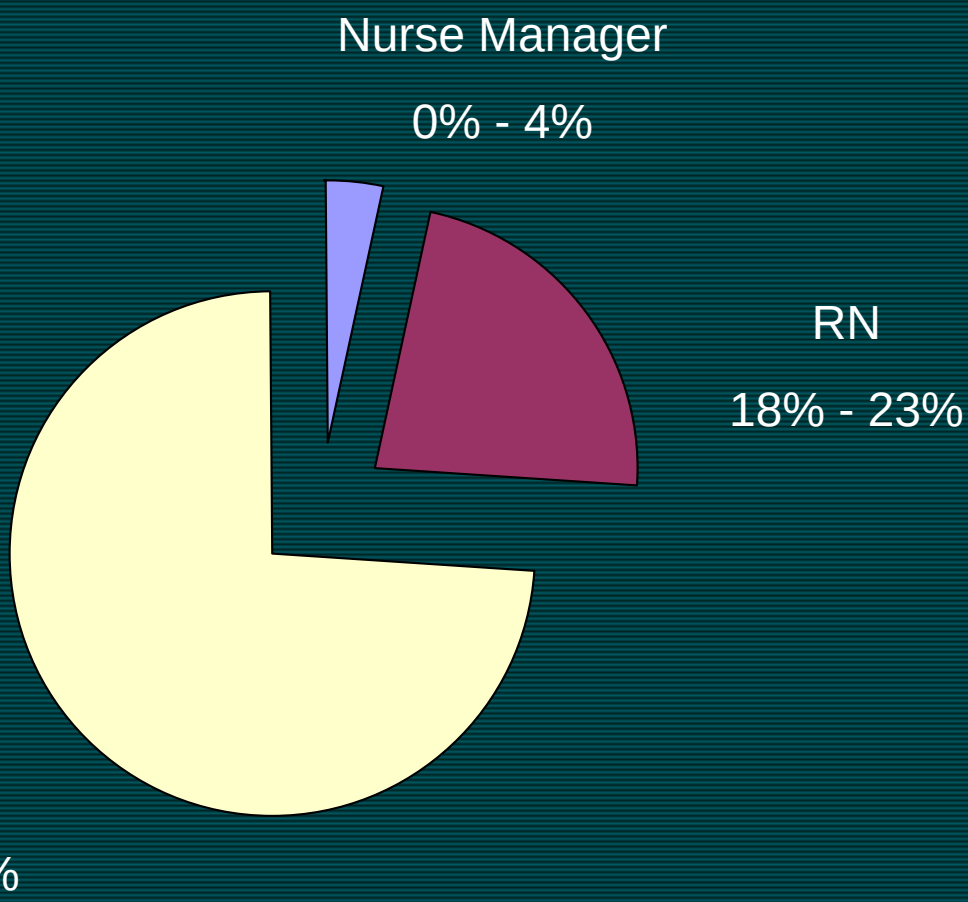
- The 158% growth of dollars and hours in FY04 was related to cut backs that occurred in FY03.
- On call hours and dollars from FY04 to FY05 was 2%, and then there was increase in both FY06 & FY07, 7% and 8% respectively.
- The overall increase is also attributable to the increase in units from FY03 - FY07, from 34 in FY03 to 48 in FY07

Nursing Vacancy Rate Analysis

UTMB RN and LVN Vacancy Rates

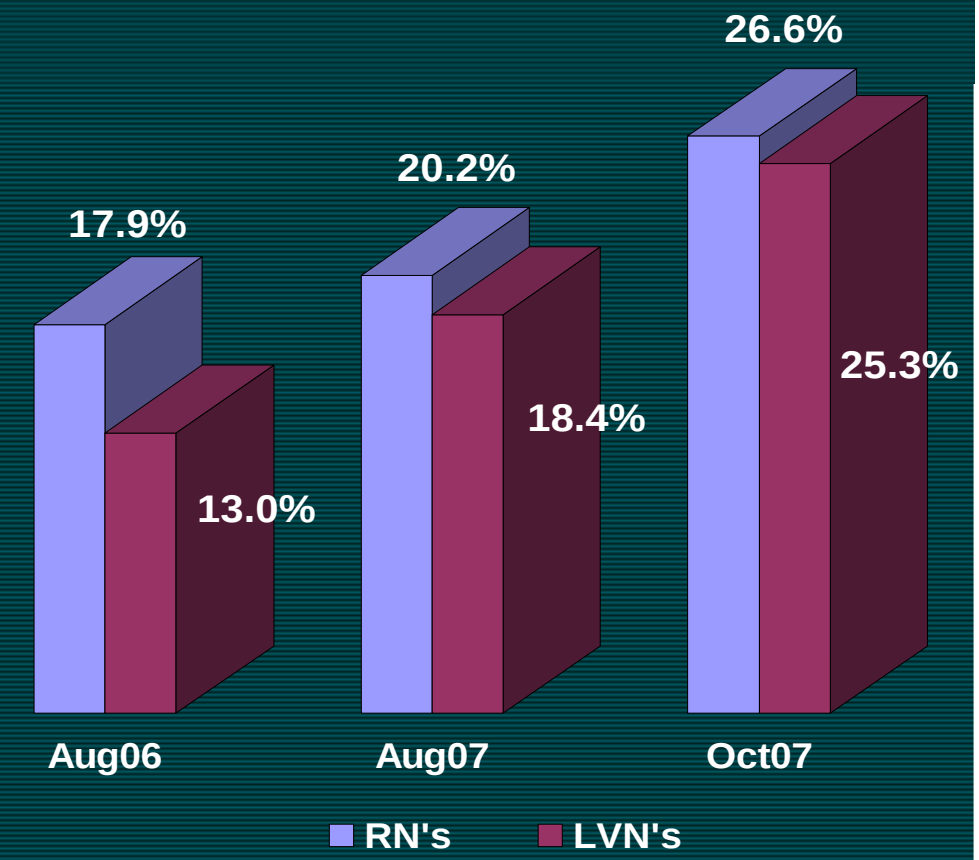


UTMB Nursing Vacancies



TTUHSC Nursing Vacancy

Filled	Aug06	Aug07	Oct07
RN's	162.35	158.04	144.98
LVN's	331.63	315.06	290.01
Vacant	**Aug06**	**Aug07**	**Oct07**
RN's	35.49	39.98	52.57
LVN's	49.34	70.94	98.44
Total Filled & Vacant	**Aug06**	**Aug07**	**Oct07**
RN's	197.84	198.02	197.55
LVN's	380.97	386.00	388.45
% of Vacancies	**Aug06**	**Aug07**	**Oct07**
RN's	17.9%	20.2%	26.6%
LVN's	13.0%	18.4%	25.3%



- Vacancy Percentage increased steadily during this time period for RN's & LVN's
- Percentage of Vacancies from Aug 06 – Oct 07 = 8% for RN's
- Percentage of Vacancies from Aug 06 – Oct 07 = 12.3% for LVN's

Assessment for Extending Coverage

- Analyze Adding Staff
  - Standard 24 hour operation Staffing
  - Currently being assessed
- Analyze Alternative Coverage Processes
  - Nursing Option
    - Add 3 LVN x < 24 hr. facilities x ($40K)
    - $6.8M UTMB: $12.4M (Agency)
    - $2.2M TTUHSC: $4.1M (Agency)
    - Telemedicine to Nearest 24 hr. facility
  - EMT Option
    - Similar Staffing Expense
    - Operational Difference
    - EMT : Physician : Transport

Questions

Attachment 5

Organ Transplants for Offenders

Law, Ethics, and Economics

William J. Winslade, Ph.D.
E. Bernadette McKinney, J.D., Ph.D.

The Issues

- Legal Duties to Offenders
  - Civil Rights Law
  - New Trend
- Medical Need
  - Aging, Chronically Ill
  - Transplants
  - Death & Dying
- Ethics
  - Professional Responsibility
  - Social Worth
- Correctional Health Budget
  - Pay Now or Pay Later
  - Treatment v. Lawsuits + Treatment

Legal Duties

- Civil Rights Law
  - 8th and 14th Amendments & §1983
  - Estelle v. Gamble Line of Cases
    - Actual Knowledge of a Serious Medical Need
    - Deliberate Indifference
- New Trend
  - Trigo v. TDCJ
  - Barron v. Keohane
  - Clark v. Hendrick

Offender Medical Needs

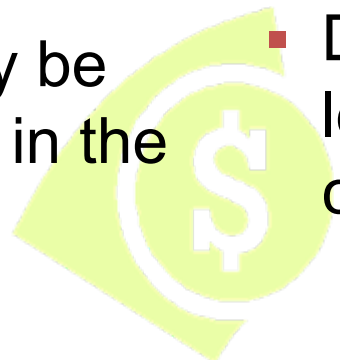
- Aging
- Poor Health
  - Infectious Diseases
  - Chronic Illnesses
    - HCV: TDCJ = est. 29% (10-20 x general population)
    - Organ damage due to substance abuse
    - HIV =5x general population
    - Kidney damage due to diabetes, hypertension, heart disease
- Need for Transplants
  - Kidneys (>60 Receive Dialysis)
  - Livers
  - Other Organs (need unknown)
- Eligibility for Transplants
  - Small number eligible
  - Many ineligible:
    - co-morbidities
    - inability to comply with treatment requirements
  - If listed, may not receive organ.

Ethics

- Professional Responsibility
- Social Worth
  - Slippery Slope
  - Outcry about God Squads
- The UNOS ethics statement
- Deserved Illness?
- Diminished Autonomy
  - Wards of State
  - No Other Access
- Basis of Deliberate Indifference Standard

Budget

- Pay Now or Pay Later
  - Many offenders cycle through system
  - Health care costs for age 50-55 at least 3x offenders <50;
    aging population
  - Kidney transplant may be less $$$ than dialysis in the long-run
  - Hepatitis C = most common reason for liver transplant
  - Costs to Treat
    HCV, Mental Illness, Drug Abuse v. Cost of Transplant
  - Costs of end-of-life care:
    ICU v. Hospice or Alternative
  - Defending lawsuits =$$$;
    losing them is even more costly.



Conclusions

- Law & Ethics 👍 Transplants
- Costs Need Further Study
- Need Policies
  - Transplant
    - Offenders Should be Eligible
    - At Public Expense
    - Limited by Circumstances
  - When No Transplant
    - Advance Directives
    - Hospice
    - Release Strategies

Consent Item 2

TDCJ Health Services
Monitoring Reports

ATTACHMENT 1

Rate of 100% Compliance with Standards by Operational Categories
First Quarter, Fiscal Year 2008
September, October, and November 2007

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*
Allred Facility	100%	52	52	52%	15	29	71%	20	28	72%	10	14	94%	15	16	100%	11	11
Allred High Security	100%	52	52	40%	8	20	77%	20	26	85%	11	13	100%	11	11	100%	11	11
Connally Facility	98%	52	53	71%	20	28	75%	27	36	93%	14	15	75%	12	16	100%	11	11
Darrington Facility	96%	51	53	80%	16	20	62%	20	32	100%	16	16	50%	5	10	100%	11	11
Ferguson Facility	100%	53	53	38%	8	21	93%	27	29	100%	13	13	45%	5	11	100%	11	11
Glossbrenner Facility	100%	53	53	81%	17	21	100%	24	24	100%	15	15	100%	4	4	100%	11	11
Roach Facility	96%	51	53	53%	11	21	58%	11	19	100%	16	16	88%	7	8	100%	11	11
Scott Facility	96%	51	53	72%	13	18	78%	24	31	100%	15	15	91%	10	11	100%	11	11
Terrell Facility	96%	51	53	62%	13	21	81%	26	32	81%	13	16	64%	7	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 2008
September, October, and November 2007

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*
Allred Facility	100%	32	32	93%	291	313	78%	47	60	95%	77	81	99%	153	154
Allred High Security	100%	32	32	85%	196	231	67%	26	30	92%	36	39	100%	11	11
Connally Facility	87%	40	46	97%	334	346	79%	46	58	99%	83	84	98%	200	205
Darrington Facility	100%	35	35	98%	213	217	61%	14	23	100%	52	52	86%	82	95
Ferguson Facility	100%	25	25	92%	291	317	100%	60	60	100%	90	90	85%	113	133
Glossbrenner Facility	100%	25	25	98%	236	242	100%	20	20	100%	40	40	100%	25	25
Roach Facility	100%	25	25	89%	209	236	81%	42	52	100%	88	88	99%	79	80
Scott Facility	100%	22	22	96%	201	210	98%	59	60	100%	74	74	99%	89	90
Terrell Facility	100%	33	33	89%	200	225	100%	30	30	94%	49	52	95%	94	99

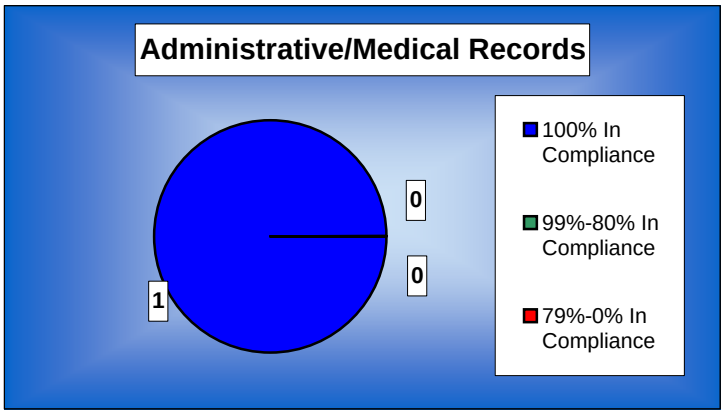
n **= number of records audited for each question.**

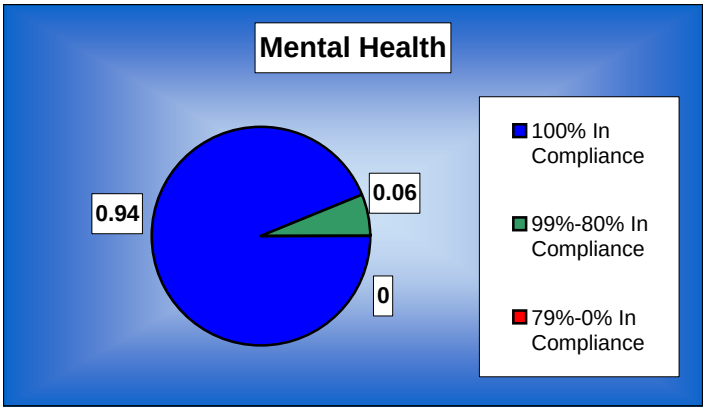
Note: Selected items requiring medical record review are reflected in this table.
The items were chosen to avoid having interdependent items counted more than once.

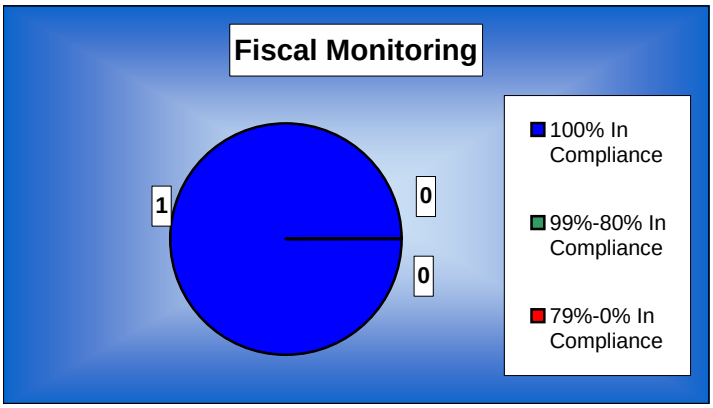
Average Percent Compliance Rate = Sum of medical records audited that were in compliance X 100
Number of records audited

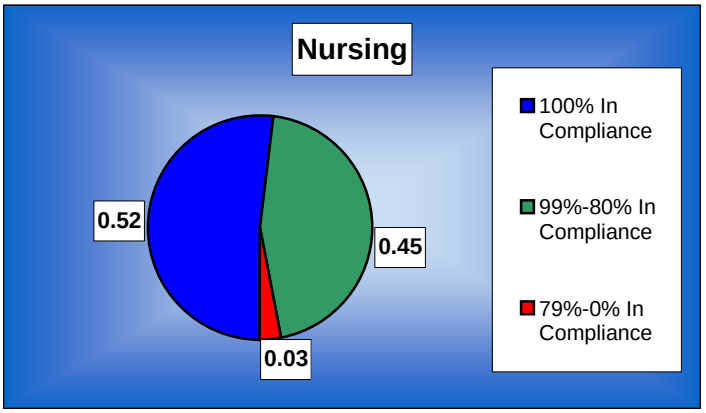
***The medical record review section of the Operations/Administration portion of the Operational Review Audit consists of only three questions, frequently with low numbers of applicable records.**

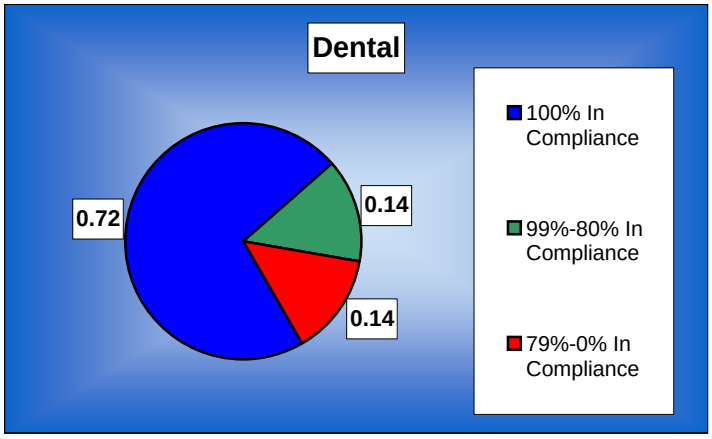
Quarterly Reports for
Compliance Rate By Operational Categories
Allred Facility
September 12, 2007

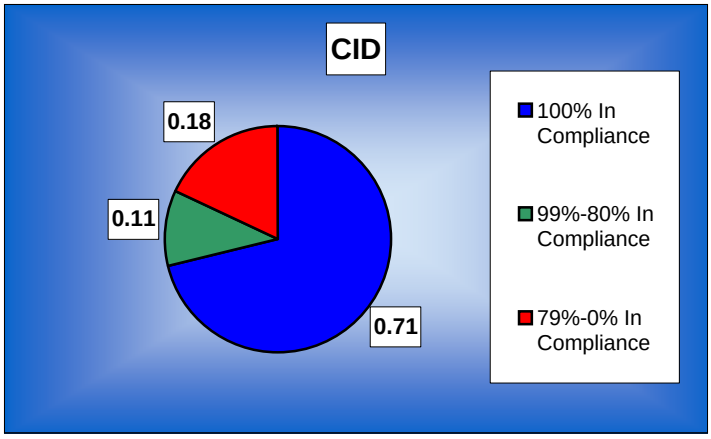




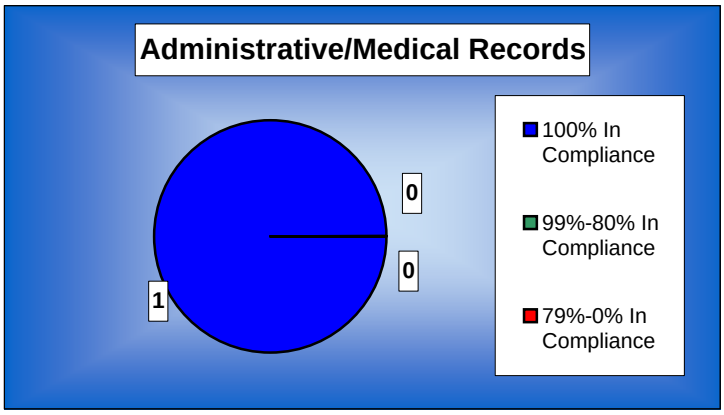


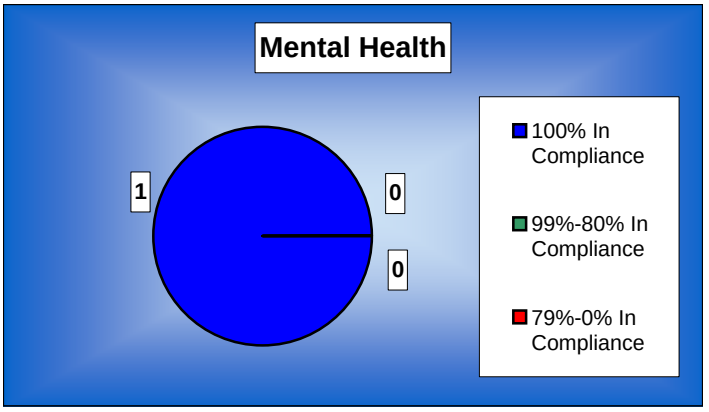


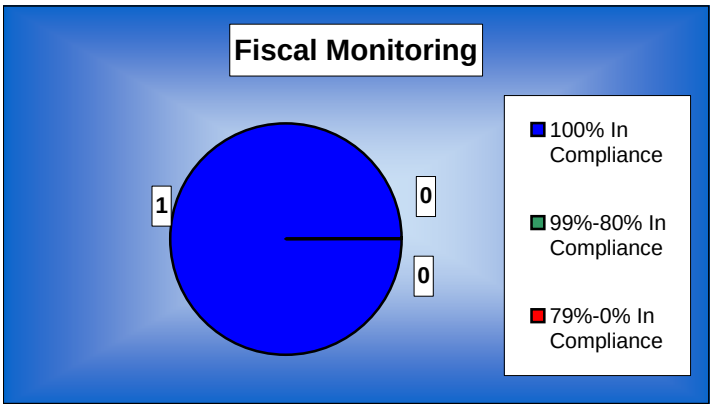


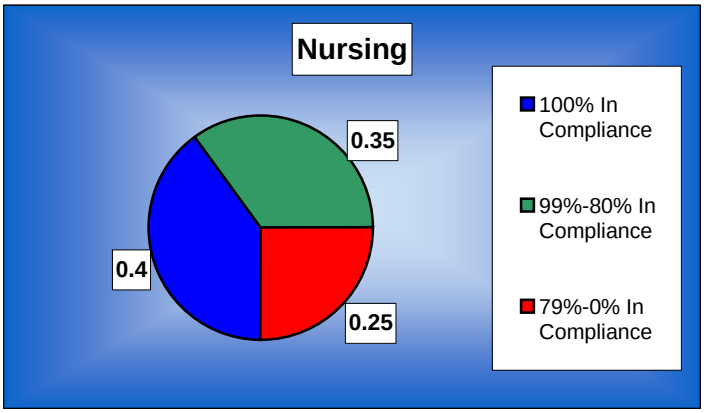


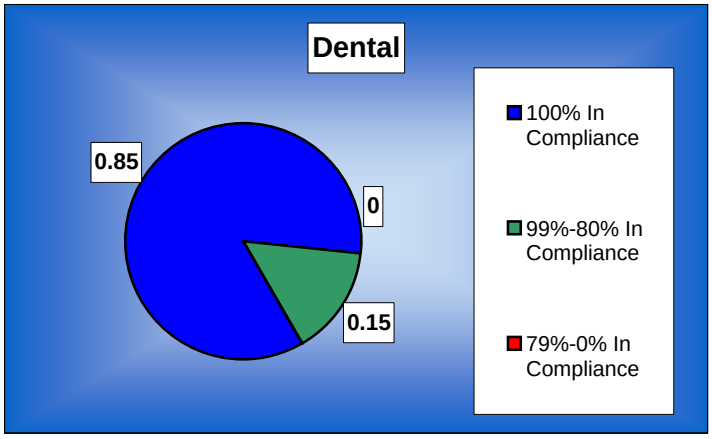
Quarterly Reports for
Compliance Rate By Operational Categories
Allred High Security Facility
September 13, 2007

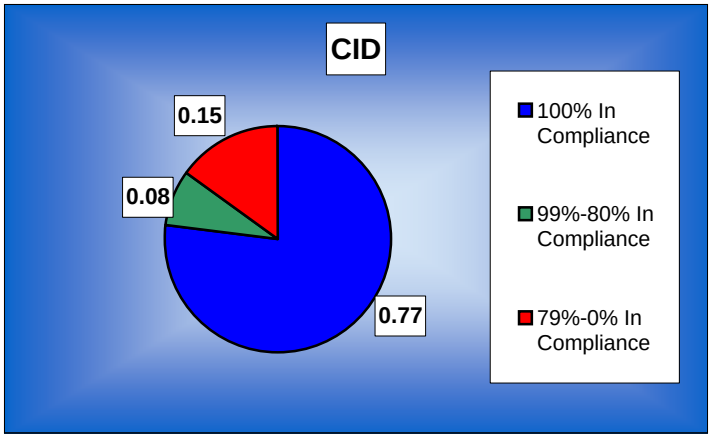




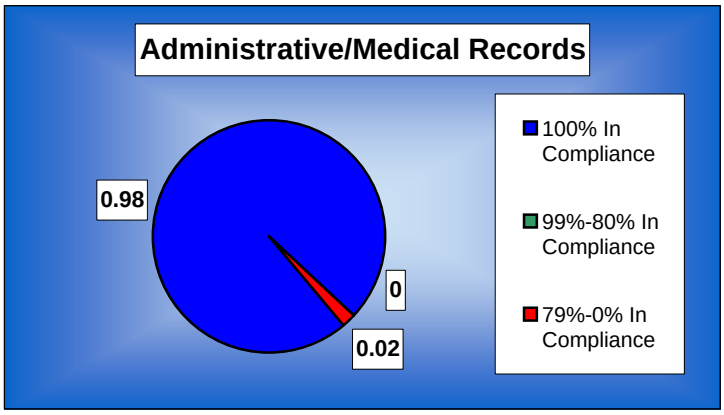


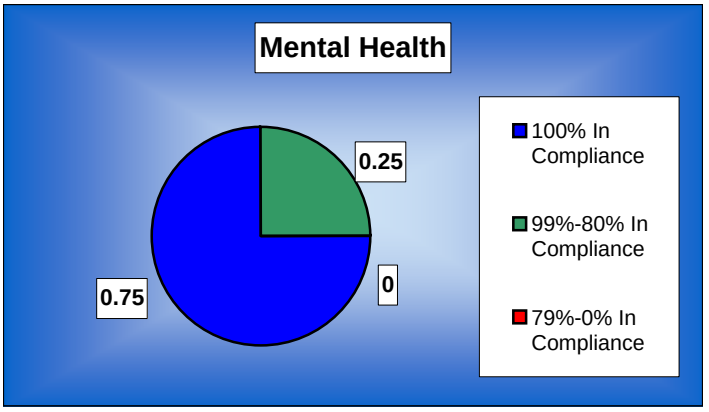


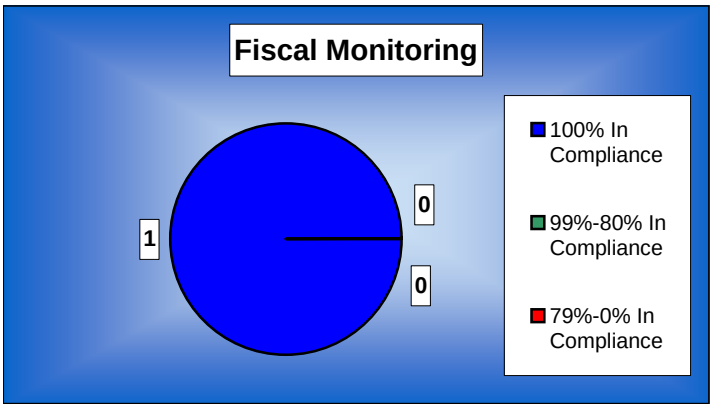


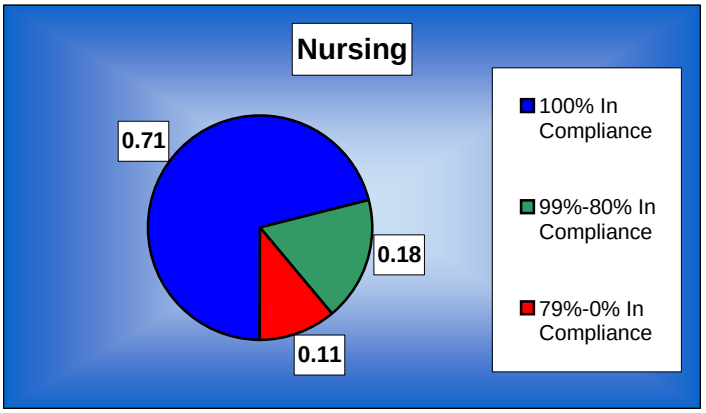


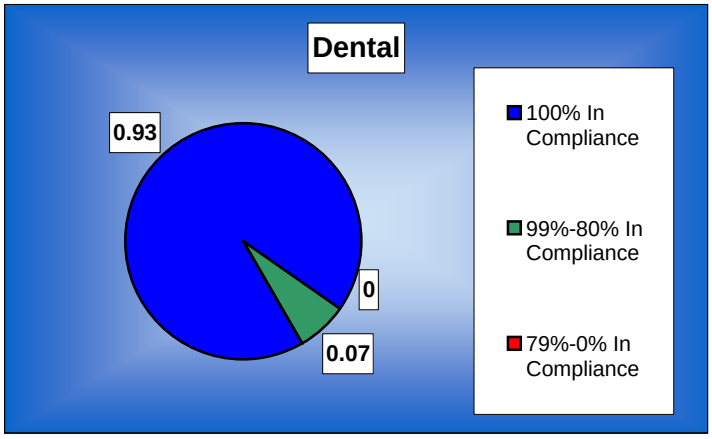
Quarterly Reports for
Compliance Rate By Operational Categories
Connally Facility
November 8, 2007

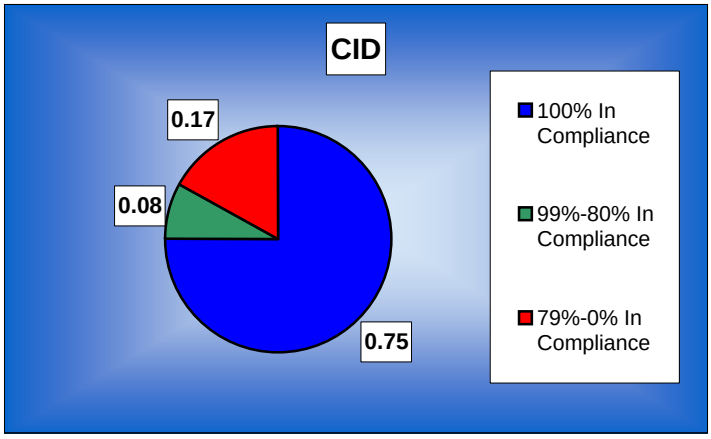




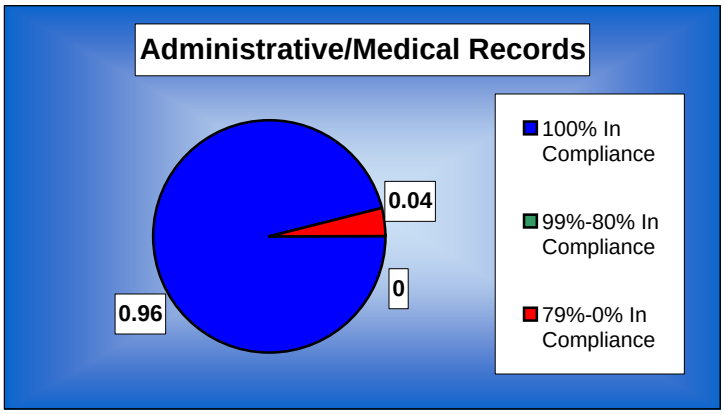


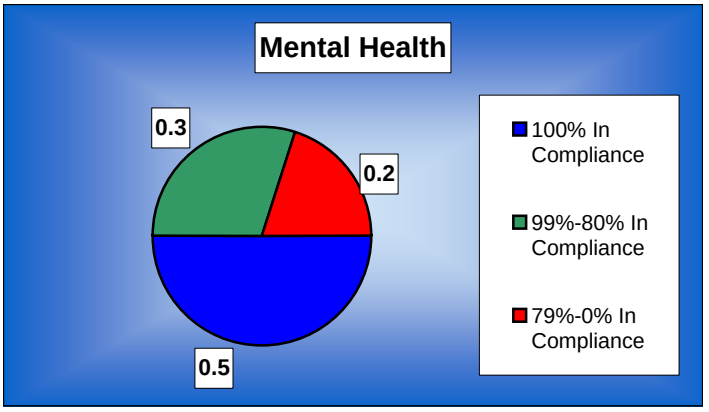


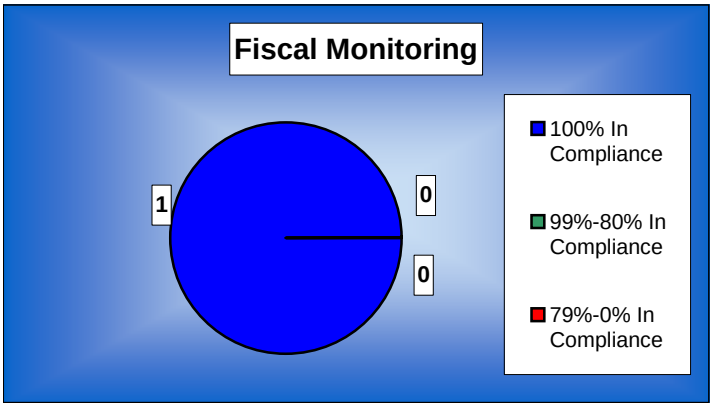


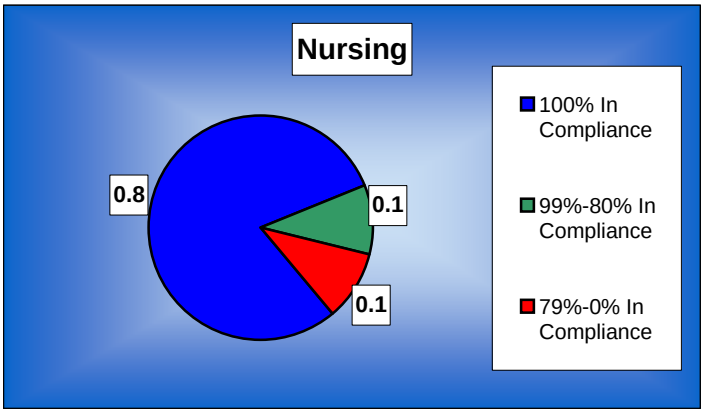


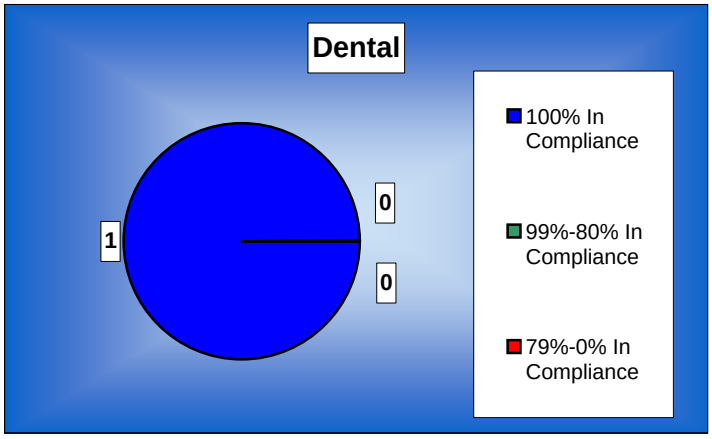
Quarterly Reports for
Compliance Rate By Operational Categories
Darrington Facility
October 3, 2007

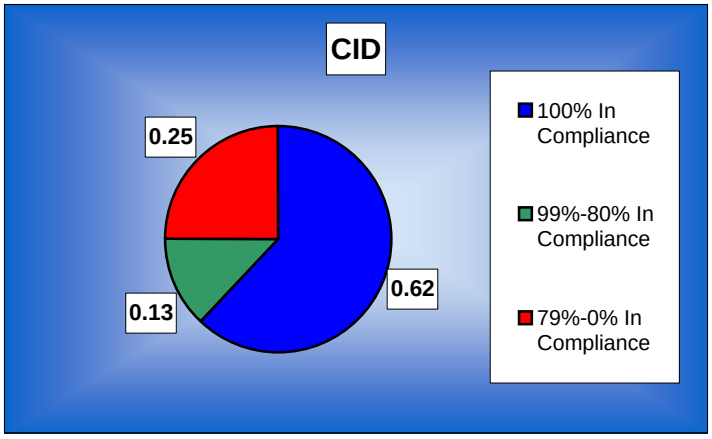




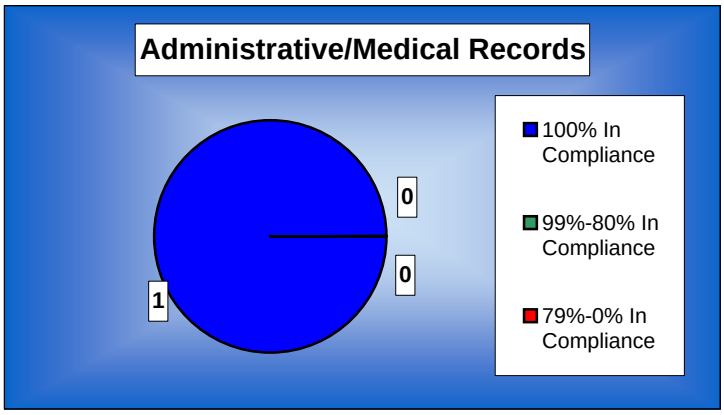


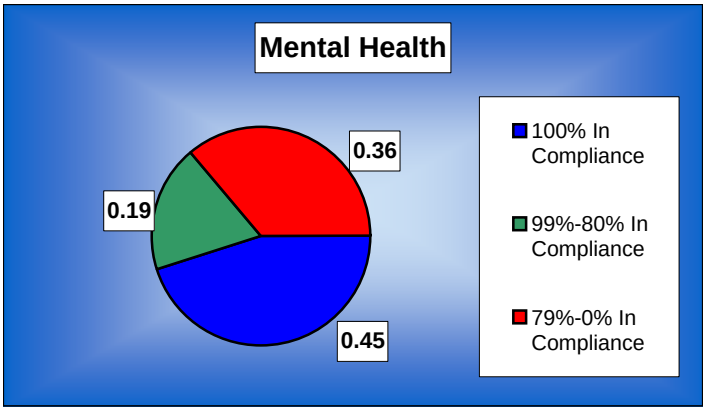


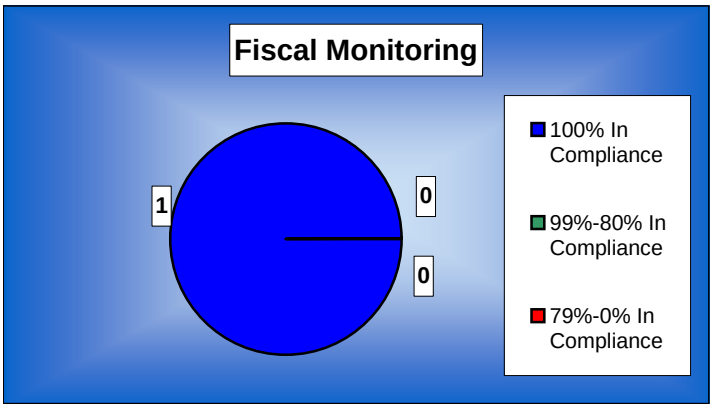


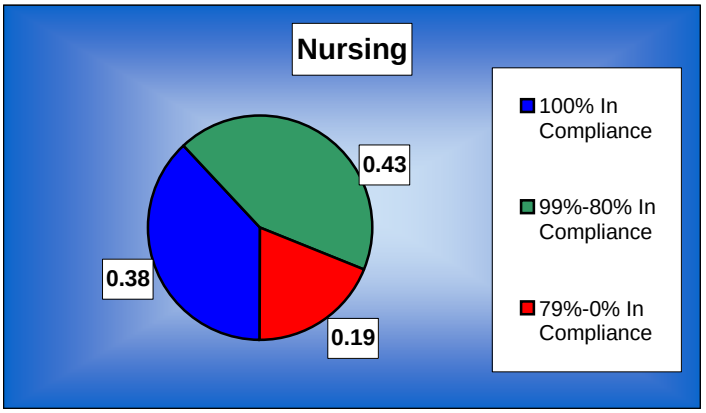


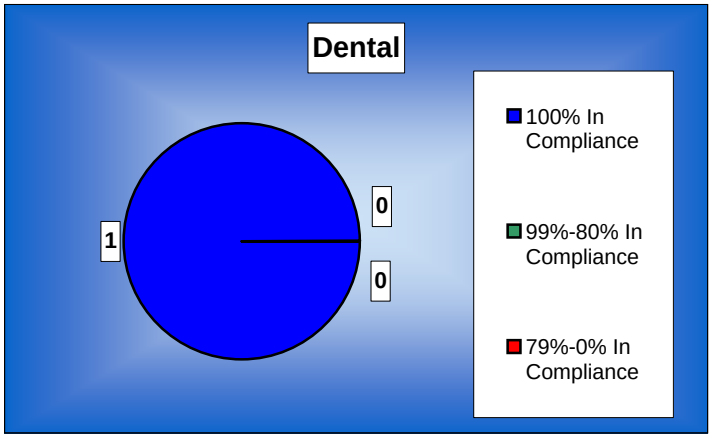
Quarterly Reports for
Compliance Rate By Operational Categories
Ferguson Facility
September 6, 2007

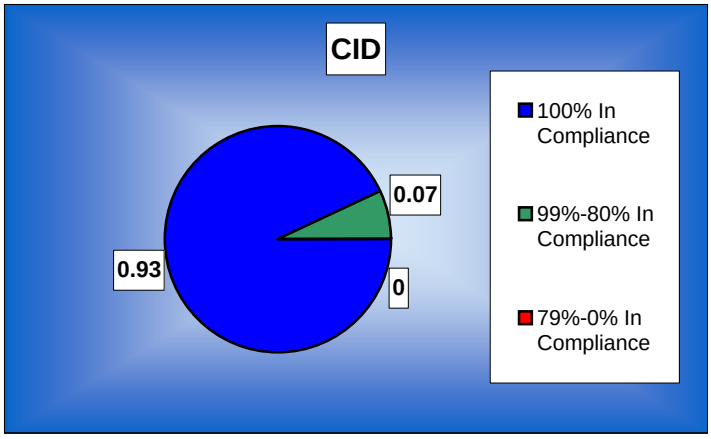




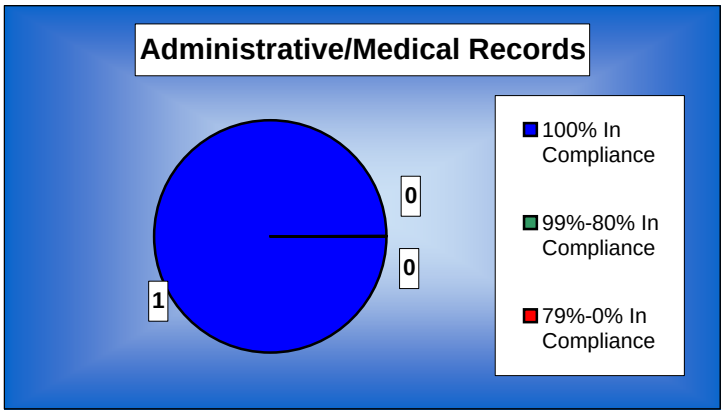


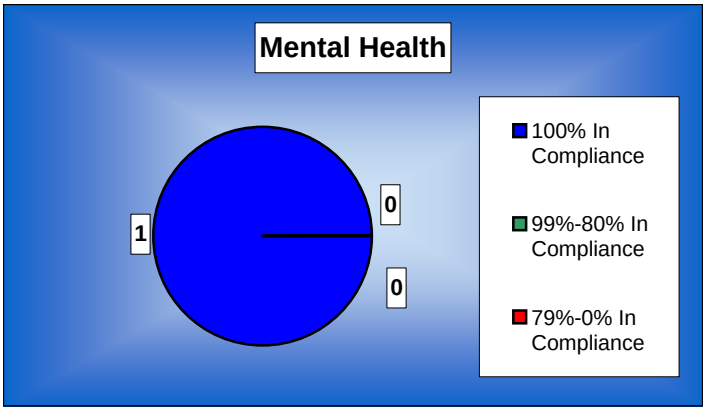


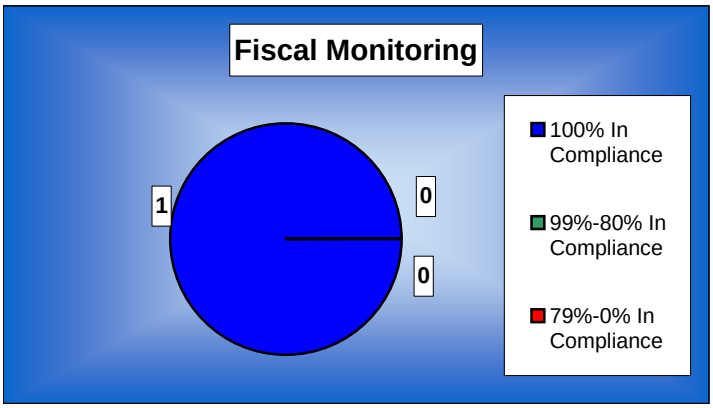


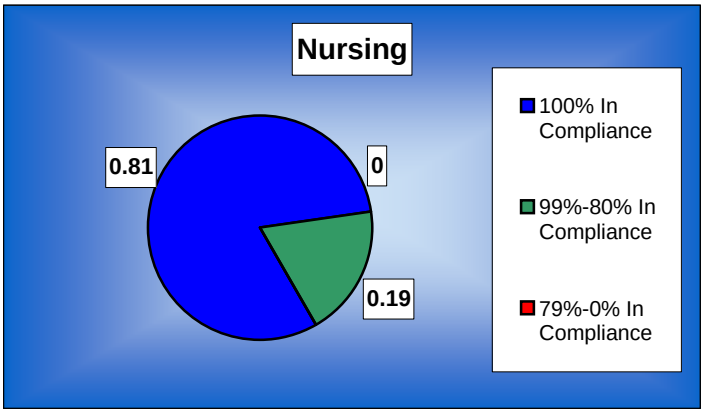


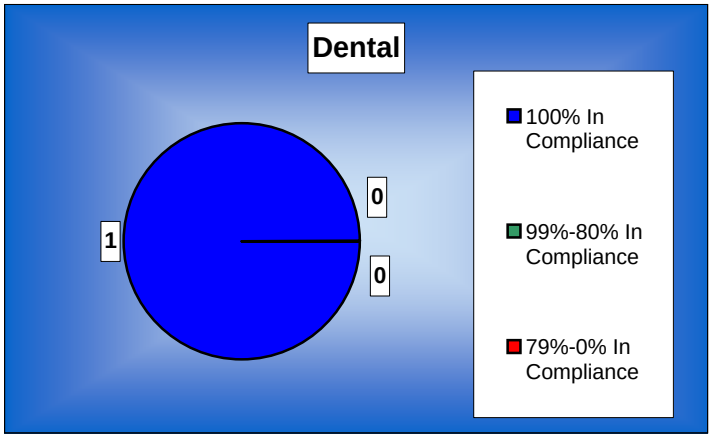
Quarterly Reports for
Compliance Rate By Operational Categories
Glossbrenner Facility
Nobember 7, 2007

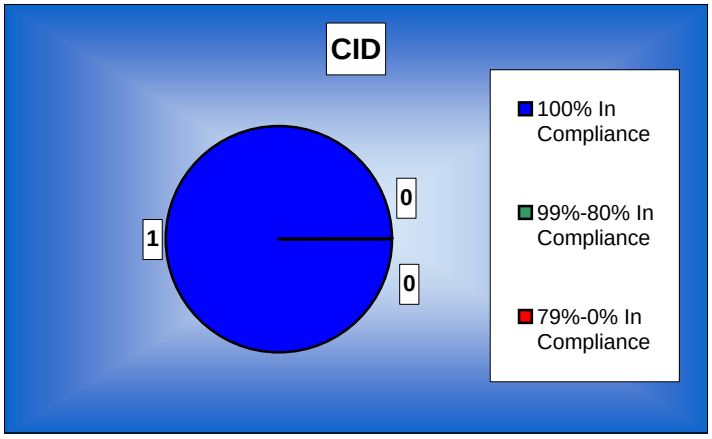




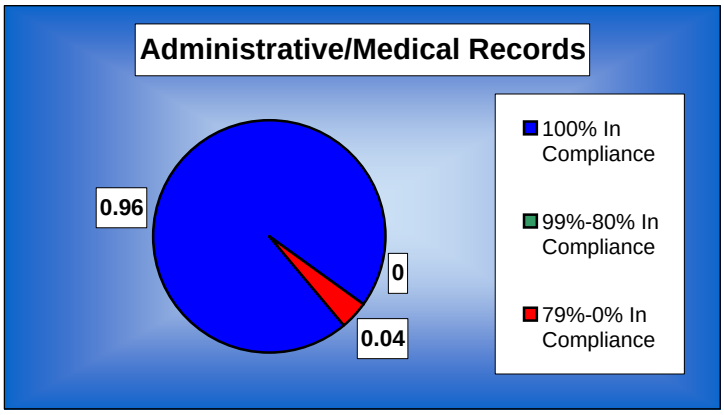


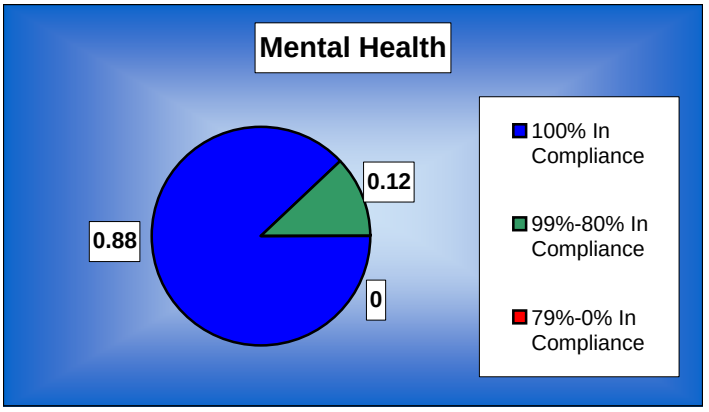


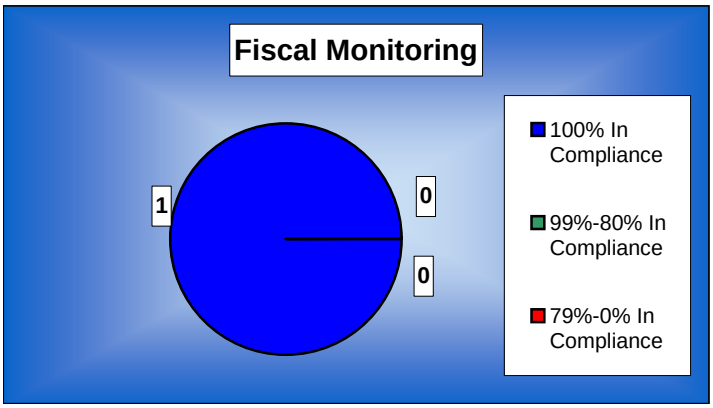


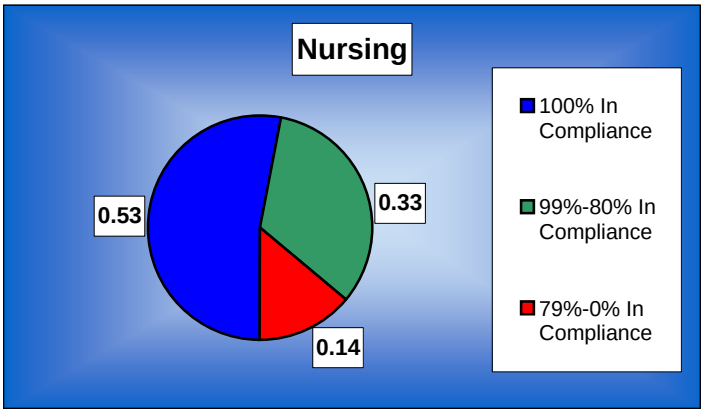


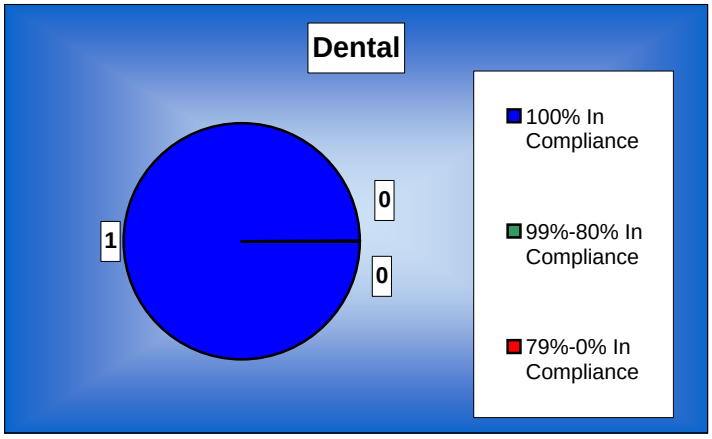
Quarterly Reports for
Compliance Rate By Operational Categories
Roach Facility
September 11, 2007

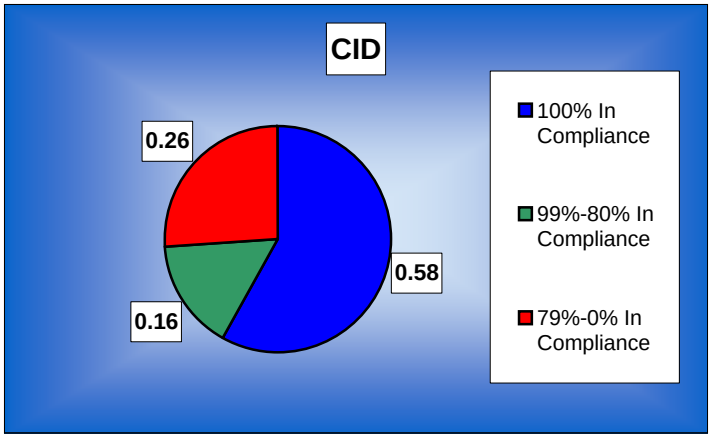




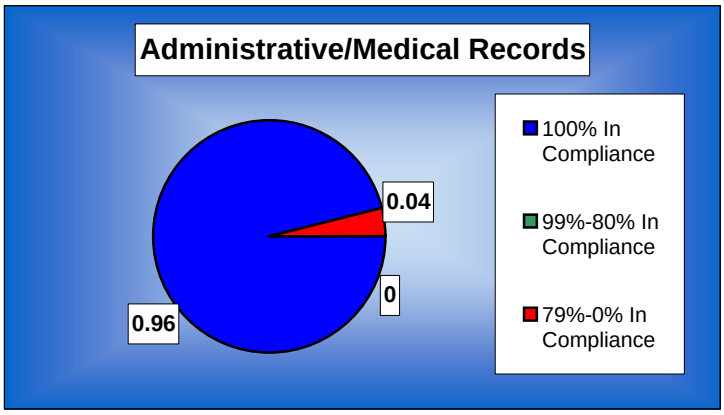


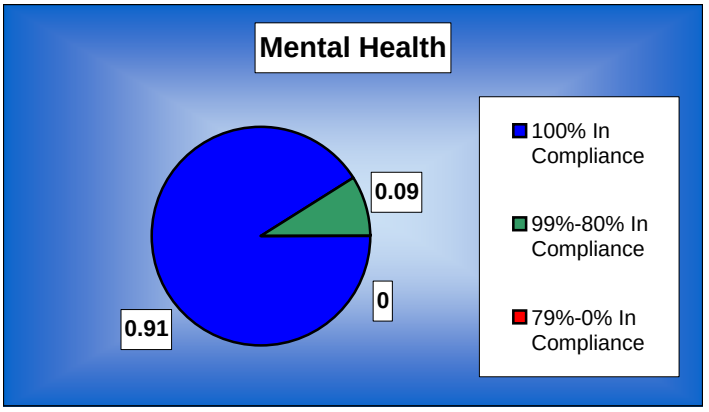


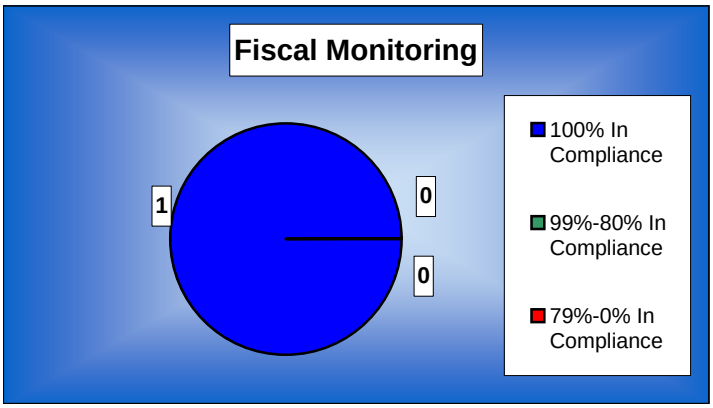


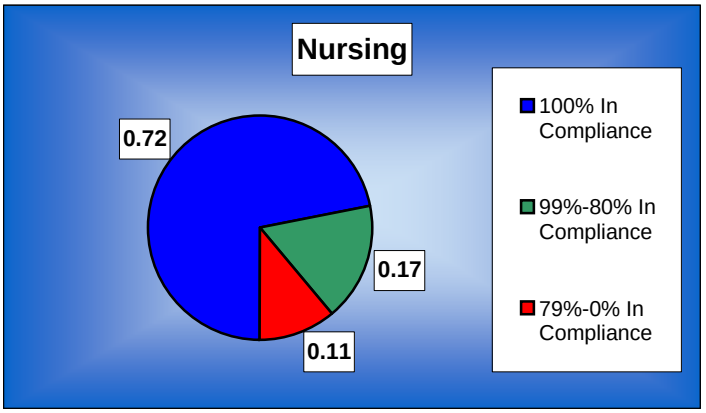


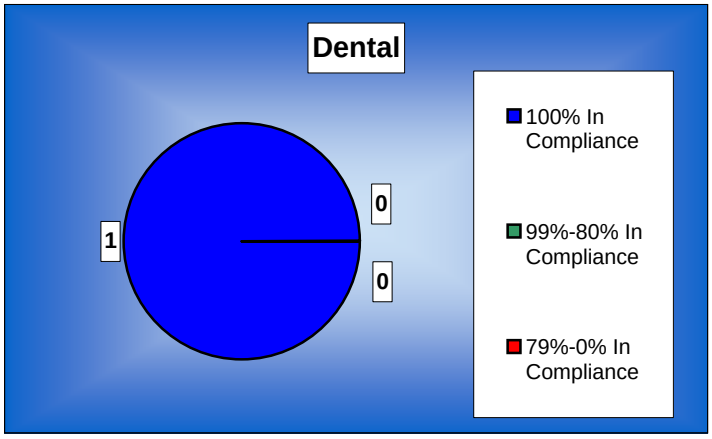
Quarterly Reports for
Compliance Rate By Operational Categories
Scott Facility
October 2, 2007

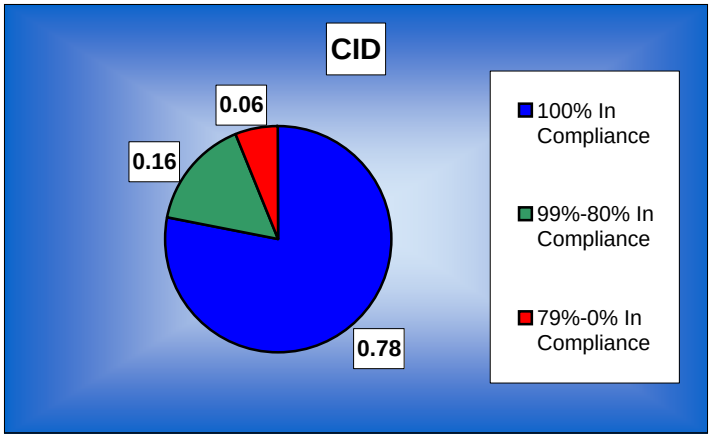




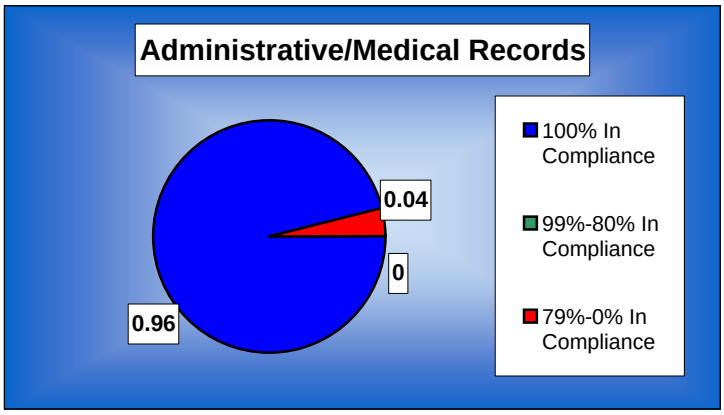


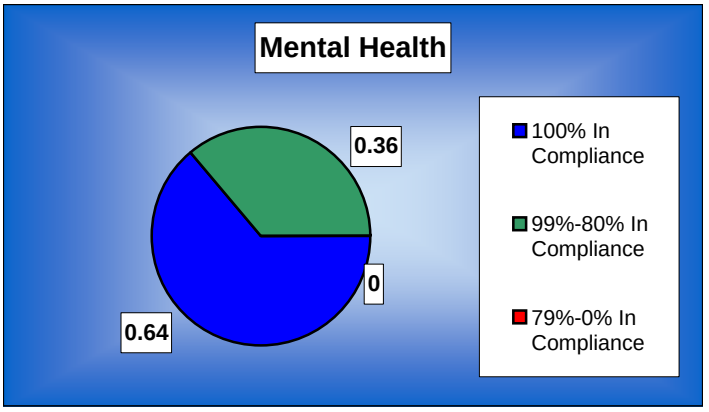


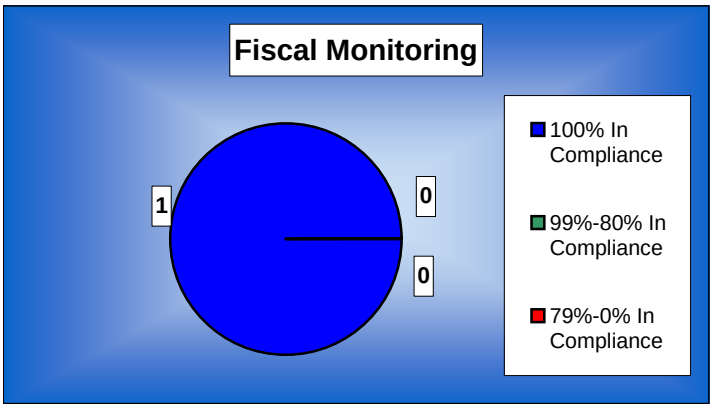


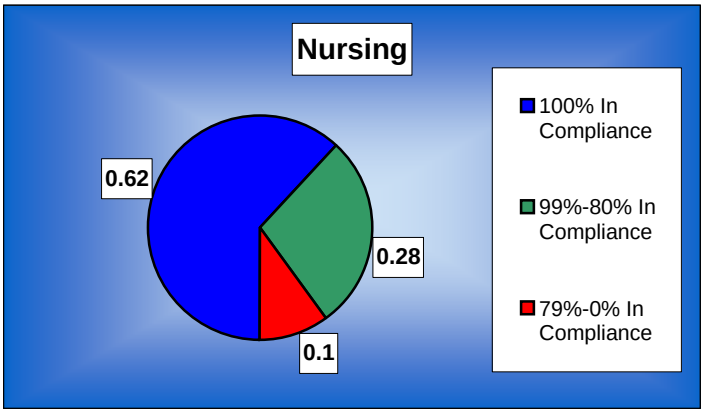


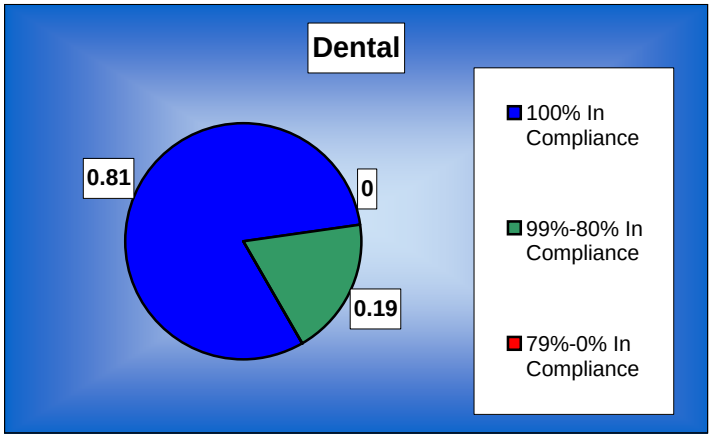
Quarterly Reports for
Compliance Rate By Operational Categories
Terrell Facility
October 4, 2007

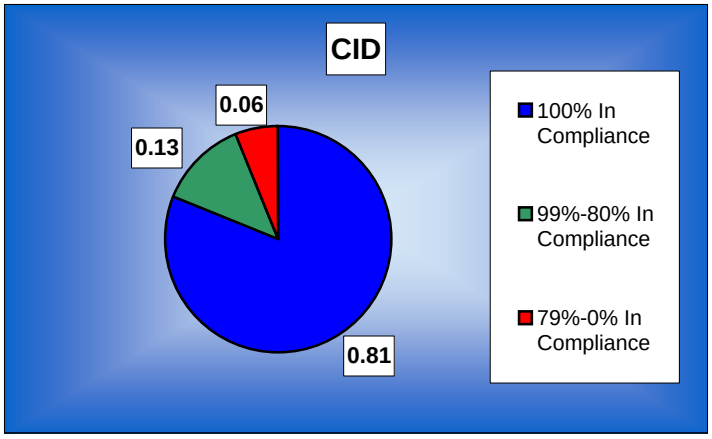












PATIENT LIAISON AND STEP II GRIEVANCE STATISTICS

QUALITY OF CARE/PERSONNEL REFERRALS AND ACTION REQUESTS

First Quarter FY2008

(September, October, and November)

STEP II GRIEVANCE PROGRAM (GRV)									
FY2008	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
September	489	30	6.13%	20	4.09%	10	2.04%	0	0.00%
October	560	37	6.61%	25	4.46%	12	2.14%	0	0.00%
November	500	37	7.40%	30	6.00%	6	1.20%	1	0.20%
Totals:	**1549**	**104**	**6.71%**	**75**	**4.84%**	**28**	**1.81%**	**1**	**0.06%**

PATIENT LIAISON PROGRAM (PLP)									
FY2008	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
September	529	4	0.76%	3	0.57%	1	0.19%	0	0.00%
October	584	1	0.17%	1	0.17%	0	0.00%	0	0.00%
November	436	16	3.67%	16	3.67%	0	0.00%	0	0.00%
Totals:	**1549**	**21**	**1.36%**	**20**	**1.29%**	**1**	**0.06%**	**0**	**0.00%**

Texas Department of Criminal Justice

Office of Preventive Medicine

Monthly Activity Report

Month: SEPTEMBER 2007

Reports Received	This Month	Same Month Last Year	Year to Date	Last Year to Date
Chlamydia	5	1	40	38
Gonorrhea	5	2	28	33
Syphilis	56	61	492	573
Hepatitis A	0	0	0	0
Hepatitis B (acute cases)	1	5	12	22
Hepatitis C	355	386	3184	3404
HIV Screens (non-pre-release)	5951	5665	55081	51025
HIV Screens (pre-release)	2227	2675	30414	31694
HIV + pre-release tests	2	3	30	63
HIV Infections	36	26	432	458
AIDS	4	3	160	91
Methicillin-Resistant *Staph Aureus*	323	329	4036	4037
Methicillin-Sensitive *Staph Aureus*	106	120	1322	1304
Occupational Exposures (TDCJ Staff)	11	17	117	173
Occupational Exposures (Medical Staff)	5	4	38	53
HIV CPX Initiation	5		41	
Tuberculosis skin tests – intake (#positive)	160	303	2572	3413
Tuberculosis skin tests – annual (#positive)	32	47	560	558
Tuberculosis cases				
(1) Diagnosed during intake and attributed to county of origin	0	1	4	6
(2) Entered TDCJ on TB medications	1	1	16	15
(3) Diagnosed during incarceration in TDCJ	2	2	11	14
TB cases under management	20	20		
Peer Education Programs	0	0	94	74
Peer Education Educators	0	0	702	454
Peer Education Participants	2715	829	29887	16434
Sexual Assault In-Service (sessions/units)	3-Mar	15/8	36/31	53/97
Sexual Assault In-Service Participants	11	44	195	482
Alleged Assaults & Chart Reviews	42	37	456	37

NOTE: Some category totals may change to reflect late reporting.
Date Compiled: 3/13/08

Texas Department of Criminal Justice

Office of Preventive Medicine

Monthly Activity Report

Month: OCTOBER 2007

Reports Received	This Month	Same Month Last Year	Year to Date	Last Year to Date
Chlamydia	9	8	49	46
Gonorrhea	3	2	31	22
Syphilis	66	58	558	631
Hepatitis A	0	0	0	0
Hepatitis B (acute cases)	3	2	15	24
Hepatitis C	346	433	3530	3837
HIV Screens (non-pre-release)	4794	6392	59875	57417
HIV Screens (pre-release)	1814	2753	32228	35082
HIV + pre-release tests	3	4	33	74
HIV Infections	20	53	452	511
AIDS	9	7	169	98
Methicillin-Resistant *Staph Aureus*	327	359	4486	4597
Methicillin-Sensitive *Staph Aureus*	106	117	1482	1491
Occupational Exposures (TDCJ Staff)	5	8	122	61
Occupational Exposures (Medical Staff)	4	7	42	58
HIV CPX Initiation	4		45	
Tuberculosis skin tests – intake (#positive)	123	353	2821	3766
Tuberculosis skin tests – annual (#positive)	32	86	606	644
Tuberculosis cases				
(1) Diagnosed during intake and attributed to county of origin	0	0	4	6
(2) Entered TDCJ on TB medications	1	2	17	17
(3) Diagnosed during incarceration in TDCJ	1	1	12	15
TB cases under management	18	21		
Peer Education Programs	1	0	95	74
Peer Education Educators	14	0	716	454
Peer Education Participants	4083	1071	35249	18200
Sexual Assault In-Service (sessions/units)	5-Jun	1-Jan	42/36	54/98
Sexual Assault In-Service Participants	49	5	244	487
Alleged Assaults & Chart Reviews	51	52	507	89

NOTE: Some category totals may change to reflect late reporting.
Date Compiled: 3/13/08

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

Month: NOVEMBER 2007

Reports Received	This Month	Same Month Last Year	Year to Date	Last Year to Date
Chlamydia	5	8	54	54
Gonorrhea	2	3	33	25
Syphilis	49	78	607	708
Hepatitis A	0	0	0	0
Hepatitis B (acute cases)	0	2	15	26
Hepatitis C	483	335	4012	4172
HIV Screens (non-pre-release)	5615	6252	65490	63669
HIV Screens (pre-release)	2828	2201	35341	37722
HIV + pre-release tests	11	1	44	75
HIV Infections	63	35	515	546
AIDS	13	2	107	100
Methicillin-Resistant *Staph Aureus*	268	293	4869	5046
Methicillin-Sensitive *Staph Aureus*	79	73	1628	1611
Occupational Exposures (TDCJ Staff)	9	12	123	214
Occupational Exposures (Medical Staff)	5	7	55	68
HIV CPX Initiation	7		56	
Tuberculosis skin tests – intake (#positive)	84	291	2999	4057
Tuberculosis skin tests – annual (#positive)	33	43	654	687
Tuberculosis cases				
(1) Diagnosed during intake and attributed to county of origin	0	0	4	6
(2) Entered TDCJ on TB medications	2	0	19	17
(3) Diagnosed during incarceration in TDCJ	2	0	14	15
TB cases under management	18	19		
Peer Education Programs	0	0	95	74
Peer Education Educators	0	0	716	454
Peer Education Participants	2745	759	38503	19615
Sexual Assault In-Service (sessions/units)	3-Mar	13/5	45/39	64/102
Sexual Assault In-Service Participants	26	84	270	571
Alleged Assaults & Chart Reviews	44	40	95	129

NOTE: Some category totals may change to reflect late reporting.
Date Compiled: 3/13/08

Office of Health Services Liaison
Utilization Review Monitoring
Facilities Audited with Deficiencies Noted
(First Quarter 2008 Report)

Medical Provider	University	Number of Audits	Number of Deficiencies	Comments (See Footnotes)
Brownfield Regional	TTUHSC			
Cogdell Memorial	TTUHSC	1	1	1a; 5
Electra Memorial	TTUHSC			
Hendrick Memorial	TTUHSC	3	1	1a; 5
Hospital Del Sol	TTUHSC	1	1	1a; 5
Hospital Galveston	UTMB	210	125	100=1a; 4=2; 3=1; 9=4; 5=11
Mitchell County	TTUHSC			
Northwest Texas	TTUHSC	3	3	3=1a; 2=5
Pampa	TTUHSC	1		
Pecos County	TTUHSC	1		
Scenic Mountain	TTUHSC			
Thomason	TTUHSC			
University Medical	TTUHSC	1	1	1a; 5
United Regional 11th St.	TTUHSC	4	3	1=1a; 2=5

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

Medical Provider	University	Number of Audits	Number of Deficiencies	Comments (See Footnotes)
Allred	TTUHSC			
Beto	UTMB	2	1	1a
Clements	TTUHSC	3		
Connally	UTMB	1	1	1a
Estelle	UTMB	6	4	1=1; 2=1a;
Hughes	UTMB			
Jester 3	UTMB			
Montford	TTUHSC	19	12	12=1a; 2=5
Polunsky	UTMB	2	2	2=1a; 2=5
Robertson	TTUHSC	3	2	2=1a; 2=5
Stiles	UTMB	2		
Telford	UTMB			
CT Terrell	UTMB			
Young	UTMB	9	4	4=1a

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

Footnotes:

1 The patient was not medically stable when returned to general population.

1a Vital signed were not recorded in the electronic medical record for the date of discharge so it is not possible to verify that these offenders were stable when they returned to general population.

2 The level of medical services available at the facility were insufficient.

3 The patient was unable to ambulate the distances required to access the dining hall, shower and unit medical department upon discharge.

4 The patient required unscheduled medical care related to the admitting diagnosis within the first seven days after discharge.

5 Was pertinent documentation regarding the inpatient stay included in the electronic medical record (i.e., results of diagnostic tests, discharge planning, medical recommendations and/or **treatments, etc.)?**

CAPITAL ASSETS CONTRACT MONITORING AUDIT
BY UNIT
FIRST QUARTER, FISCAL YEAR 2008

September	Numbered Property On Inventory Report	Total Number of Deletions	Total Number of Transfers	Total Number of New Equipment
Allred	98	0	0	0
Ferguson	36	0	0	0
Roach	29	0	0	0

October	Numbered Property On Inventory Report	Total Number of Deletions	Total Number of Transfers	Total Number of New Equipment
Darrington	81	0	0	2
Scott	30	0	13	8
Terrell	51	1	2	0

November	Numbered Property On Inventory Report	Total Number of Deletions	Total Number of Transfers	Total Number of New Equipment
Connally	75	0	0	0
Glossbrenner	19	0	0	0

[redacted]

CAPITAL ASSETS AUDIT
FIRST QUARTER, FISCAL YEAR 2008

Audit Tools	September	October	November	Total
Total number of units audited	3	3	2	8
Total numbered property	163	162	94	419
Total number out of compliance	0	0	0	0
Total % out of compliance	0.00%	0.00%	0.00%	0.00%

AMERICAN CORRECTIONAL ASSOCIATION
ACCREDITATION STATUS REPORT
First Quarter FY-2008

University of Texas Medical Branch

Unit	Audit Date	% Compliance	
		Mandatory	Non-Mandatory
Goodman	September 10, 2007	100 %	99.1
Hilltop	September 17, 2007	100%	97.7
Johnston	October 15, 2007	100 %	99.1
Lychner/Kegans	October 22, 2007	100%	97.2
McConnell	October 1, 2007	100 %	98.6
Travis	October 29, 2007	100%	98.8
Byrd	November 5, 2007	100 %	98.6

Texas Tech University Health Science Center

Unit	Audit Date	% Compliance	
		Mandatory	Non-Mandatory
Clements	November 12, 2007	100 %	99.1

Executive Services
Active Monthly Research Projects – Medical
Health Services Division

November 2007

Project Number: 408-RM03

Researcher: Ned Snyder

IRB Number: 02-377

IRB Expires: June 30, 2008

Research Began: June 03, 2003

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

Data Collection Began: July 1, 2003

Proponent: University of Texas Medical Branch at Galveston

Data Collection End: July 03, 2008

Project Status: Data Analysis

Progress Report Due: January 14, 2008

Projected Completion Date: July 31, 2008

Units: Hospital Galveston

Project Number: 433-RM04

Researcher: Ned Snyder

IRB Number: 03-357

IRB Expires: July 31, 2008

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: July 31, 2008

Project Status: Data Collection

Progress Report Due: January 3, 2008

Projected Completion Date: July 31, 2008

Units: UTMB

Project Number: 450-RM04

Researcher: Everett Lehman

IRB Number: 04.DSHEFS.02XP

IRB Expires: July 14, 2008

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: June 30, 2006

Project Status: Formulating Results; Data Collection Complete

Progress Report Due: May 14, 2008

Projected Completion Date: September 1, 2007

Units: Lychner, Stringfellow

Project Number: 475-RM05

Researcher:
Robert Morgan

IRB Number:
L05-077

IRB Expires:
February 27, 2008

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

Progress Report Due:
January 6, 2008

Projected Completion Date:
January 1, 2008

Units: Gatesville, Montford

Project Number: 486-RM05

Researcher:
William O'Brien

IRB Number:
05-298

IRB Expires:
August 31, 2007

09/05/07: E-mail requesting current approval.

10/19/07: E-mail second request for new IRB.

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, 2007

Project Status:
Data Analysis / Data Collection

10/22/07: Received e-mail from Dr. O'Brien, the sponsor has withdrawn support, and now it will be funded by Merck, and not Tibotec. Dr. O'Brien will submit a revision of the proposal for renewal.

Progress Report Due:
July 18, 2007

09/05/07: E-mail requesting updated progress report.

10/19/07: E-mail second request for update.

Projected Completion Date:
November 31, 2008

Units: Hospital Galveston

Project Number: 490-RM06

Researcher:
Sharon Melville

IRB Number:
Exempt

IRB Expires:
DNA

Research Began:
March 1, 2006

Title of Research:
Medical Monitoring Project (MMP)

Data Collection Began:
August 11, 2006

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

Data Collection End:
April 30, 2010

Project Status:
Data Collection

Progress Report Due:
October 22, 2008

Projected Completion Date:
April 30, 2010

Units: System-wide

Project Number: 499-RM06

Researcher:	IRB Number:	IRB Expires:	Research Began:
Albert D. Wells	06-307	August 31, 2008	April 4, 2007

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

Data Collection Began:
May 1, 2007

Proponent:
University of Texas Medical Branch, Galveston

Data Collection End:
June 7, 2007

Project Status:	Progress Report Due:	Projected Completion Date:
Data Analysis	January 31, 2008	August 31, 2008

Units: N/A (Data Only)

Project Number: 503-RM06

Researcher:	IRB Number:	IRB Expires:	Research Began:
William O'Brien	06-189	April 30, 2008	October 23, 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 26, 2006

Proponent:
University of Texas Medical Branch at Galveston

Data Collection End:
October 31, 2008

Project Status:	Progress Report Due:	Projected Completion Date:
Data Collection	July 16, 2007 09/05/07: E-mail requesting updated progress report. 10/19/07: E-mail second request for progress report.	To be determined by trial sponsor

Units: UTMB

Project Number: 513-MR07

Researcher:	IRB Number:	IRB Expires:	Research Began:
H. Morgan Scott	Exempt	DNA	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:
August 31, 2007

Project Status:	Progress Report Due:	Projected Completion Date:
Data Analysis	March 6, 2008	August 31, 2008

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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Project Number: 515-MR07

Researcher:	IRB Number:	IRB Expires:	Research Began:
Jacques Baillargeon	06-249	January 18, 2008	October 27, 2006

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

Data Collection Began:
March 5, 2007

Proponent:
University of Texas Medical Branch, Galveston

Data Collection End:
December 31, 2007

Project Status:	Progress Report Due:	Projected Completion Date:
Data Analysis	January 2, 2008	December 31, 2009

Units: N/A (Data Only)

Project Number: 523-MR07

Researcher:	IRB Number:	IRB Expires:	Research Began:
Robert Morgan	L06-193	August 22, 2007 09/05/07: E-mail requesting current approval. *See Projected Completion Date	April 17, 2007

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

Data Collection Began:
April 23, 2007

Proponent:
Texas Tech University, Department of Psychology

Data Collection End:
May 7, 2007

Project Status:	Progress Report Due:	Projected Completion Date:
Data Collection	March 6, 2008	*Currently analyzing data and as they complete the data analyses, research reports will be submitted.

Units: Montford

Project Number: 527-MR07

Researcher:	IRB Number:	IRB Expires:	Research Began:
Ned Snyder	05-277	July 31, 2007 09/05/07: E-mail requesting current approval. 10/19/07: E-mail second request for current IRB approval.	April 17, 2007

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

Data Collection Began:
March 12, 2007

Proponent:
University of Texas Medical Branch, Galveston

Data Collection End:
July 31, 2008

Project Status:	Progress Report Due:	Projected Completion Date:
Data Collection	January 12, 2008	July 31, 2008

Units: UTMB

Medical Research Projects Pending Approval
November 2007

Project Number: 541-MR07

Researcher: Michael Davis

IRB Number: 07-007

IRB Expires: February 16, 2008

Application Received: May 8, 2007

Title of Research:
Effects of telecardiology on cardiovascular disease management: Recent review of health outcomes

Completed Application Received: May 25, 2007

Proponent:
UTMB

Peer Panel Scheduled: June 13, 2007

Project Status:
11/13/07: Research Agreement prepared sent to Dr. Davis for signature.

Progress Report Due: N/A

Peer Panel Recommendations: Approved w/ Conditions

Units: N/A

Project Number: 542-MR07

Researcher: Dr. Jacques Baillargeon

IRB Number: **07-277**

IRB Expires: August 31, 2008

Application Received: September 14, 2007

Title of Research:
Psychiatric Barriers to Outpatient Care in Released HHIV-Infected Offenders

Completed Application Received:

Proponent:
University of Texas Medical Branch

Peer Panel Scheduled:

Project Status:
10/19/07: Proposal prepared and sent to OGC for approval.

10/19/07: Proposal prepared and sent to Health Services (Dr. Kelley) for approval.

Progress Report Due:

Peer Panel Recommendations:

Units:

Project Number: 544-MR07

Researcher:
Dr. Roger Soloway

IRB Number:

IRB Expires:

Application Received:
September 27, 2007

Title of Research:
Prevention of Hepatocellular Carcinoma Recurrence with Pegylated Alpha-Interferon + Ribavirin in Chronic Hepatitis C after Definitive Treatment

Completed Application Received:

Proponent:
University of Texas Medical Branch at Galveston

Peer Panel Scheduled:
Not Scheduled

Project Status:
10/04/07: Faxed to OIG for background check of researchers.

10/09/07: Received clearance on all researchers.

10/19/07: E-mail to Dr. Soloway with update of project

10/19/07: Mailed application and proposal to OGC and Health Services for approval/disapproval.

10/26/07: E-mail to Dr. Soloway requesting copy of the IRB.

Progress Report Due:

Peer Panel Recommendations:

Units:

TDCJ HEALTH SERVICES

ADMINISTRATIVE SEGREGATION MENTAL HEALTH AUDITS

FIRST QUARTER FY 2008

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	9/5&6/07	100%	100%	1	8	492	87/112	6-Apr
CLEMENTS (ECB)	9/19&20/07	100%	100%	0	13	440	216/91	6-May
McCONNELL	9/25&26/07	100%	100%	0	6	452	46/124	6-Apr
WYNNE	10/3&10/4/07	100%	100%	0	7	360	27/105	6-Mar
ALLRED (ECB)	10/9&10/2007	100%	100%	0	8	432	48/123	6-Apr
ALLRED (12 Bldg.)	10/10&10/11/07	92%	100%	3	6	493	109/87	6-May
BETO	10/15&17/07	83%	100%	0	6	264	57/88	6-Apr
COFFIELD	10/17&18/07	100%	100%	0	6	665	63/190	6-Apr
MOUNTAIN VIEW	10/24/2007	100%	N/A	0	0	12	10-Feb	4-Feb
LEWIS (ECB)	11/8&9/07	100%	100%	1	7	443	54/145	6-Mar
POLUNSKY	11/13&15/07	83%	N/A	1	9	452	76/155	6-Jun
MURRAY	11/20/2007	100%	100%	1	3	66	Aug-42	4-Feb
HUGHES	11/27&28/07	100%	100%	0	11	487	65/191	6-Jun
TOTAL		1,258	1100	7	90	5,058	663/1,463	52/74
AVERAGE		96.76%	100%	0.54	6.92	389.1	51.0/112.54	4.0/5.69

Consent Item 3(a)

University Medical Director's Report

The University of Texas Medical Branch

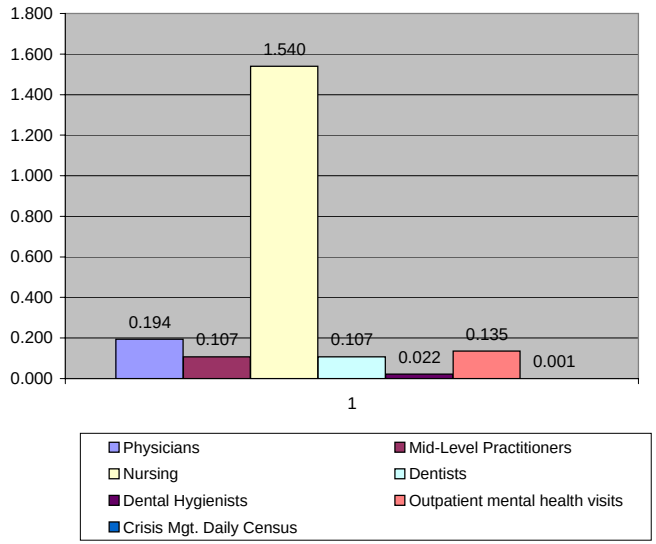
Correctional Health Care
MEDICAL DIRECTOR'S REPORT

FIRST QUARTER
FY2008

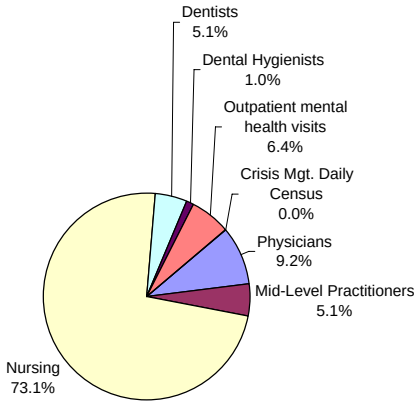
Medical Director's Report:

Average Population	September 120,196		October 120,296		November 120,538		Qtly Average 120,343	
	Number	Rate Per Offender	Number	Rate Per Offender	Number	Rate Per Offender	Number	Rate Per Offender
Medical encounters								
Physicians	23,321	0.194	26,327	0.219	20,340	0.169	**23,329**	**0.194**
Mid-Level Practitioners	11,964	0.100	13,671	0.114	12,979	0.108	**12,871**	**0.107**
Nursing	180,171	1.499	198,078	1.647	177,596	1.473	**185,282**	**1.540**
Sub-total	**215,456**	**1.793**	**238,076**	**1.979**	**210,915**	**1.750**	**221,482**	**1.840**
Dental encounters								
Dentists	12,070	0.100	14,532	0.121	12,181	0.101	**12,928**	**0.107**
Dental Hygienists	2,340	0.019	2,979	0.025	2,567	0.021	**2,629**	**0.022**
Sub-total	**14,410**	**0.120**	**17,511**	**0.146**	**14,748**	**0.122**	**15,556**	**0.129**
Mental health encounters								
Outpatient mental health visits	16,041	0.133	17,303	0.144	15,563	0.129	**16,302**	**0.135**
Crisis Mgt. Daily Census	85	0.001	73	0.001	76	0.001	**78**	**0.001**
Sub-total	**16,126**	**0.134**	**17,376**	**0.144**	**15,639**	**0.130**	**16,380**	**0.136**
Total encounters	**245,992**	**2.047**	**272,963**	**2.269**	**241,302**	**2.002**	**253,419**	**2.106**

Encounters as Rate Per Offender Per Month



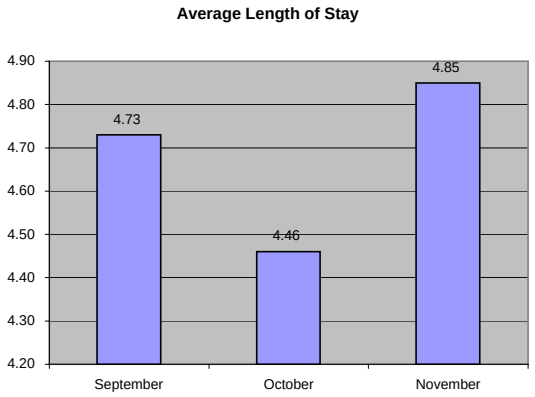
Encounters by Type

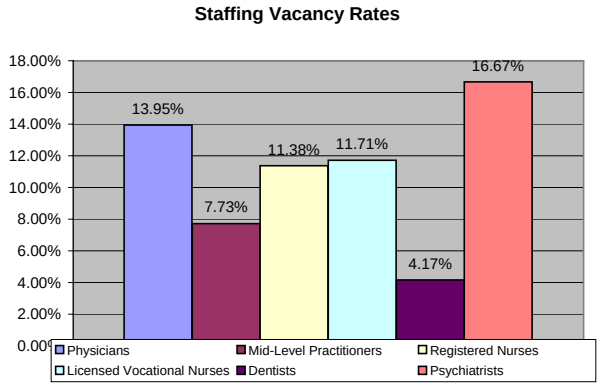


Medical Director's Report (Page 2):

	September	October	November	Qtly Average
Medical Inpatient Facilities				
Average Daily Census	78.00	78.00	92.00	**82.67**
Number of Admissions	390.00	423.00	445.00	**419.33**
Average Length of Stay	4.73	4.46	4.85	**4.68**
Number of Clinic Visits	1,637.00	1,994.00	1,935.00	**1,855.33**
Mental Health Inpatient Facilities				
Average Daily Census	1,049.67	1,021.45	1,013.86	**1,028.33**
PAMIO/MROP Census	695.20	691.19	697.57	**694.65**
Specialty Referrals Completed	743.00	934.00	730.00	**802.33**
Telemedicine Consults	441	530	556	**509.00**

	Average This Quarter			Percent
Health Care Staffing	**Filled**	**Vacant**	**Total**	**Vacant**
Physicians	61.70	10.00	71.70	13.95%
Mid-Level Practitioners	107.50	9.00	116.50	7.73%
Registered Nurses	366.00	47.00	413.00	11.38%
Licensed Vocational Nurses	671.00	89.00	760.00	11.71%
Dentists	69.00	3.00	72.00	4.17%
Psychiatrists	15.00	3.00	18.00	16.67%





Consent Item 3(b)

University Medical Director's Report

Texas Tech University
Health Sciences Center

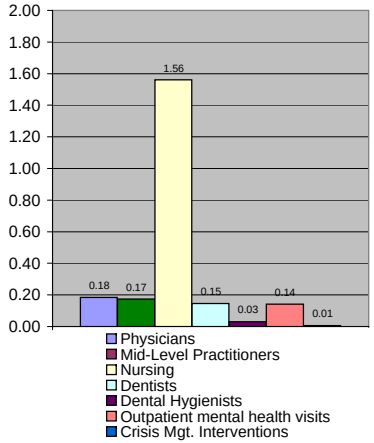
Correctional Managed Health Care
MEDICAL DIRECTOR'S REPORT

FIRST QUARTER
FY 2008

Medical Director's Report:

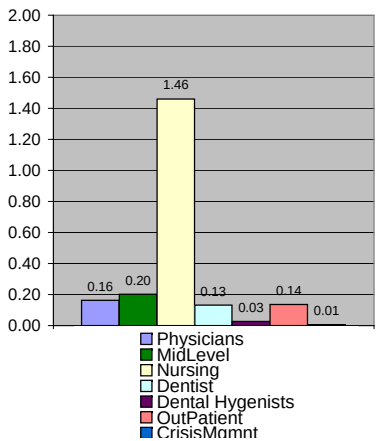
	September		October		November		Quarterly Average	
Average Population	31,409.15		31,293.02		31,182.82		31,295.00	
Medical Encounters	Number	Rate Per Offender	Number	Rate Per Offender	Number	Rate Per Offender	Number	Rate Per Offender
Physicians	5,286	0.168	5,358	0.171	4,722	0.151	5,122	0.16
Mid-Level Practitioners	5,923	0.189	7,213	0.230	5,915	0.190	6,350	0.20
Nursing	45,276	1.441	48,713	1.557	43,109	1.382	45,699	1.46
Sub-Total	**56,485**	**1.798**	**61,284**	**1.958**	**53,746**	**1.724**	**57,172**	**1.83**
Dental Encounters								
Dentists	4,103	0.131	4,471	0.143	3,754	0.120	4,109	0.13
Dental Hygienists	837	0.027	997	0.032	726	0.023	853	0.03
Sub-Total	**4,940**	**0.157**	**5,468**	**0.175**	**4,480**	**0.144**	**4,963**	**0.16**
Mental Health Encounters								
Outpatient mental health visits	3,831	0.122	4,617	0.148	4,347	0.139	4,265	0.14
Crisis Mgt. Interventions	219	0.007	240	0.008	198	0.006	219	0.01
Sub-Total	**4,050**	**0.129**	**4,857**	**0.155**	**4,545**	**0.146**	**4,484**	**0.14**
Total Encounters	**65,475**	**2.085**	**71,609**	**2.288**	**62,771**	**2.013**	**66,618**	**2.13**

Encounters as Rate Per Offender Per Quarter



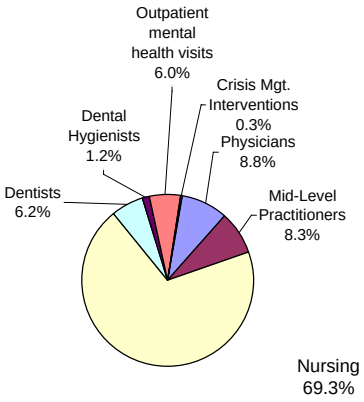
4th Quarter 2007

Encounters as Rate Per Offender Per Quarter



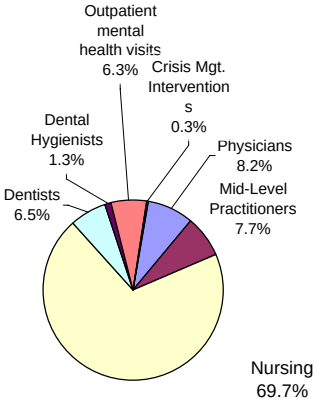
1st Quarter 2008

Encounters by Type



4th Quarter 2007

Encounters by Type

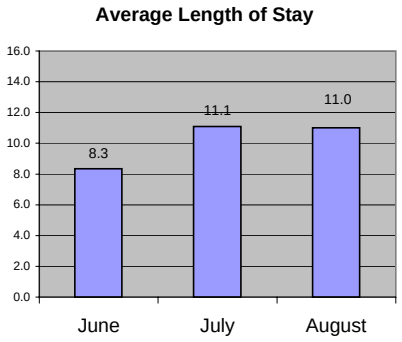


1st Quarter 2008

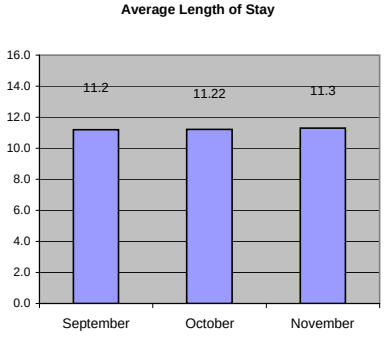
Medical Director's Report (page 2):

	September	October	November	Quarterly Average
Medical Inpatient Facilities				
Average Daily Census	87.67	82.81	87.4	**85.96**
Number of Admissions	250	255	237	**247.33**
Average Length of Stay	11.2	11.22	11.3	**11.24**
Number of Clinic Visits	612	729	610	**650.33**
Mental Health Inpatient Facilities				
Average Daily Census	513	511	519	**514.33**
PAMIO/MROP Census	399	420	431	**416.67**
Specialty Referrals Completed	1190	1272	1228	**1230.00**
Telemedicine Consults	295	301	217	**271.00**

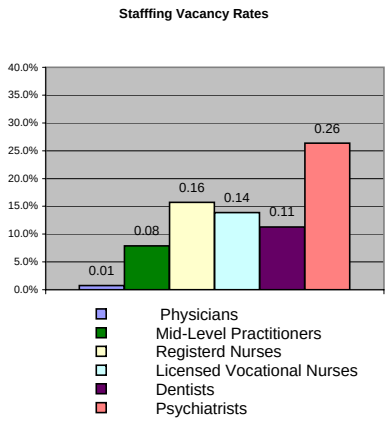
Health Care Staffing	Average This Quarter			Percent
	Filled	Vacant	Total	Vacant
Physicians	23.22	0.11	23.33	0.48%
Mid-Level Practitioners	26.02	0.39	26.41	1.48%
Registerd Nurses	146.16	40.08	186.23	21.52%
Licensed Vocational Nurses	295.94	62.39	358.33	17.41%
Dentists	17.82	2.53	20.34	12.42%
Psychiatrists	9.76	2.2	11.96	18.40%



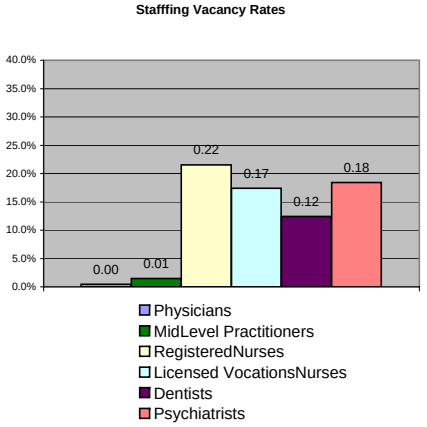
4th Quarter 2007



1st Quarter 2008



4th Quarter 2007



1st Quarter 2008

Consent Item 4

Summary of CMHCC Joint Committee / Work Groups

Correctional Managed Health Care
Joint Committee/Work Group Activity Summary
for March 2008 CMHCC Meeting

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 Dental Work Group
- Joint Mortality and Morbidity Committee
- Joint Nursing Work Group

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 14, 2008

Key Activities:

(1) Reviewed monthly detailed Access to Care Indicator data for the First Quarter of FY 2008. Discussed compliance issues and corrective actions taken.

ATC Indicators	Percent of Facilities with Quarterly Average 80% Compliance or Above
#1: SCR physically triaged within 48 hrs (72 hrs Fri and Sat)	*100.0%*
#2: Dental chief complaint documented in MR at time of triage	*100.0%*
#3: Referral to dentist (nursing/dental triage) seen within 7 days of SCR receipt	*95.2%*
#4: SCR/referrals (mental health) physically triaged within 48 hrs (72 hrs Fri/Sat)	*98.1%*
#5: MH chief complaint documented in the MR at time of triage	*99.0%*
#6: Referred outpatient MH status offenders seen within 14 days of referral/triage	*97.1%*
#7: SCR for medical services physically triaged within 48 hrs (72 hrs Fri/Sat)	*99.0%*
#8: Medical chief complaint documented in MR at time of triage	*100.0%*
#9: Referrals to MD, NP or PA seen within 7 days of receipt of SCR	*98.1.%*

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

- Infection Control
- Mental Health PULHES
- Monitoring CD4 Viral Load Analysis HIV+
- Transient Offender Post-Operative Antibiotics

(3) Heard an update on Correctional Managed Health Care Committee

(4) Reviewed Monthly Medical Grievance Exception Reports.

(5) Discussed issues related to SAFE Prisons Program

(6) Discussed issues related to EMR

(7) Heard an update on Nursing Work Group

Joint Policy and Procedure Committee

Co-Chair: 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 10, 2008

Key Activities:

(1) Discussed policy revisions to D-28.4, First Aid Kits

(2) Discussed policy revisions to I-71.2, Patient Self-Determination Act, The Texas Natural Death Act

(3) Discussed revisions to policy A-06.2, Nursing Peer Review Plan

(4) Approved revisions to policy A-08.6, Medically Recommended Intensive Supervision Screening

(5) Approved revisions to policy E-31.2 Organ or Tissue Donation

(6) Reviewed draft to policy E-31.4, Extraordinary Healthcare Determination

(7) Approved revisions to policy E-34.2, Periodic Physical Examination

(8) Approved revisions to policy E-34.4, Reporting Suspected Abuse

(9) Approved revisions to policy E-36.1 Dental Treatment Priorities

(10) Approved revisions to policy E-36.7, Dental Clinic Operations Reporting

(11) Approved revisions to policy E-37.1, Daily Triaging of Health Complaints

(12) Approved revisions to policy E-37.4, Lockdown Procedures

(13) Approved revisions to policy E-42.2, Missed Clinic Appointments

(14) Approved revisions to policy E-44.1, Continuity of Care

(15) Approved revisions to policy G-51.3, Admission Health Appraisals: Physically Handicapped

(16) Approved revisions to policy H-61.1, Confidentiality and Release of Information.

Joint Pharmacy and Therapeutics Committee

Chair: Dr. Sheri Talley

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

Meeting Dates: Jan. 10, 2008

A. Key Activities

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

- Psychiatry
- Disease Management Guideline Triage
- Coronary Artery Disease
- Linezolid

2) Reviewed and discussed monthly reports as follows:

- Adverse Drug Reaction Reports
- Pharmacy clinical activity
- Non-formulary deferrals
- Utilization related reports on:
    - HIV interventions
    - HIV utilization
    - Hepatitis C utilization
- Quarterly Medication Incident Reports
- FY07 Reports on:
    - Top 50 Drugs Prescribed by Cost
    - Top 50 Drugs Prescribed by Volume
    - FY07 P & T Initiatives
    - Total Number of RX Prescribed
    - Number RX PMPY
    - Drug Costs PMPD for Major Cost Drivers

- Total Returns and Percentage of Total Dollars
- Pharmacists Workload
- Pharmacist Intervention

(3) Follow-up discussion related to Enfuvirtide (Fuzeon) patients.

(4) Follow-up discussion of Nonformulary Medication Conversion Chart

(5) Reviewed action request to revise the bipolar depression disease management guidelines.

(6) Reviewed action request for Triamterene (Dyrenium®) formulary addition

(11) Reviewed formulary addition requests on Raltegravir (Isentress®)

(12) Reviwed Crestor® versus Liptor®

(12) Reviewed Policy and Procedures Revisions:

- P&P 10-35: Ordering warehouse medication
- P&P 15-40: Return of damaged or misshipped drugs
- P&P 15-45: Drug recalls / defective products
- P&P 20-05: Use of controlled substance
- P&P 20-15: Controlled substance record keeping
- P&P 25-05: Incoming inmates free world prescriptions and medications
- P&P 25-10: Medications dispensed to inmates being released from TDCJ
- P&P 30-05: IV Admixture

(13) Discussed manufacturer discontinuations on Supra Clens

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: February 14, 2008

Key Activities:

(1) Discussion on Follow-Up on TB Treatment

(2) Follow-up on Syphilis Changes to HSM85 form

(3) Discussion on DOT for MRSA

(4) Discussion and Review of Strategic National Stockpile

(5) Review and updated policies B-14.27 through B-14.50

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 23, 2008

Key Activities:

(1) Discussion of X-Ray Focus Study Review

(2) Review of staffing and non-compliance reports.

(3) Review of Dental Services Manual.

(4) Review of Staffing Plan Development

(5) Discussion of Diabetes DMG

(6) Heard update on Oral Surgery

(7) Review of Endo Consent Form

(8) Review of Pre-Employment Drug Testing

(9) Review of Benefit Eligible FTE's

(10) Review of Patient Satisfaction Survey

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 Dates:	November 7, 2007 (review of 41 cases), December 12, 2007 (review of 39 cases) and January 9, 2008 (review of 34 cases).
Key Activity:	Review and discussion of reports on offender deaths and determinations as to the need for peer review.

Joint Nursing Work Group

Chair: Mary Goetcher, RN

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

Meeting Date: February 12, 2008

Key Activities:

(1) Heard updates Estes Fire - Security to Bring to Clinic

(2) Heard discussion of Safety Needles Regulation

(3) Heard discussion on LVN Scope of Practice

(4) Reviewed Policy E39.1, Ad Seg Visits

(5) Reviewed Infirmary Policies on TDCJ Operational Review

(6) Heard Updates on Protocols and Standing Orders

(7) Heard Updates on Staffing Study

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: March 11, 2008

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:

Contract Amendment for San Saba and Marlin

The contract amendment adding Marlin and San Saba has been executed. San Saba began accepting inmates in February and Marlin is scheduled to open in April.

Senate Criminal Justice Committee Meeting

Senator John Whitmire held a meeting of the Senate Criminal Justice Committee on January 24th to review homicides and medical care within the Texas Department of Criminal Justice. The Committee heard invited testimony only. Testifying before the Committee was Ben G. Raimer. M.D. and Glenda Adams, M.D., University of Texas Medical Branch (UTMB); Executive Director Brad Livingston and Lannette Linthicum, M.D., Texas Department of Criminal Justice (TDCJ). Denise DeShields, M.D., Texas Tech University Health Sciences Center (TTUHSC) was in attendance as well as the CMHCC staff.

Staffing Study as Per House Bill 1, Article 5, Rider 87

Rider 87 requires the Texas Department of Criminal Justice to perform a staffing study for health and psychiatric care for each facility within the Correctional Institution Division. Dr. Lannette Linthicum has initiated the study in conjunction with UTMB and TTUHSC. The intent is to complete the study prior to submission of the Legislative Appropriations request for TDCJ.

Appropriations Request Planning

The partners need to start working on what they feel will be essential for the upcoming appropriations request. Items will need to be well justified and prioritized. Information regarding instructions and timeframes will be distributed as soon as they become available.

Interim Charge: Senate Criminal Justice Committee

The Senate Criminal Justice Committee has tentatively scheduled a hearing related to its interim charges for April 2nd. The hearing will address monitoring the implementation of SB 909, Sunset Bill.

CMHCC staff as well as the partner agency staff will be in attendance.

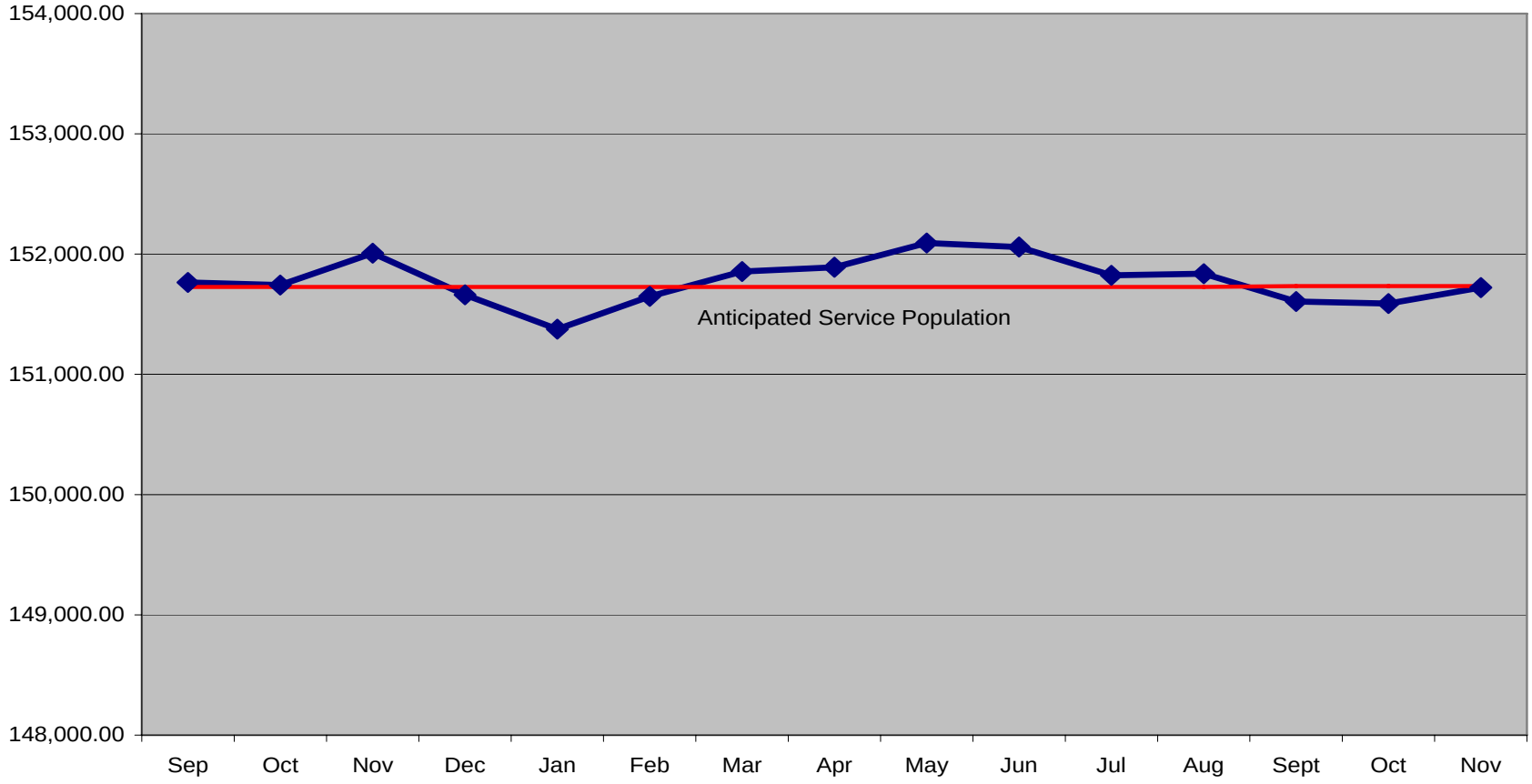
ARH:dm

Correctional Managed Health Care Committee

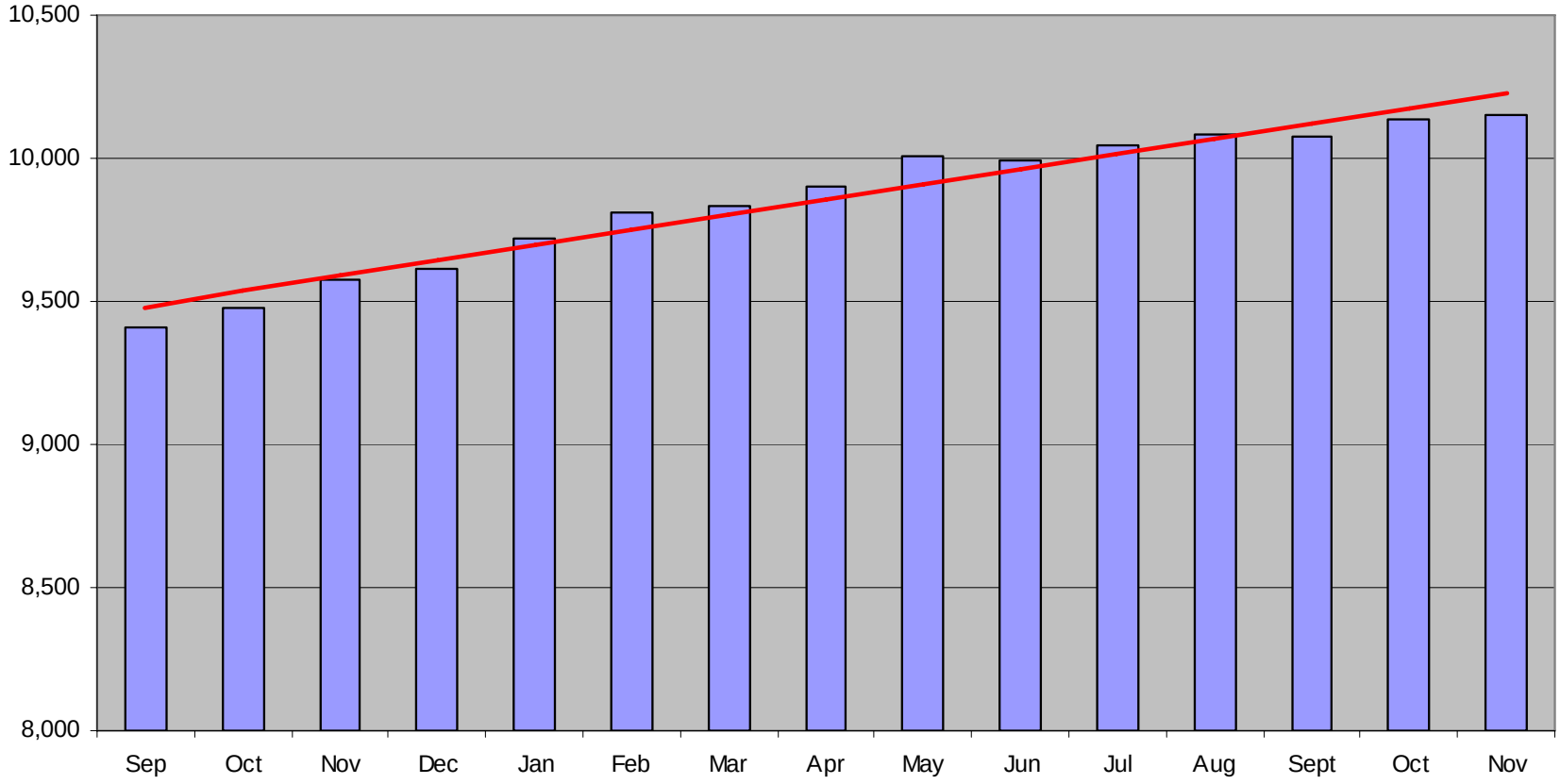
Key Statistics Dashboard

March 2008

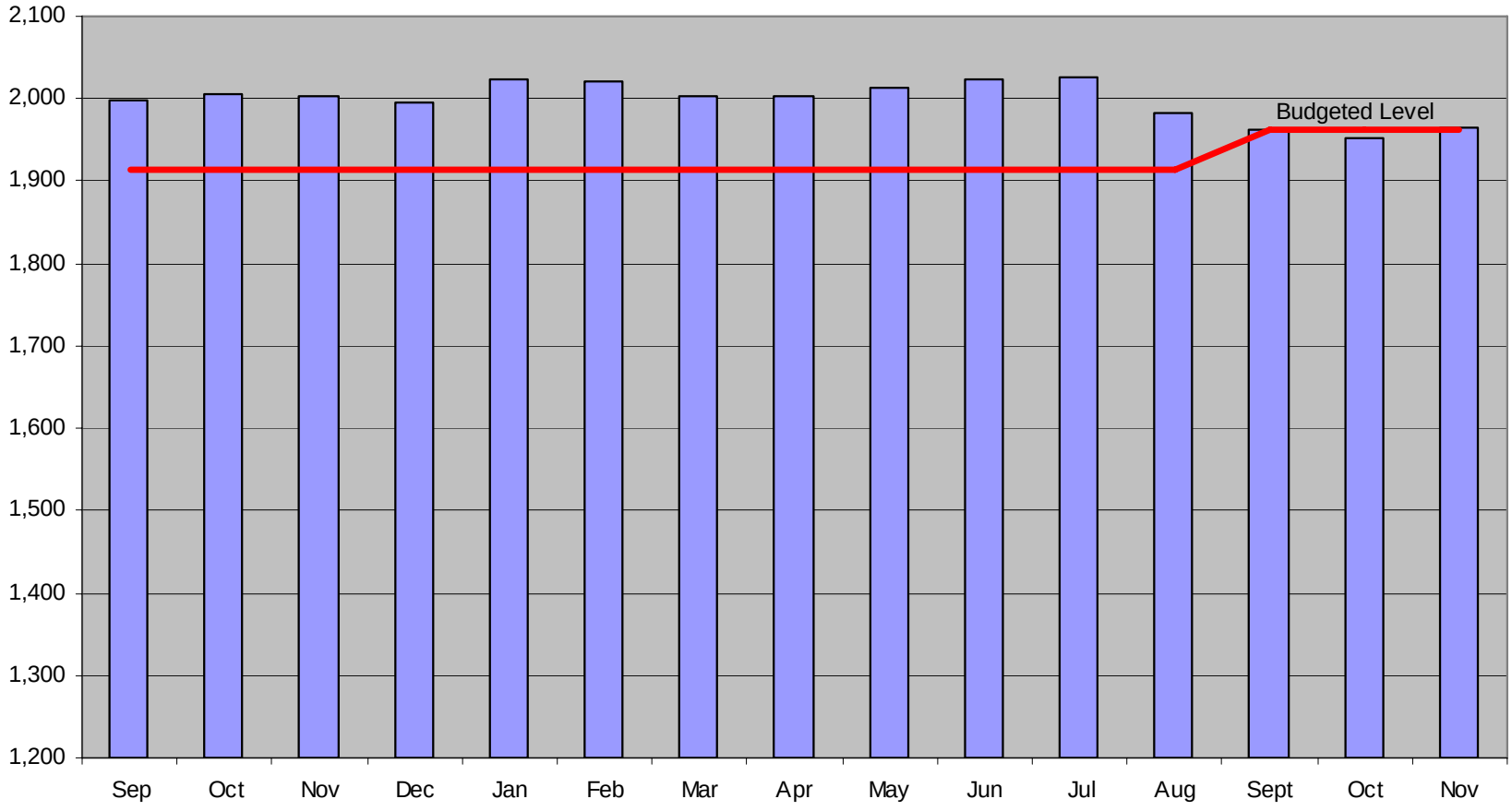
CMHC Service Population
FY 2007-2008 to Date



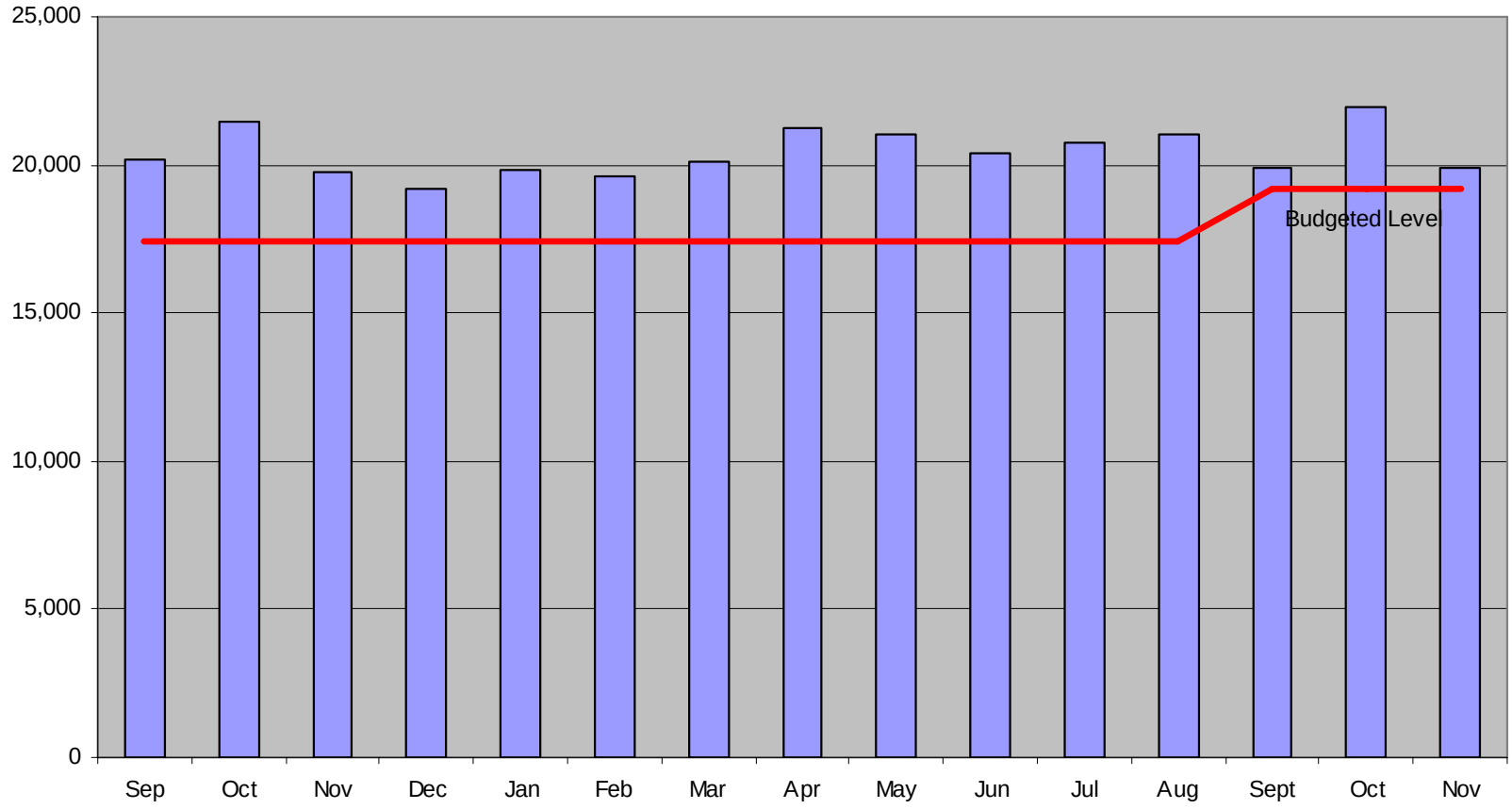
Offenders Age 55+
FY 2007-2008 to Date



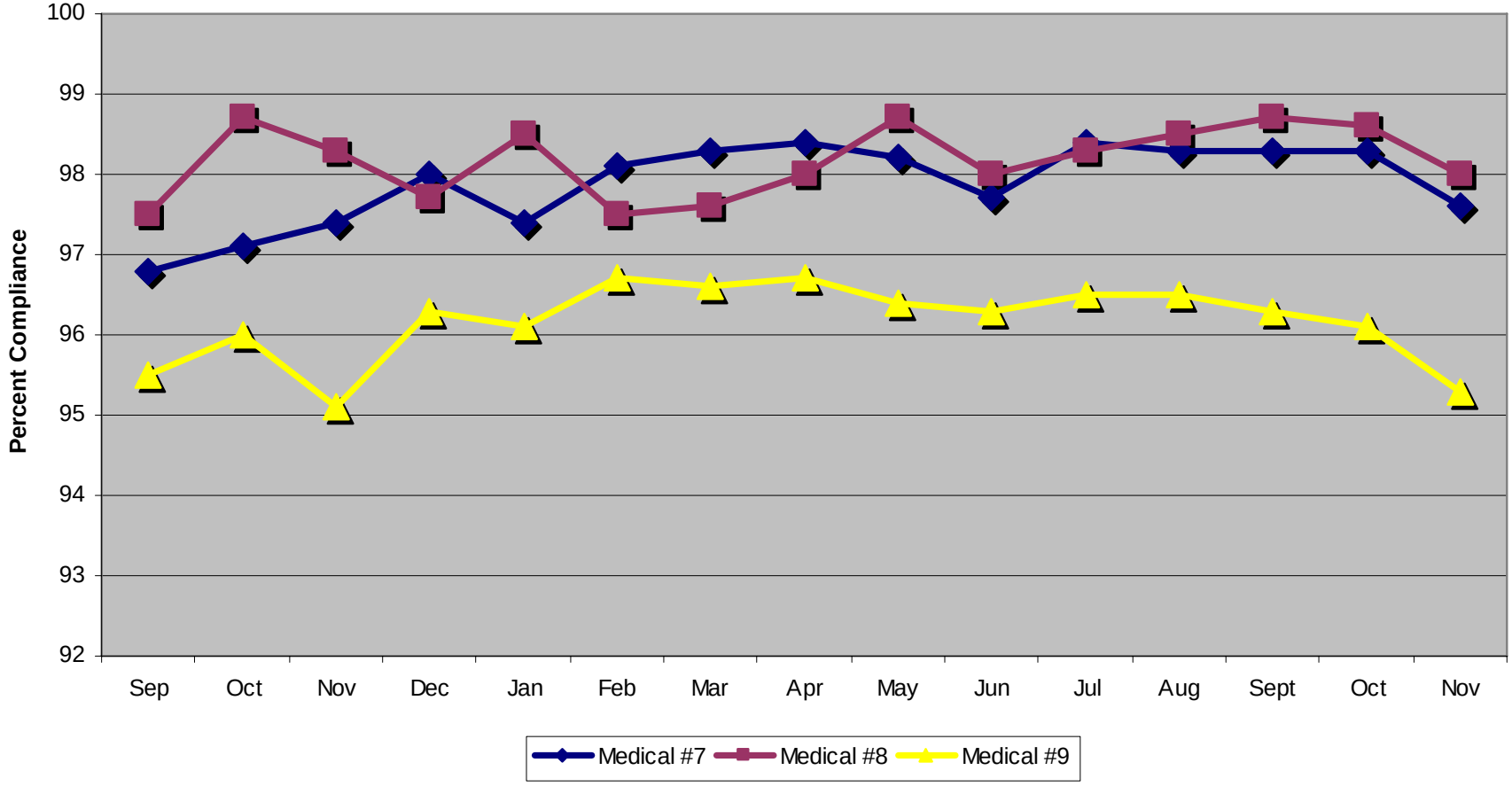
Psychiatric Inpatient Census



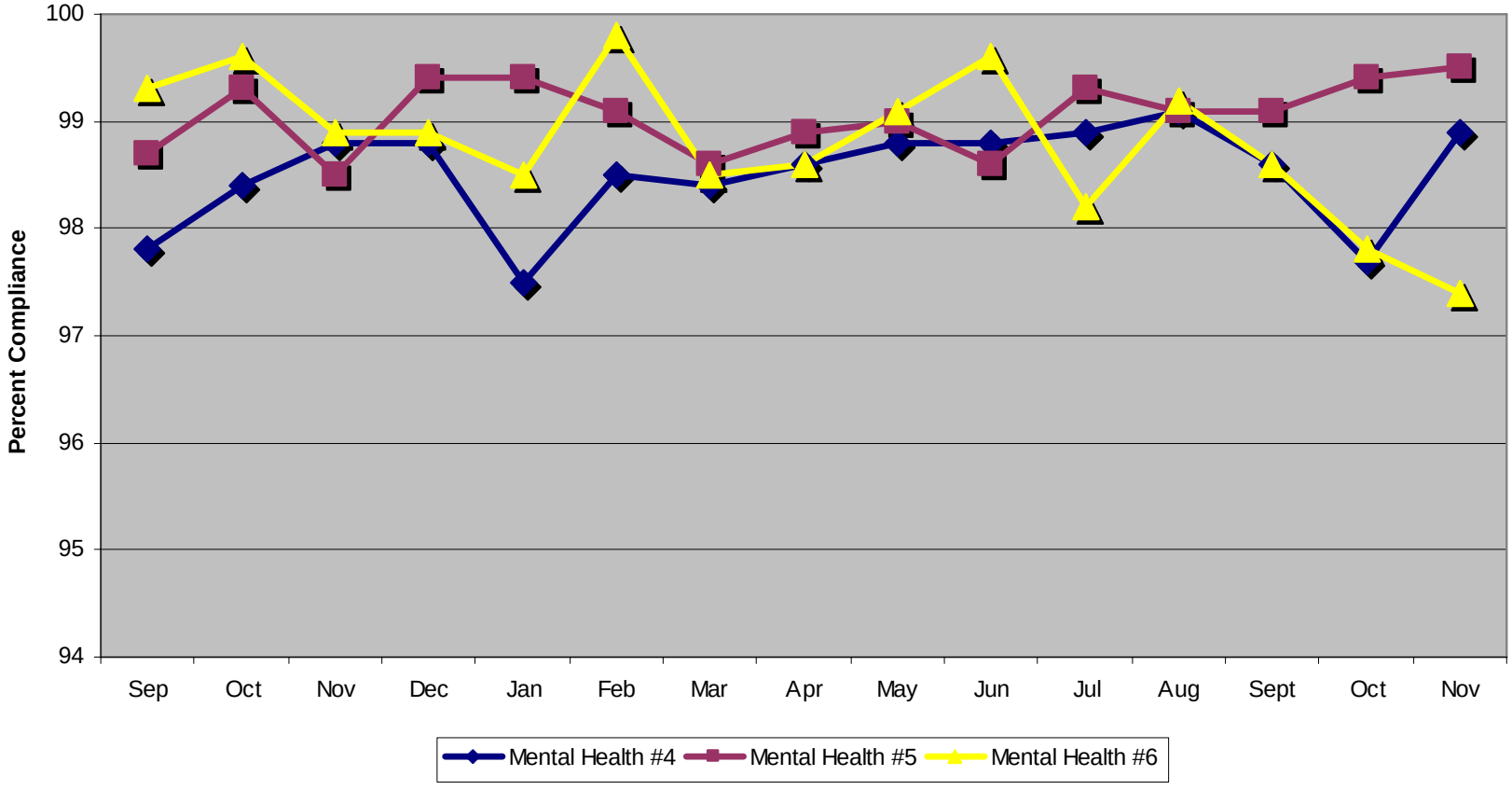
Psychiatric Outpatient Census



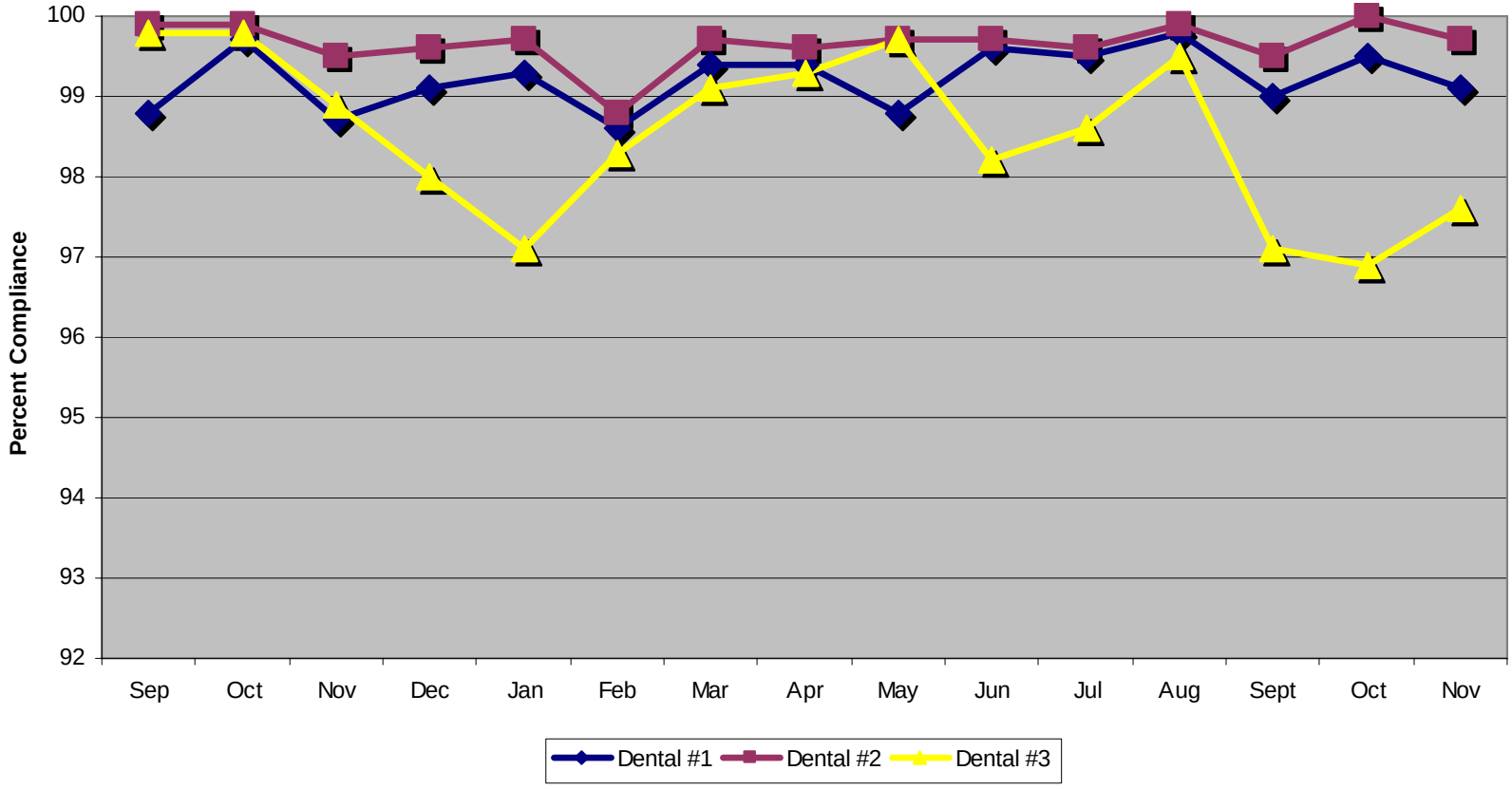
Medical Access to Care
Indicators FY 2007-2008 to Date



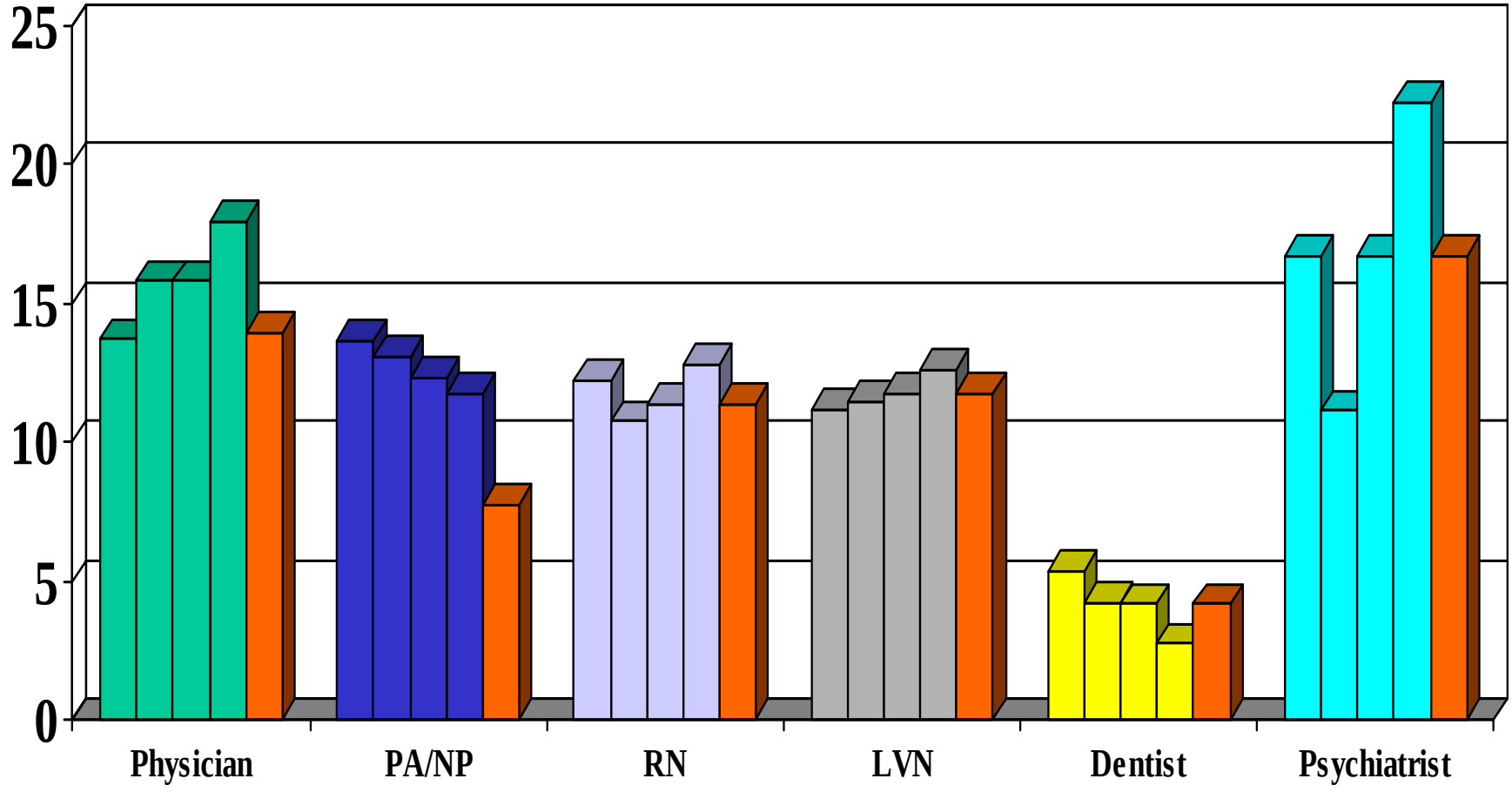
Mental Health Access to Care
Indicators FY 2007-2008 to Date



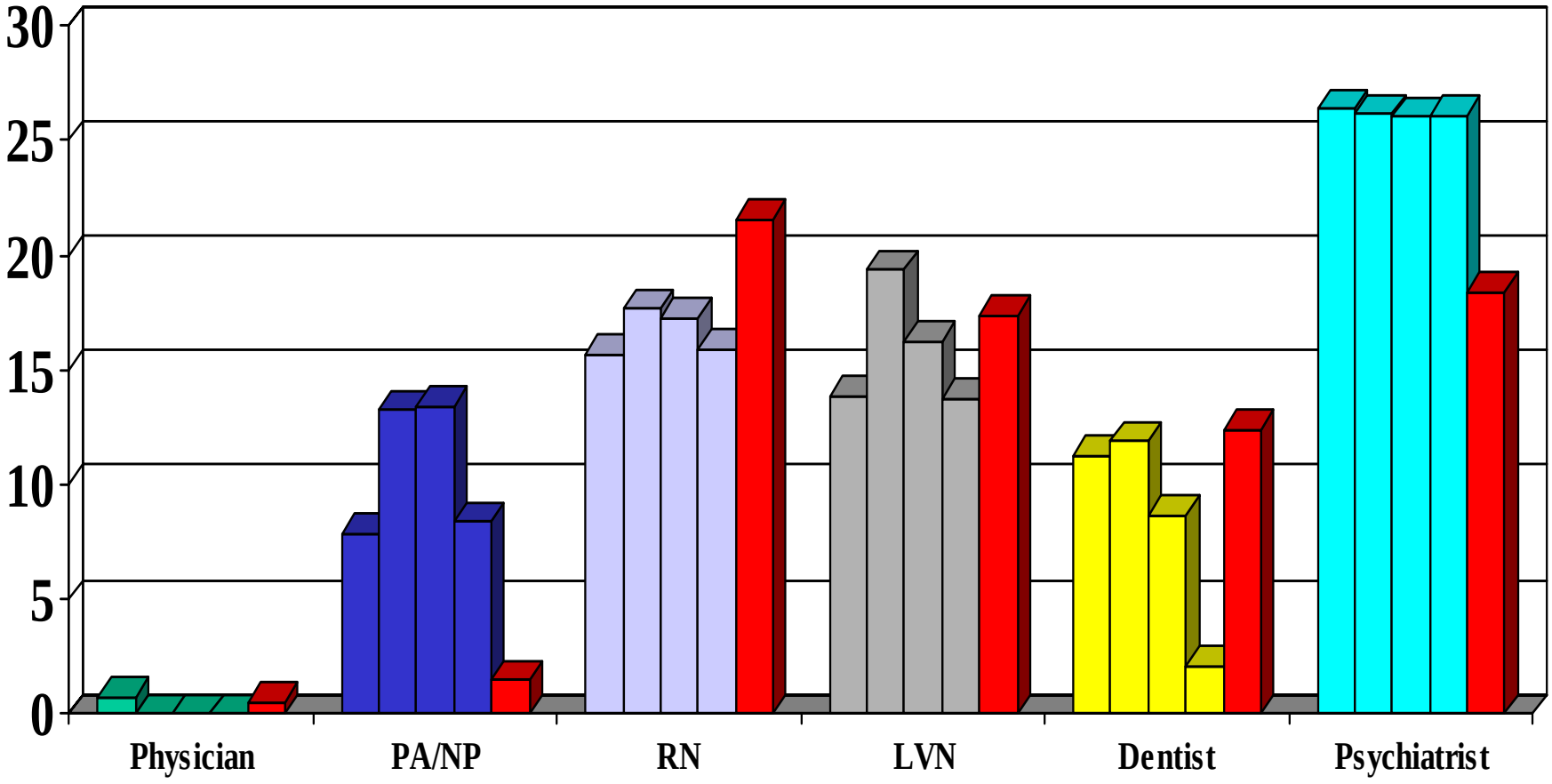
Dental Access to Care
Indicators FY 2007-2008 to Date



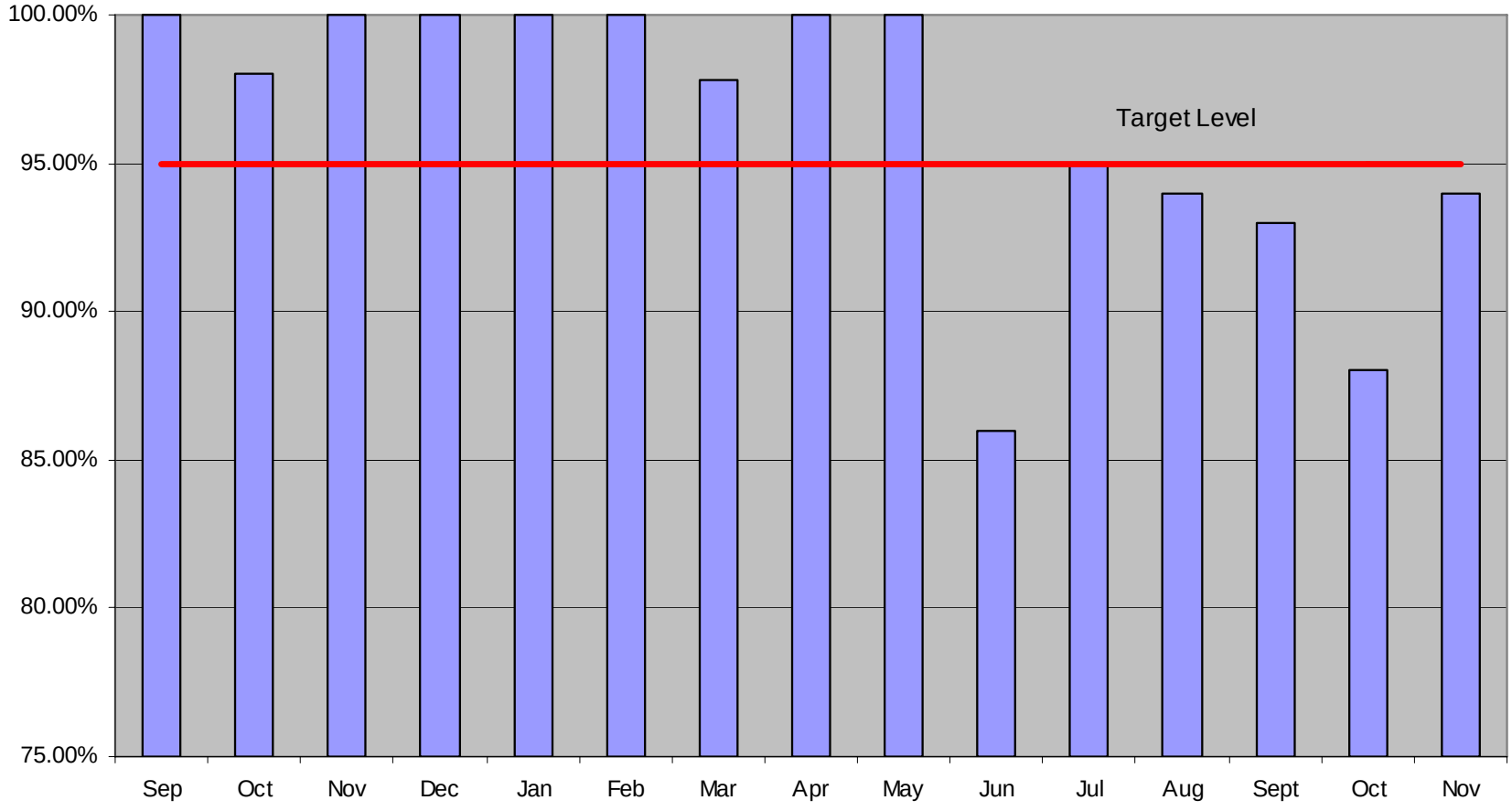
UTMB Vacancy Rates (%)
by Quarter FY 2007-FY 2008



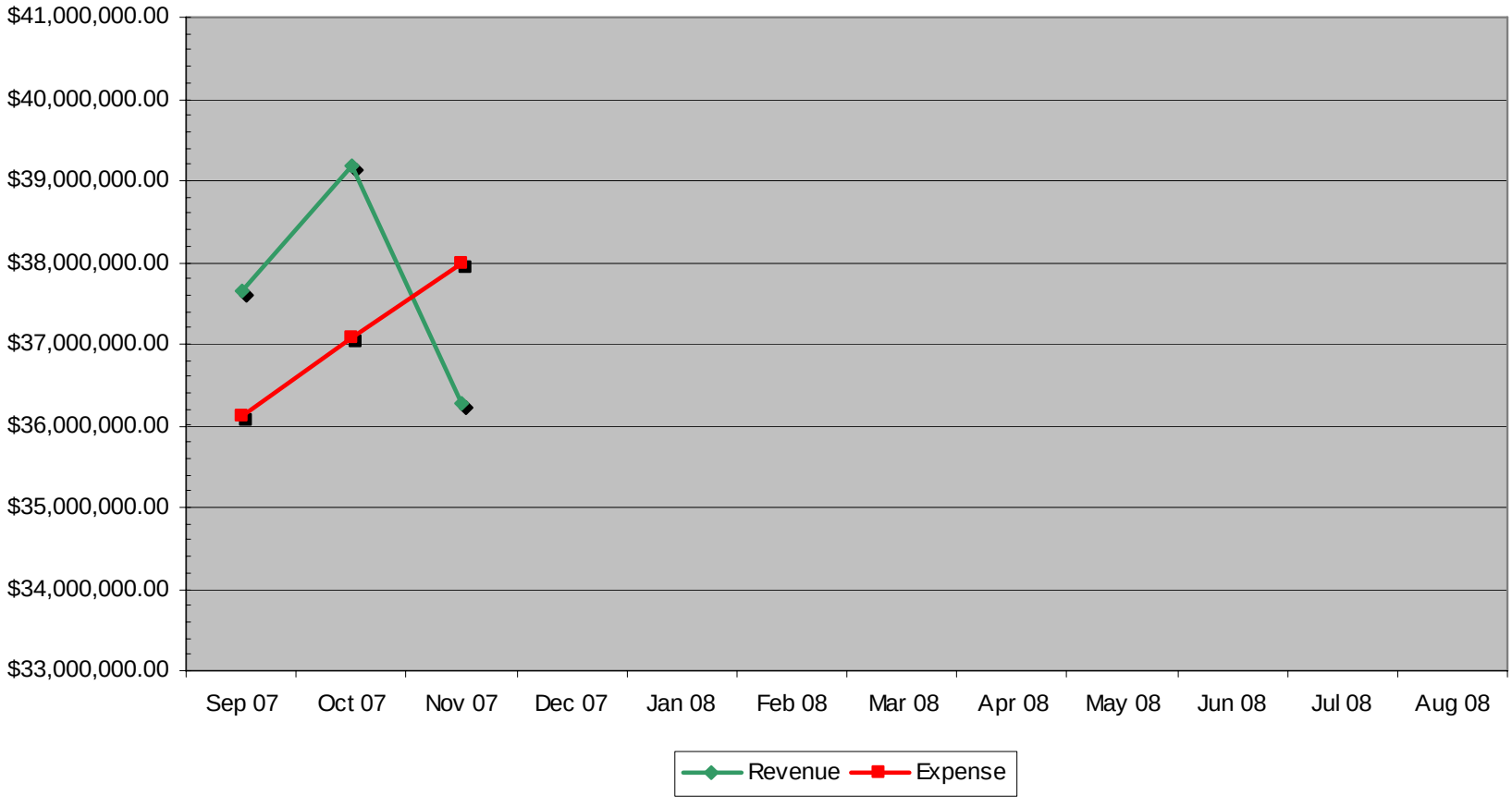
TTUHSC Vacancy Rates (%) by Quarter FY 2007-FY 2008



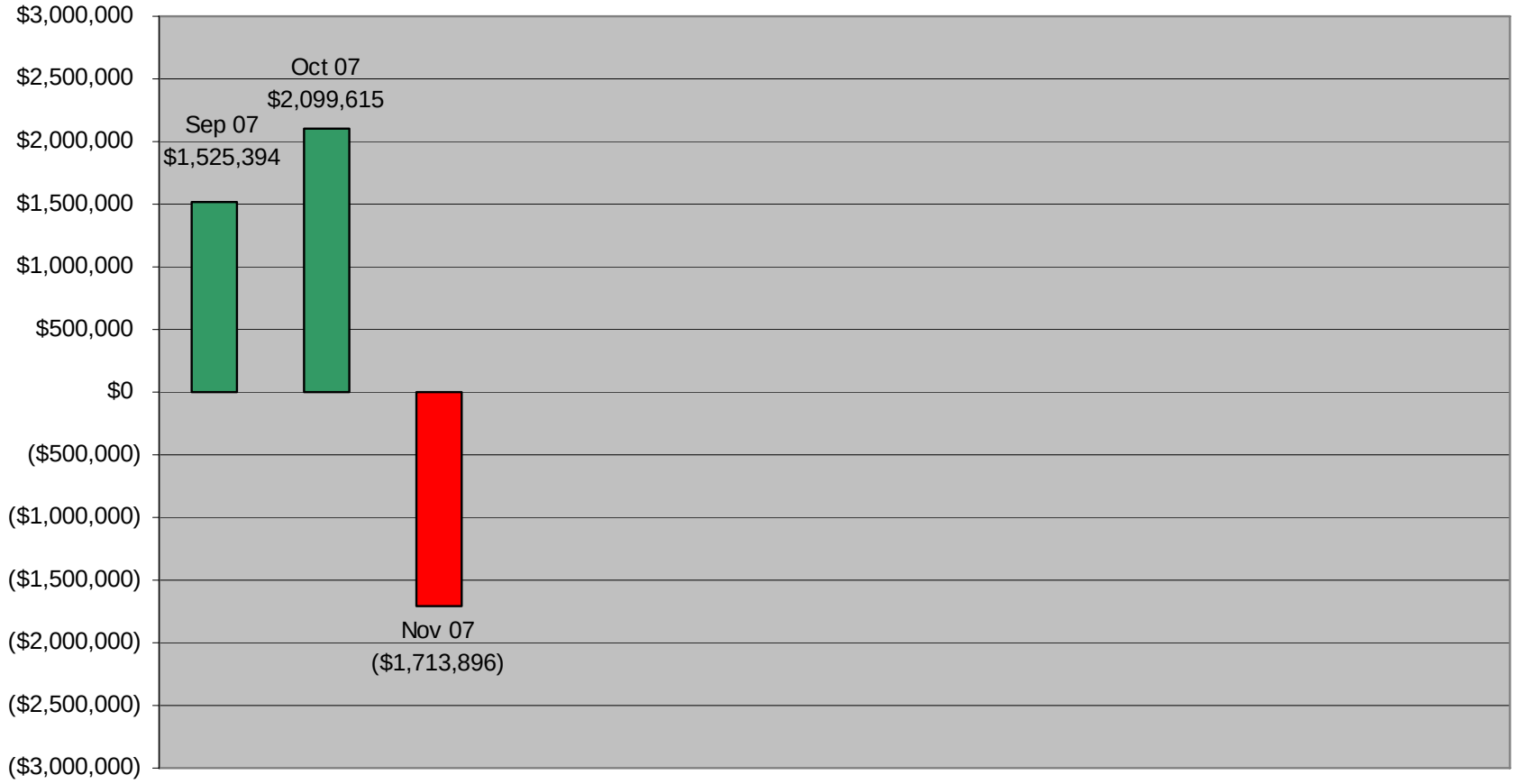
Percent of Timely MRIS Summaries



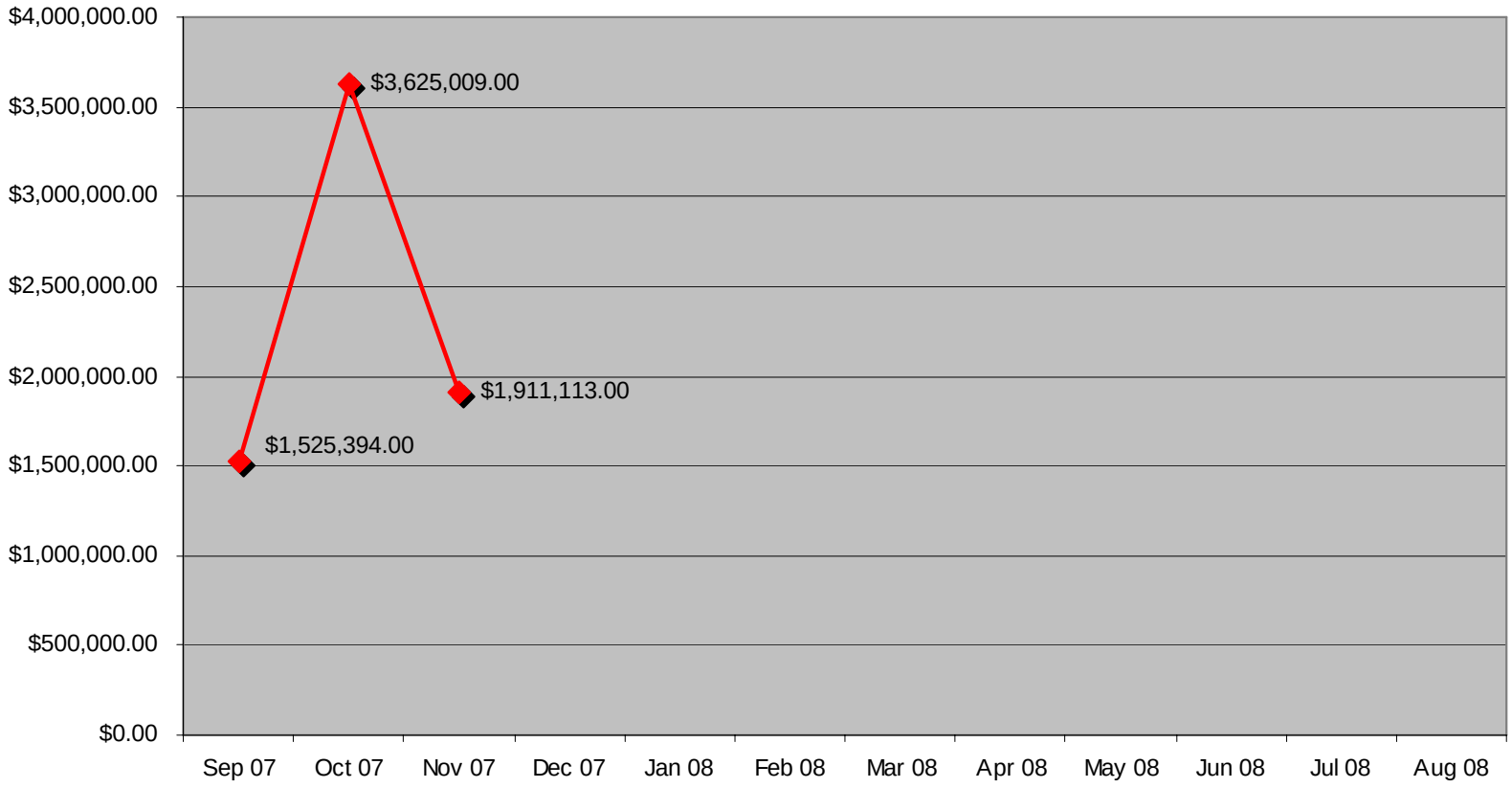
Statewide Revenue v. Expenses by Month
FY 2008



Statewide Loss/Gain by Month
FY 2008



Statewide Cumulative Loss/Gain
FY 2008



Summary of Critical Correctional Health Care Personnel Vacancies
Prepared for the Correctional Managed Health Care Committee

As of March 2008

Title of Position	CMHCC Partner Agency	Vacant Since (mm/yyyy)	Actions Taken to Fill Position
Physician I - II	UTMB CMC	9/1/2006	Local and National Advertising, Conferences. Currently 13 vacancies systemwide including Hospital Galveston and TYC
Mid Level Practitioners (PA and FNP)	UTMB CMC	9/1/2006	Local and National Advertising, Career Fairs, Conferences. Currently 12 openings systemwide, concentrated in Beeville and Palestine areas and includes Mental Health Services.
PAMIO Mental Health Director	TTUHSC	10/2005	Enhanced Advertisement and Recruitment through Newly Contracted Agencies
Correctional Dentist	TTUHSC	07/2003 – 09/2007	Enhanced Advertisement and Recruitment through Newly Contracted Agencies; Publications, Advertisement, Local Recruiting
Correctional Physician	TTUHSC	08/2007	Enhanced Advertisement and Recruitment through Newly Contracted Agencies.

Physician II	TDCJ	9/1/07	Multiple postings and advertisement in journals and newspapers; 3/1/08: continue to post and recruit applicants.
Nurse II – Contract and Quality Monitor	TDCJ	1/1/08	Retirement. 12/6/07: Salary increased per DM; 1/17/08: Chg job description; 1/25/08: Posted; 3/12/08: Waiting on applicant clearance.
Nurse II – Contract and Quality Monitor	TDCJ	9/1/07	Posted 8/15/07, 9/11/07, 9/21/07, 10/1/07, and 10/17/07. No applicants. Division Director has requested an across the board salary increase for all RN II positions. 12/6/07: Salary increase approved; 1/17/08: Chg job description; 1/25/08: Posted; 3/12/08: Waiting on applicant clearance.
Nurse II – Contract and Quality Monitor	TDCJ	9/1/07	Posted 8/15/07, 9/11/07, 9/21/07, 10/1/07, and 10/17/07. No applicants. Division Director has requested an across the board salary increase for all RN II positions. 12/6/07: Salary increase approved; 1/17/08: Chg job description; 1/25/08: Posted; 3/12/08: Waiting on applicant clearance.
Nurse II – Contract and Quality Monitor	TDCJ	9/1/07	Posted 8/15/07, 9/11/07, 9/21/07, 10/1/07, and 10/17/07. No applicants. Division Director has requested an across the board salary increase for all RN II positions. 12/6/07: Salary increase approved; 1/17/08: Chg job description; 1/25/08: Posted; 3/12/08: Waiting on applicant clearance.

Nurse II – Contract and Quality Monitor	TDCJ	9/1/07	Posted 8/15/07, 9/11/07, 9/21/07, 10/1/07, and 10/17/07. No applicants. Division Director has requested an across the board salary increase for all RN II positions. 12/6/07: Salary increase approved; 1/17/08: Chg job description; 1/25/08: Posted; 3/12/08: New Hire to begin on 3/17/08.
Nurse II – Contract and Quality Monitor	TDCJ	8/15/07	Posted 8/08/07, 8/24/07, 9/12/07, 9/21/07, 10/1/07, 10/17/07 and 10/26/07. No applicants. Division Director has requested an across the board salary increase for all RN II positions. 12/6/07: Salary increase approved; 1/17/08: Chg job description; 1/25/08: Posted; 3/12/08: New Hire to begin 3/17/08.
Nurse II – Contract and Quality Monitor	TDCJ	6/14/07	Posted 8/8/07, 8/24/07, 9/12/07, 10/1/07, and 10/17/07. No applicants. Division Director has requested an across the board salary increase for all RN II positions. 12/6/07: Salary increase approved; 1/17/08: Chg job description; 2/13/08: Convert full time RN into 2 part time RN positions; 3/12/08: In process of posting.
Public Health Technician II – HIV (LVN III)	TDCJ	11/1/07	The Division Director has requested an upgrade of this position to an LVN. Decision Memorandum approved 12/6/07. New LVN created; 12/19/07: Posted; 2/1/08: Position filled.

TEXAS DEPARTMENT OF CRIMINAL JUSTICE

HEALTH SERVICES DIVISION

MEDICAL DIRECTORS' REPORT

First Quarter FY-2008

Lannette Linthicum, MD, CCHP-A, FACP

TDCJ Medical Director's Report

Office of Health Services Monitoring (OHSM)

Operational Review Audit (ORA)

- During the first quarter of FY-2008, nine Operational Review Audits were conducted at the following facilities: Allred, Allred High Security, Connally, Darrington, Ferguson, Glossbrenner, Roach, Scott and Terrell. The ten items most frequently out of compliance follow:

1. Item 5.11 requires Emergency Room Forms (HSM-16), be filled out completely and legibly to include assessment, intervention, medications administered, disposition and signature. Eight of the nine facilities were not in compliance with this requirement. The eight facilities out of compliance were: Allred, Allred High Security, Connally, Darrington, Ferguson, Roach, Scott and Terrell. Corrective actions were requested from the eight facilities, all of which were submitted. The Allred and Allred High Security Facilities Corrective Action Plans were approved on 12/10/07, and the Roach Facility Corrective Action Plan was approved on 12/17/07. Five of the eight facility audits remain open.

2. Item 5.14 requires the Certification and Record of Segregation Visits form be dated and signed and have a current housing list attached. Seven of the nine facilities were not in compliance with this requirement. The seven facilities out of compliance were: Allred, Allred High Security, Connally, Darrington, Roach, Scott and Terrell. Corrective actions were requested from the seven facilities, all of which were submitted. The Allred and Allred High Security Facilities Corrective Action Plans were approved on 12/10/07, and the Roach Facility Corrective Action Plan was approved on 12/17/07. Four of the seven facility audits remain open.

3. Item 5.19 requires the medical provider document on the Report of Physical Exam (HSM-4), physical exams annually, on male offenders 60 years of age or older, to include digital rectal exam and fecal occult blood testing. Seven of the nine facilities were not in compliance with this requirement. The seven facilities out of compliance were: Allred, Allred High Security, Connally, Ferguson, Roach, Scott and Terrell. Corrective actions were requested of the seven facilities, all of which were submitted. The Allred and Allred High Security Facilities Corrective Action Plans were approved on 12/10/07, and the Roach Facility Corrective Action Plan was approved on 12/17/07. Four of the seven facility audits remain open.

4. Item 5.20 requires physical exams to be documented on the Report of Physical Exam (HSM-4), every three years on male offenders 50 to 59 years of age, to include digital rectal exam and fecal occult blood testing. Seven of the nine facilities were not in compliance with this requirement. The seven facilities out of compliance were: Allred, Connally, Darrington, Ferguson, Roach, Scott and Terrell. Corrective actions were requested of the seven facilities, all of which were submitted. The Allred Facility Corrective Action Plan was approved on 12/10/07, and the Roach Facility Corrective Action Plan was approved on 12/17/07. Five of the seven facility audits remain open.

5. Item 5.10 requires in the medical records of offenders who have been receiving therapeutic diets in excess of seven days, reflect that nutritional counseling has been provided within 30 days. Six of the nine facilities were not in compliance with this requirement. The six facilities out of compliance were: Allred High Security, Connally, Ferguson, Roach, Scott and Terrell. Corrective actions were requested of the six facilities, all of which were submitted. The Allred High Security Facility Corrective Action Plan was approved on 12/10/07, and the Roach Facility Corrective Action Plan was approved on 12/17/07. Four of the six facility audits remain open.

Operational Review Audit (ORA) Cont'd.

6. Item 6.37 requires the pneumococcal vaccine be offered to offenders with certain chronic diseases (e.g., heart disease, emphysema, COPD, diabetes.) Note that asthma is not included unless it is associated with COPD, emphysema or long term systemic steroid use. Six of the nine facilities were not in compliance with this requirement. The six facilities out of compliance were: Allred High Security, Darrington, Ferguson, Roach, Scott and Terrell. Corrective actions were requested of the six facilities, all of which were submitted. The Allred High Security Facility Corrective Action Plan was approved on 12/10/07, and the Roach Facility Corrective Action Plan was approved on 12/17/07. Four of the six facility audits remain open.

7. Item 6.39 requires offenders who have been diagnosed with Methicillin-Resistant Staphylococcus (MRSA), Diabetes or Human Immunodeficiency Virus (HIV) Infection with an additional diagnosis of Methicillin-Sensitive Staphylococcus Aureus (MSSA), MRSA or Serious MSSA, to be placed on Directly Observed Therapy (DOT). If DOT was not utilized, documentation reflecting compliance checks every forty-eight (48) hours must be present. Six of the nine facilities were not in compliance with this requirement. The six facilities out of compliance were: Allred, Allred High Security, Connally, Darrington, Scott and Terrell. Corrective actions were requested of the six facilities, all of which were submitted. The Allred and Allred High Security Facilities Corrective Action Plans were approved on 12/10/07, and the Roach Facility Corrective Action Plan was approved on 12/17/07. Three of the six facility audits remain open.

8. Item 4.03 requires offenders who submit requests or are referred for service are physically triaged by mental health services or medical staff within 48 to 72 hours of receipt of the request or referral. Five of the nine facilities were not in compliance with this requirement. The five facilities out of compliance were: Allred, Darrington, Ferguson, Roach and Terrell. Corrective actions were requested of the five facilities, all of which were submitted. The Allred Facility Corrective Action Plan was approved on 12/10/07, and the Roach Facility Corrective Action Plan was approved on 12/17/07. Three of the five facility audits remain open.

9. Item 6.04 requires all offenders receiving Tuberculosis (TB) preventative medication to have the following documentation in the medical record, monthly TB clinic visit, a completed Tuberculosis Patient Monitoring Record (HSM-19), compliance that has been accurately documented and toxicity checks. Five of the nine facilities were not in compliance with this requirement. The five facilities out of compliance were: Allred, Allred High Security, Darrington, Ferguson and Roach. Corrective actions were requested of the five facilities, all of which were submitted. The Allred Facility Corrective Action Plan was approved on 12/10/07, and the Roach Facility Corrective Action Plan was approved on 12/17/07. Three of the five facility audits remain open.

10. Item 6.36 requires the influenza vaccine be offered annually to all offenders over 55 years of age and older, pregnant females after the first trimester and that the vaccinations are documented on the Abstract of Immunization Record (HSM-2). If the vaccination is refused, a signed Refusal of Treatment Form (HSM-82) must be placed in the medical record. Five of the nine facilities were not in compliance with this requirement. The five facilities out of compliance were: Allred, Allred High Security, Darrington, Ferguson and Roach. Corrective actions were requested of the five facilities, all of which were submitted. The Allred and Allred High Security Facilities Corrective Action Plans were approved on 12/10/07, and the Roach Facility Corrective Action Plan was approved on 12/17/07. Two of the five facility audits remain open.

Grievances and Patient Liaison Correspondence

During the first quarter of FY-2008 (September, October, and November), the Patient Liaison Program and the Step II Grievance Program received 3,098 correspondences: Patient Liaison Program with 1,549 and Step II Grievance with 1,549. Of the total number of correspondence received, 125 (4.03 percent) Action Requests were generated by the Patient Liaison Program and the Step II Grievance Program.

Quality Improvement (QI) Access to Care Audits

During this first quarter, the Quality Improvement/Quality Monitoring (QI/QM) staff performed 42 Access to Care audits. The Access to Care audits that were conducted looked at verification of facility information and a random sample conducted by the Office of Health Services Monitoring (OHSM) staff. 378 indicators were reviewed, from the 42 Access to Care audits, and 27 indicators fell below 80 percent. This was seven percent of all the reviewed indicators and represents a noted decrease from previous quarters. The facility staff at these locations were contacted, so that closer bipartisan monitoring could take place.

Capital Assets Monitoring

The Capital Assets Contract Monitoring Office audited nine units during the first quarter. These audits are conducted to determine compliance with the Health Services Policy and State Property Accounting (SPA) policy inventory procedures. Audit findings documented that each of the nine units audited were within the compliance range: Allred, Allred High Security, Connally, Darrington, Ferguson, Glossbrenner, Roach, Scott and Terrell.

Office of Preventive Medicine

The Preventive Medicine Program monitors the incidence of infectious disease within the Texas Department of Criminal Justice. The following is a summary of this monitoring for the first quarter of FY-2008.

- 171 reports of suspected syphilis were received this quarter compared with 169 in the previous quarter. These figures represent a slight overestimation of the actual number of total cases, as some of the suspected cases will later turn out to be a resolved prior infection, rather than new cases.

- 918 Methicillin-Resistant Staphylococcus Aureus (MRSA) cases were reported compared to 981 during the same quarter of FY-2007.

- There was an average of 19 Tuberculosis (TB) cases under management per month during this quarter, which is similar to the average of 20 per month during the same quarter of the previous fiscal year.

- In 2006, the Office of Preventive Medicine began reporting the activities of the Sexual Assault Nurse Examiner (SANE) Coordinator. This position is funded through the Safe Prisons Program and is trained and certified as a SANE. Although we do not teach the SANE Curriculum because of restrictions imposed by the State Attorney General's Office, the position provides inservice training to unit providers in the performance of medical examination, evidence collection and documentation, and use of the sexual assault kits. 12 training sessions have been held on eleven units so far this year, with 86 medical staff receiving training. This position also audits the documentation and services provided by medical personnel for each sexual assault reported. There have been 137 chart reviews performed for the period of September through November 2007. 18 baseline labs were drawn. Two deficiencies were found regarding referral to mental health services and corrective action letters were sent on these. If indicated, prophylactic medication is offered and during this quarter, five prophylaxis were given.

Office of Preventive Medicine Cont'd.

- The peer education statistics for programs and educators requires explanation. In the month column, the numbers indicate the number of new programs and new peer educators added that month. In the year to date columns, the numbers indicate the total number of programs and the total number of active peer educators system-wide in that month. The number of peer educators decreased from last year because those who are inactive or who have been released were removed from the rolls. There are currently programs on 95 of 111 units. Only the Goodman Unit, private facilities, and Substance Abuse Felony Program (SAFP) facilities do not have peer education programs at this point.

Mortality and Morbidity

There were 117 deaths reviewed by the Mortality and Morbidity Committee during the months of September, October, and November 2007. Of those 117 deaths, seven were referred to peer review committees. The following is a summary of those referrals.

Peer Review Committee	**Number of Cases Referred**
Physician & Nursing Peer Review	1
Nursing Peer Review	1
Physician Peer Review	5
Total	**10**

Mental Health Services Monitoring & Liaison

The following is a summary of the activities performed by the Office of Mental Health Monitoring and Liaison (OMH M&L) during the first quarter of FY-2008.

- Ten facilities had compliances of 100% for Access to Mental Health Care (Indicators 4 & 5), one had a compliance of 92%, and two had compliances of 83%. The average compliance for Access to Mental Health Care Indicators 4 & 5 for the first quarter was 96.76%.
- For Clinician Access to Care (Access to Mental Health Care Indicator 6), 11 facilities had compliances of 100% and two were non-applicable. The average compliance for Access to Mental Health Care Indicator 6 was 100%. An average of 0.54 offenders per facility were referred to the facilities' Mental Health Services departments for further evaluation. An average of 6.92 requests, for Mental Health Services per facility, were forwarded to the facilities' Mental Health Services departments.

Clinical Administration

Health Services Liaison Utilization Review Monitoring

During the first quarter of FY-2008 ten percent of the combined UTMB and TTUHSC hospital and infirmary discharges were audited. There were 225 hospital discharges and 46 infirmary discharges audited. The chart below is a summary of the audits showing the number of cases with deficiencies.

Hospital Discharges – UTMB and TTUHSC

Month	Unstable Discharges [1] (Cases with deficiencies)	Readmissions [2] (Cases with deficiencies)	Lack documentation (Cases with deficiencies)
September 2007	0	6	6
October 2007	0	0	4
November 2007	0	0	6

Health Services Liaison Utilization Review Monitoring Cont'd.

Infirmary Discharges – UTMB and TTUHSC

Month	Unstable Discharges [1] (Cases with deficiencies)	Readmissions [2] (Cases with deficiencies)	Lack documentation (Cases with deficiencies)
September 2007	1	1	7
October 2007	0	0	2
November 2007	0	0	4

Footnotes:

[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

The following Texas Department of Criminal Justice units were accredited by the American Correctional Association (ACA) during the first quarter FY-2008: Byrd, Clements, Goodman, Hilltop, Johnston, Lychner/Kegans, McConnell, and Travis

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 – 28
- Academic Longitudinal Research Projects – 5
- Academic Research Projects pending approval – 9

Synopsis of Hepatitis Policy Changes:

1. Entire policy was rewritten and reformatted. It was separated into two documents, one containing the policy requirements, and the other a technical reference that gives background information and serves as a resource for clinical decision making.

2. Adds requirements for baseline testing, chronic care follow-up and criteria to consider antiviral treatment for hepatitis B that are distinct from hepatitis C and follow guidelines of the American Association for the Study of Liver Disease. The criteria for treatment are based on the amount of virus detectable in serum, the ALT level and whether “e” antigen is present. Previous criteria were the same as for hepatitis C and based only on the ALT level.

3. The criteria for considering an offender with hepatitis C for antiviral treatment has changed considerably. The basic criterion is a new indicator, the AST Platelet Ratio Index (APRI) which correlates with fibrosis in the liver. APRI scores below 0.42 will generally not be considered for treatment. Those with scores over 1.2 will be considered for treatment without a liver biopsy. Those with scores in between will have a liver biopsy and be treated according to the findings.

4. Retreatment for hepatitis C may now be considered if an offender relapsed after treatment with standard interferon with or without ribavirin, or who did not respond to standard interferon alone.

5. A new section has been added for management of advanced liver disease. Included in this section is screening for hepatocellular carcinoma by ultrasound every 6 months, considering referral for liver transplant evaluation, instructions to obtain an advance directive, consider for hospice placement and referral for Medically Recommended Intensive Supervision.

6. Two items mentioned in the advanced liver disease section would require further development. One is sheltered housing for patients with end stage liver disease. The other is the Extraordinary Care Review Panel that would review cases being considered for liver transplant evaluation.

Issue	Current Policy	Proposed Policy
Hepatitis A vaccine	For susceptible HCV+ or HBV+ patients	For susceptible HCV+ or HBV+ patients
Hepatitis B vaccine	All susceptible offenders (in Immunization policy)	All susceptible offenders (in Immunization policy)
Post exposure Hep A	Immune Globulin (old ACIP guideline)	Immune Globulin or vaccine (new ACIP guideline)
Post exposure Hep B	HBIG + vaccine	HBIG + vaccine
Hepatitis B screening	All known HIV or HCV+ offenders. For others, consider if risk factors present	Anti-HBs at intake. HBsAg for pregnant women and dialysis patients. Anti-HBs q6 months for dialysis.
Chronic Hep B treatment	Minimally addressed. Use chronic HCV criteria to consider treatment. Refer to GI if they meet criteria. Annual follow-up if not treated.	Treatment criteria based on ALT levels, HBeAg and HBV-DNA, following AASLD guidelines. Biopsy usually not required. Annual follow-up if not treated.
Screening for hepatocellular carcinoma	Not addressed	Chronic HBV with risk factors, cirrhosis. Obtain ultrasound q6 months
Hepatitis C screening	All known HIV or chronic HBV+ offenders. For others, consider if risk factors present. May repeat every 12 months upon request.	All known HIV or chronic HBV+ offenders. For others, consider if risk factors present. May repeat every 12 months upon request.
Chronic Hep C treatment	Consider if ALT $\geq$ 2 x upper limit of normal at least two times more than a month apart. Biopsy usually not required. Consider regardless of APRI if early signs of liver failure present. Observe standard contraindications. Annual follow-up if not treated.	Calculate APRI. Biopsy and treat according to results if APRI > 0.42 and < 1.2. Treat without biopsy if APRI $\geq$ 1.2. Consider regardless of APRI if early signs of liver failure present. Observe standard contraindications. Annual follow-up if not treated.
Retreatment of Hep C	Not done	Consider if patient failed or relapsed from previous treatment that did not include pegylated interferon and ribavirin.
Advanced liver disease	Calculate MELD score. Consider hospice placement.	Offer pneumococcal and influenza vaccines. Screen for hepatocellular carcinoma q6 months. Consider referral to an Extraordinary Care Review Panel (this would need to be created) for possible referral to be considered for liver transplant. Consider for nomination for MRIS. Refer for sheltered housing if patient has recurrent encephalopathy, bleeding varices or massive ascites.
Technical reference	None	Discusses information to be considered in making clinical decisions.

Cost Estimate for Proposed Hepatitis Policy

Hepatitis C

This estimate assesses the relative cost of three strategies for the management of patients with chronic hepatitis C.

Strategy A reflects the current policy, which considers a patient a candidate for treatment if they have at least two ALT levels more than a month apart that are 2 times or more higher than the upper limit of normal, or if they have lab results that indicate early liver failure. Patients who meet criteria and do not have contraindications are treated without liver biopsy.

Strategy B reflects the proposed policy, which considers a patient a candidate for treatment if they have an APRI score greater than 0.42. The APRI score is a ratio of the AST level and platelet count. If the APRI score is over 1.2 they are treated without biopsy, while those between 0.42 and 1.2 are biopsied first and treated according to their biopsy results.

Strategy C reflects the NIH Consensus Conference statement of 1999, which recommends biopsy of all HCV positive patients with persistently elevated ALT levels, and treatment according to biopsy results.

For all three strategies, patients are excluded from biopsy or treatment if they have laboratory evidence of uncompensated cirrhosis. Other exclusions would include patient refusal and clinical contraindications, but these exclusions are not included in the calculations, and are assumed to apply in equal proportions across all three strategies.

Also, for all three strategies, HIV-HCV coinfection is considered for treatment regardless of ALT levels. For strategies A and B, they are treated without biopsy if the ALT level is elevated, or according to biopsy result if the ALT is normal.

The numbers given below are calculated based on the current costs of liver biopsy and drugs, divided proportionately between Texas Tech University (20% of patients) and UTMB (80%). The cohort is based on an estimated 400 new cases reported each month, with the assessment taking place 6 months after the date of diagnosis. The cohort is reduced by 40%, to 240, because approximately that proportion of offenders are released within 6 months of their hepatitis C diagnosis. Liver biopsy costs for UTMB differ, depending on whether the procedure is done by Radiology or by Gastroenterology. Treatments are divided between those with genotypes 2 and 3 (31%) who receive 6 months treatment and those with other genotypes (69%) who receive 12 months treatment. The cost comparison does not account for patients who start treatment and later refuse or those for whom treatment is stopped because of non-response or drug toxicity, assuming that these factors apply proportionately across all three strategies.

The proportion of the cohort meeting the criteria for each strategy was determined by reviewing the laboratory results in the electronic medical record for two cohorts of hepatitis C patients. One cohort was those reported to the Office of Preventive Medicine in September 2005 and the other were cases reported in September 2006. The results for the two cohorts were averaged for the calculations, as the results of the individual cohorts were very similar.

Because of the factors that are not included in the cost analysis, the results should not be construed as the actual overall cost, but rather, compared with each other to arrive at the relative cost of the three strategies.

Table 1. Baseline Assumptions

Original cohort size (cases reported per month)	400
Percent of offenders released within 6 months of diagnosis	40%
Proportion of offenders receiving care from Texas Tech	20%
Proportion of offenders receiving care from UTMB	80%
Proportion of offenders with genotypes 2 or 3	31%
Proportion of offenders with other genotypes	69%
Percentage of liver biopsies with fibrosis scores of 2 or higher	44.2%
Cost of pegylated interferon and ribavirin for 1 month (weighted average)	$602
Cost of liver biopsy by UTMB Radiology	$1,952
Cost of liver biopsy by UTMB Gastroenterology	$1,469
Cost of liver biopsy in Texas Tech sector	$3,875

Table 2 shows the number who would have a liver biopsy and receive treatment under each strategy, per month.

Strategy	A - Current	B - Proposed	C - NIH
Treat without biopsy	75.6	33.6	0
Biopsies required	0	94.8	169.2
Fibrosis score 2 or higher	n/a	41.9	77.4
Treatments based on biopsy	0	41.9	77.4
Total treatments	75.6	75.5	77.4
Genotype 2/3	23.4	23.4	24.0
Other genotype	52.2	52.1	53.4

Finally, Table 3 shows the monthly cost for biopsy and treatment for each of the strategies, subdivided by whether the UTMB biopsies are done by Radiology or Gastroenterology. Even though the columns are headed UTMB, the cost includes the Texas Tech sector.

	A – Current Policy	B – Proposed Policy		C – NIH Consensus	
		UTMB Rad	UTMB Gastro	UTMB Rad	UTMB Gastro
Biopsy	No biopsies	$221,585.52	$184,878.96	$409,512.48	$341,675.04
Treatment	$461,446.77	$460,846.16	$460,846.16	$472,667.99	$472,667.99
Total	$461,446.77	$682,431.68	$645,725.12	$882,180.47	$814,343.03
Monthly difference	$0.00	$220,984.91	$184,278.35	$420,733.69	$352,896.25
Relative cost	base	+40%	+48%	+91%	+76%
Estimated cure rate*	37%	52%	52%	57%	57%

* percentage of cases for whom treatment would be indicated by biopsy who have sustained viral response

Several questions probably arise from this estimate. Why would the workgroup propose a policy that provides fewer treatments at greater cost?

First, the workgroup feels that using ALT levels alone to determine treatment is not advocated by any recognized authorities.

Furthermore, an informal study done by Dr. Lau before she left UTMB suggests that about 1/3 of the treatments provided under the current policy would not have been indicated had a biopsy been done. Conversely, about 1/3 of patients for whom treatment would be indicated by biopsy do not meet qualification for treatment under the current policy. It is interesting to note that the number of patients treated under each strategy is similar. The workgroup feels the treatments would be better targeted using either the proposed policy or the NIH Consensus strategy, giving better long-term outcomes in prevention of end stage liver disease and hepatocellular carcinoma, i.e, more lives saved for the dollars spent.

The closest thing to a national standard of care is the NIH Consensus Conference statement. The workgroup chose to deviate from that standard because we feel evidence shows the use of the APRI score is more efficient. Although the positive and negative predictive values of the APRI score are not 100% (more like 93%), the amount of misclassification of cases into treatment and non-treatment groups may be similar, and possibly superior, to biopsy alone, since biopsy is subject to sampling error.

Again, remember that the dollar amounts in this analysis do not represent actual expenditures, because the numbers really biopsied and treated will be less. These numbers should be taken as maximum amounts. For example, the model predicts under current policy we would be spending over $461,000 a month on drugs for hepatitis C, while the actual amount reported by the CMHC Pharmacy is far lower.

Hepatitis B

A similar analysis for hepatitis B was not feasible. Since there is currently little guidance published for management of chronic hepatitis B in TDCJ, none of the cases reviewed had enough of the necessary lab work to enable a cost of treatment projection under the proposed policy. In addition, most screening has been done on patients who are HCV and/or HIV positive, and thus the reported cases are not representative of the general spectrum of chronic hepatitis B.

For what it is worth, from January 1, 2007 - June 30, 2007, the Office of Preventive Medicine received 68 reports of offenders with hepatitis B. Of those, 32 are still incarcerated as of February, 2008. Of the 32, 8 had the basic criterion of ALT over two times the upper limit of normal. This is the basic group that would be eligible for treatment. So, based on the data available, about 16 offenders would be considered for hepatitis B treatment per year. Cost of a course of treatment would average about $4,000-6,000 per year per patient, or about $64,000-$96,000 per year overall.

CMHCC Infection Control Manual

DRAFT

B-14.13 Hepatitis Policy

This policy is not intended to delineate all aspects of the care of an offender with hepatitis. In particular, the minimal requirements in this policy are intended only to help gather necessary information for a provider to make an appropriate clinical decision about the management of each patient.

POLICY: To provide guidance regarding the transmission, clinical management, housing, and work assignment of offenders with Hepatitis A (HAV), Hepatitis B (HBV), and Hepatitis C (HCV).

PROCEDURES

I. Hepatitis A

A. Screening
1. Screening with an anti-HAV total antibody test must be done on offenders who are newly diagnosed with HIV or chronic hepatitis B or C.

B. Prevention
1. Encourage good handwashing and good general personal hygiene.
2. Vaccinate susceptible offenders who have HIV infection or chronic liver disease including chronic hepatitis B or chronic hepatitis C.

C. Management of cases
1. Housing
   a. Contact isolation in inpatient settings, until 2 weeks after onset of symptoms, and diarrhea, if any, is resolved.
   b. Outpatients must be assigned to a single cell for two weeks after onset of symptoms or two weeks after diagnosis, if asymptomatic. The cell must undergo cleaning and disinfection after the period of isolation is finished, before any other offender occupies the cell.
2. Work restrictions
   a. Food handlers must be excluded from work until two weeks after onset of symptoms or until resolution of jaundice, whichever is later.

D. Management of contacts
1. All cellmates or dormitory mates (persons sharing toilet facilities) must be tested for anti-HAV total antibody if not already known to be anti-HAV

positive. In addition, sexual contacts and close contacts who shared eating utensils during the infectious period must be identified and tested.

2. Contacts who are anti-HAV antibody negative should receive 0.02 mL/kg of immune globulin IM within 14 days of their last exposure to the case. If the contact is younger than 40 and has no evidence of chronic underlying liver disease, a single dose of hepatitis A vaccine may be used instead of the immune globulin.
3. Contacts who are anti-HAV antibody negative must be excluded from food service work for 8 weeks after their last exposure to the case.
4. If the index case is a food handler, contact the Office of Preventive Medicine immediately for recommendations about management of coworkers and the general offender population.

E. Reporting

1. Acute hepatitis A is required by law to be reported within 7 days.
2. Report to the Office of Preventive Medicine according to procedures in Infection Control Policy Manual B-14.19.

II. Hepatitis B

A. Screening

1. During the intake medical evaluation, offenders should be asked about risk factors for hepatitis B infection and be screened with a HBsAg test if risk factors are present. Offenders must be screened with an anti-HBs antibody test during the intake medical evaluation unless they have a documented history of previous completed hepatitis B vaccination series or a reliable history of previous hepatitis B infection, to determine whether hepatitis B vaccine must be offered.
2. Every offender who is found to be HIV positive or HCV positive must be screened with anti-HBs antibody, HBsAg and anti-HBc total antibody as part of the baseline evaluation.
3. Chronic hemodialysis patients who have not responded to vaccination must be screened for HBsAg monthly. All hemodialysis patients must be screened for anti-HBs antibody every 6 months. It these patients previously had a protective antibody level that falls below the protective threshold, they should be given a booster dose of hepatitis B vaccine.
4. Pregnant offenders must be screened for hepatitis B surface antigen during the first trimester or at the first prenatal visit, whichever is earlier. They must be screened even if they have been previously tested or have

been vaccinated, unless they are already documented to have chronic hepatitis B. Women who continue to have risk factors for infection during their pregnancy must be screened again at the time of delivery.

B. If a patient is found to be HBsAg positive, obtain an anti-HBc IgM antibody test. (Note: do not order an anti-HBc total antibody test as it will not provide the information that is required to establish a diagnosis of acute or chronic infection)
   1. If the anti-HBc IgM is negative, the patient has chronic hepatitis B and should be managed according to the procedures for chronic hepatitis B. The case must be reported within 7 days to the Office of Preventive Medicine as a chronic hepatitis B case.
   2. If the anti-HBc IgM is positive, the patient has acute hepatitis B or was infected with hepatitis B in the recent preceding months.
      a. Report the case within 7 days to the Office of Preventive Medicine as acute hepatitis B.
      b. Elicit contact history for the previous 3 months to determine the source case as well as persons who may be candidates for post-exposure prophylaxis.
      c. Obtain HBsAg and anti-HBs antibody tests in 6 months to document resolution of the infection. If HBsAg remains positive after 6 months the case has become chronic and should be managed according to the procedures for chronic hepatitis B. File a follow-up report with the Office of Preventive Medicine noting that the case is chronic if HBsAg is positive for 6 months or longer.

C. Prevention
   1. Educate staff and offenders about routes of transmission, prevention and early reporting of signs and symptoms of infection.
   2. Discourage high risk behaviors including tattooing, unprotected sex and sharing needles or personal grooming items such as razors, toothbrushes and tweezers.
   3. Vaccinate susceptible offenders as directed in CMHC Infection Control Manual Policy B-14.07.
   4. Identify close contacts (sexual partners and those who share needles) of newly diagnosed cases and offer testing and education to those contacts.
      a. Any sexual contacts within the 2 weeks preceding diagnosis and any needle sharing contacts within 1 week preceding diagnosis who has not previously completed a hepatitis B vaccination series should receive 5 ml of HBIG IM and begin the hepatitis B vaccination series.

b. Those who have been previously vaccinated should be tested for HBsAg and anti-HBs antibody.
   1). If both tests are negative they should receive HBIG if less than 14 days have elapsed since their last sexual exposure or less than 7 days since their last needle exposure to the index case. They should also repeat the hepatitis B vaccine series, regardless of the length of time since their last exposure to the case.
   2). If there is not enough time to get the laboratory results before the 14 day or 7 day limit expires, administer HBIG without waiting for the lab results.

D. Procedures for Chronic Hepatitis B
   1. These patients must be enrolled in chronic care clinic.
   2. Assign mainframe medical alert code 7032.
   3. Baseline evaluation includes history, physical assessment and the following laboratory tests:
      a. CBC, albumin, bilirubin, prothrombin time, ALT, AST and alpha fetoprotein.
      b. Anti-HAV antibody tests unless the offender has a history of hepatitis A or is documented to be immune.
      c. Anti-HCV and anti-HIV antibody tests unless previously documented to be positive.
      d. HBeAg, anti-HBe antibody and HBV-DNA.
   4. Vaccinate against hepatitis A if susceptible.
   5. Patient should be referred to be evaluated for treatment if
      a. HBeAg is positive, HBV-DNA is ≥ 20,000 and ALT ≥ 2 x ULN, or
      b. HBeAg is negative, HBV-DNA is ≥ 2,000 and ALT ≥ 2 x ULN
      c. Consider referring for treatment if HBeAg is positive, HBV-DNA is ≥ 20,000, ALT 1-2 x ULN and patient is over 40.
      d. The presence of cirrhosis is not a contraindication to treatment, and, in fact, makes referral for evaluation for treatment more urgent if cirrhosis is uncompensated.
   6. If the patient is not referred for treatment consideration after the baseline evaluation, monitor ALT every 3 months, and HBV-DNA every 6 months for 1 year. If baseline HBeAg was positive, also monitor this test every 6 months.
      a. If, after the initial year of monitoring or thereafter, the patient meets criteria in II.D.5, above, or if they have persistently elevated ALT 1-2 times ULN and either HBeAg positive or HBV-DNA > 2,000, they should be referred for evaluation for treatment.

b. If the patient is not referred to be evaluated for treatment, continue monitoring the patient as least once per year, clinically and with CBC, albumin, bilirubin, prothrombin time, ALT, AST, alpha fetoprotein, HBV-DNA and, if the previous HBeAg test was positive, HBeAg.
c. At each chronic care clinic appointment review clinical status and labs to determine if referral to be evaluated for treatment is indicated.
d. Whether treated or not, the following groups of HBsAg+ offender patients are at increased risk for hepatocellular carcinoma (HCC) and should have an abdominal ultrasound test to screen for HCC every 6 months:
   i. Asian males age 40 and older
   ii. Asian females age 50 and older
   iii. Patients with confirmed cirrhosis or lab results suggestive of cirrhosis (compensated or uncompensated)
   iv. Patients with a family history of HCC
   v. Africans over age 20

III. Hepatitis C

A. Screening
1. Offenders should be evaluated for risk factors for hepatitis C and signs or symptoms of liver disease during the intake medical evaluation and offered hepatitis C screening with an anti-HCV antibody test if risk factors or signs or symptoms are present.
2. Offenders diagnosed with chronic hepatitis B or HIV infection must be tested for hepatitis C as part of the baseline evaluation of these conditions.
3. Offenders may be tested for anti-HCV antibody once every 12 months at their request. They do not have to disclose any high risk behavior to qualify for testing.
4. Screening with an anti-HCV antibody test should also be performed after an exposure, according to Infection Control Manual Policy B-14.06, and whenever clinically indicated.

B. Prevention
1. Educate staff and offenders about routes of transmission, prevention and early reporting of signs and symptoms of infection.
2. Discourage high risk behaviors including tattooing, unprotected sex and sharing needles or personal grooming items such as razors, toothbrushes and tweezers.

3. Any identified needle sharing contacts should have an anti-HCV antibody test. If it is negative, repeat the test in 6 months. There is no post-exposure preventive treatment recommended for hepatitis C.

C. Baseline evaluation and initial management of offenders newly identified to be anti-HCV antibody positive.
   1. Offenders who enter TDCJ on treatment for hepatitis C with interferon with or without ribavirin must have that treatment continued unless the provider documents that it must be discontinued for medical reasons.
   2. Take a targeted history to determine the probable date infection was acquired. For example, the date of infection in an injection drug user would be the year he started sharing needles or works. Also obtain history of previous and present alcohol use, co-infections such as HIV or HBV, drug use, symptoms of liver disease, and previous treatment.
   3. Perform a physical examination looking for signs of advanced liver disease, evidence of other causes of liver disease such as Wilson's disease, and extrahepatic manifestations of hepatitis C.
   4. Obtain the following baseline laboratory tests:
      a. CBC with platelet count
      b. Prothrombin time
      c. ALT, AST, alkaline phosphatase, bilirubin, albumin, BUN, creatinine
      d. HIV, anti-HBsAb, anti-HBc total antibody, HBsAg, and anti-HAV total antibody.
   5. Vaccinate the offender against hepatitis B if all hepatitis B serum markers are negative.
   6. Vaccinate against hepatitis A if the anti-HAV test is negative.
   7. Educate the patient about transmission of HCV, his obligation to avoid infecting others, the natural history of HCV infection, effect of alcohol and other hepatotoxins on his disease, etc.
   8. Patients who are HIV positive or HBsAg positive must be referred to a designated clinic or physician to be evaluated for possible treatment of hepatitis C.
   9. Compensated cirrhosis (low albumin but ≥ 3.0, low platelet count but ≥ 70,000, elevated bilirubin but < 2.0, and/or prolonged prothrombin time less than 2 seconds greater than control) is not a contraindication to antiviral treatment. These patients should be evaluated for treatment even if their APRI score is less than 0.42 or if they have only a short time left in the system, as they may be approaching the point where antiviral treatment is contraindicated because of advanced liver disease.

10. For other patients, if the baseline transaminases and liver function tests are all WNL, consider one or more HCV-RNA, ALT and AST tests over 3-6 months to confirm or rule out current infection. If the ALT and AST results are all WNL and at least two negative HCV-RNA results have been obtained, that patient can be diagnosed with resolved HCV and discharged from follow-up after appropriate counseling about the possibility of future re-infection if high risk behavior is repeated.
11. If current infection is confirmed by abnormal baseline tests or positive HCV-RNA, calculate the APRI score using the formula below:

    APRI = ((AST/ULN) ÷ (platelet count)) x 100

    Where ULN = upper limit of normal for the AST level and platelet count is in 1,000/mm^3

    An APRI score calculator is available on CMCWEB under the Tools submenu.

12. If the APRI is > 0.42 the patient should be considered for referral to a designated clinic or physician to be evaluated for possible treatment of HCV.
    a. Almost all offenders with an APRI score over 0.42 should be referred, but the decision must be individualized. Considerations that may lead to a decision not to refer could include the patient not wanting treatment, presence of a contraindication to the treatment, or presence of comorbidity that is likely to be fatal before hepatitis C becomes symptomatic. This list is not exhaustive.
    b. If a patient with an APRI score > 0.42 is not referred, the rationale for not referring must be documented in the medical record.
13. Although patients with APRI scores ≤ 0.42 generally do not require evaluation for possible treatment, the provider may consider referral if they believe the patient may be a candidate for treatment. Clinical considerations could include
    a. History suggesting that infection was acquired many years previously.
    b. Clinical or laboratory evidence of a failing liver.
    c. Comorbid conditions that might cause elevation of the platelet count or unusually low AST levels, giving an unreliable APRI score.

D. Follow-up after the baseline evaluation

1. Patients with HCV infection must be enrolled in chronic care clinic and seen at least once every 12 months.
2. Annual evaluation must include clinical evaluation for signs or symptoms of liver disease and at least the following laboratory tests: AST, bilirubin, albumin, and CBC with platelets.
3. At each annual evaluation the APRI score must be calculated based on the current AST and platelet count and a determination made whether the patient should be referred for evaluation for treatment.
4. If the patient has evidence of compensated or uncompensated cirrhosis, follow-up as indicated under Advanced Liver Disease, below.

E. Retreatment
1. Patients who have responded to therapy with standard interferon with or without ribavirin who relapse after completion of therapy may be considered for retreatment with pegylated interferon and ribavirin.
2. Non-responders to treatment with standard interferon may be considered for retreatment with pegylated interferon and ribavirin.
3. Retreatment is not recommended for non-responders or relapsers who received pegylated interferon and ribavirin.

F. Reporting
1. Anti-HCV positive offenders must be reported to the Office of Preventive Medicine within 7 days.
2. If the patient has had a documented seroconversion to HCV positive, or has clinical signs and symptoms of acute hepatitis or has ALT > 5 times higher than the upper limit of normal, report the case as acute hepatitis C.
3. Enter the mainframe medical alert code 7054 on HCV positive offenders.

IV. Advanced Liver Disease

A. Patients with cirrhosis are in the high risk groups that must be offered influenza and pneumococcal vaccines according to Infection Control Manual Policy B-14.07.

B. Baseline evaluation of patients with cirrhosis includes clinical evaluation for signs or symptoms of hepatic encephalopathy and ascites. Hepatic encephalopathy is a clinical diagnosis and ordinarily, serum ammonia levels are unnecessary. Ammonia levels are often falsely elevated if the serum specimen is not handled properly or is not immediately delivered to the lab. A baseline alpha fetoprotein must be obtained, and the patient should be

referred for endoscopy to screen for esophageal varices. If the patient has esophageal varices or ascites consider the use a beta blocker to treat portal hypertension.

C. Patients with compensated or uncompensated cirrhosis should have an abdominal ultrasound every 6 months to screen for hepatocellular carcinoma.

D. Consider referring patients with uncompensated cirrhosis for review by the Extraordinary Care Review Panel (ECRP) for possible referral to be considered for liver transplant. The decision to refer a patient to the ECRP must be made on a case by case basis.

E. For patients with uncompensated cirrhosis, discuss prognosis of their illness and their treatment preferences, obtaining an advance directive when appropriate.

F. Patients with evidence of compensated or uncompensated cirrhosis must be enrolled in chronic care clinic. They must have bilirubin, creatinine, INR, alpha fetoprotein and abdominal ultrasound done every 6 months in addition to any laboratory tests that are clinically indicated.

G. At each chronic care visit, calculate the Model for End-stage Liver Disease (MELD) score. A patient with a MELD score of 30 or greater (associated with a 52% risk of mortality within 3 months) should be referred to a hospice unit if the patient agrees to the conditions of hospice placement, or submitted to the ECRP to be considered for referral to be evaluated for liver transplant if that has not already been done. An individual should not be accepted for or denied hospice care solely on the basis of his/her MELD score, however. The MELD score can be calculated online at:
http://www.unos.org/resources/MeldPeldCalculator.asp?index=98

A MELD score calculator is also available on CMCWEB under the Tools submenu.

The MELD formula is also given below:

Risk Score = 10 * ((.957 * ln(Creat)) + (.378 * ln(Bili)) + (1.12 * ln(INR))) + 6.43

Where

- ln means the natural logarithm (base *e*)
- For any lab values < 1, use the value 1 in the formula
- If creatinine is > 4, use the value 4
- If the patient has been dialyzed 2 or more times in the previous week, use the value 4 for creatinine
- The risk score should be rounded to the nearest integer
- This formula only applies to adults

H. Every patient with uncompensated cirrhosis should be considered for nomination for Medically Recommended Intensive Supervision (MRIS). The point at which referral should be made is subjective, but at a minimum, patients with a MELD score over 30 or with recurrent ascites, recurrent bleeding esophageal varices or recurrent hepatic encephalopathy should be nominated for MRIS.

I. Patients who are not considered for hospice care or who do not desire hospice may have to be placed in sheltered housing if they are not able to take care of themselves in general population. Carefully consider whether patients with a prior episode of hepatic encephalopathy, bleeding esophageal varices, massive edema or massive ascites should be in sheltered housing [or an ESLD special housing unit if one is created] even if they appear to be able to take care of themselves at the time they are seen.

Infection Control Manual Policy B-14.13 Hepatitis Attachment 1

Contraindications to Drugs Used in the Treatment of Chronic Hepatitis

Interferon (including pegylated interferon)

Absolute contraindications

- Uncompensated cirrhosis
- Potentially life-threatening non-hepatic disease such as far advanced AIDS, malignancy, severe COPD or severe ASHD
- Uncontrolled autoimmune disorders
- Poorly controlled diabetes
- Uncontrolled hyperthyroidism
- Solid organ transplant
- Ongoing alcohol or injection drug use
- Suicidal ideation or other uncontrolled neuropsychiatric disorder
- Poorly controlled seizure disorder

Relative contrindications

- Neutropenia or thrombocytopenia
- Poorly controlled HIV infection on HAART

Ribavirin

Absolute contraindications

- Previously demonstrated hypersensitivity to the drug
- Pregnancy (during treatment and for 6 months afterward; also applies to partners of males who are treated)
- Hemoglobinopathies and hemolytic or other severe anemias
- Ischemic cardiovascular or cerebrovascular disease
- Renal insufficiency with serum creatinine > 2.0

Adefovir

Absolute contraindication

- Previously demonstrated hypersensitivity to the drug

Relative contraindications

- Renal insufficiency (monitor renal function)
- Inability to continue drug after release
- Potential for hepatomegaly, steatosis and lactic acidosis. Increased risk with obesity, females, prolonged treatment.

Lamivudine

Absolute contraindication

- Previously demonstrated hypersensitivity to the drug

Relative contraindications

- Renal insufficiency (monitor renal function)
- Inability to continue drug after release
- HIV infection (do not use monotherapy against HIV)

Emtricitabine

Absolute contraindication

- Previously demonstrated hypersensitivity to the drug

Relative contraindications

- Potential for hepatomegaly, steatosis and lactic acidosis. Increased risk with obesity, females, prolonged treatment.
- HIV infection (do not use monotherapy against HIV)

Infection Control Manual Policy B-14.13 Hepatitis Attachment 2

Hepatitis Reporting Form

Name: _____ TDC Number: _____

Facility: _____ UH Number:_____

Diagnosis:

☐ Acute Hepatitis A
☐ Acute Hepatitis B
☐ Acute Hepatitis C

☐ Chronic Hepatitis B
☐ Chronic Hepatitis C

Supporting Data:

Symptoms (acute disease only): Date of Symptom Onset: _____

- ☐ Nausea, vomiting or anorexia
- ☐ Diarrhea
- ☐ Jaundice or icterus
- ☐ Fever, malaise, flu-like symptoms

Lab: (lab tests done are based on clinical considerations and should not be ordered simply to complete this report form. **This form is for reporting purposes only and is not intended as a clinical guideline**)

Test	Date, if done	Pos	Neg	Not Done or Unknown
Acute Hepatitis A				
Hep A antibody (anti-HAV IgM Ab)	_____	☐	☐	☐
Hepatitis B				
Hep B surface antigen (HBsAg)	_____	☐	☐	☐
Hep B core antibody (anti-HBc IgM Ab)	_____	☐	☐	☐
Hep B surface antibody (anti-HBs Ab)	_____	☐	☐	☐
Hepatitis C				
Hep C antibody (anti-HCV Ab)	_____	☐	☐	☐
Hepatitis D				
Delta hepatitis antibody (anti-HDV Ab)	_____	☐	☐	☐

Highest* ALT (SGPT) level: _____ Date: _____

Highest* AST (SGOT) level: _____ Date: _____

* for acute illness only

Expected Serological Patterns					
Acute Hepatitis A	Resolved Hepatitis A (not reportable)	Acute Hepatitis B	Chronic Hepatitis B	Resolved Hepatitis B (not reportable)	Hepatitis C
Anti-HAV IgM (+)	Anti-HAV IgM (-) Anti-HAV IgG (+)	HBsAg (+) HbeAg (+) Anti-HBc IgM (+)	HBsAg (+) HBeAg (+ in majority) Anti-HBc total (+) Anti-HBc IgM (-)	HBsAg(-), HBeAg(-) Anti-HBs (usually +) Anti-HBc total (usually +)	Anti-HCV (+)

Infection Control Manual Policy B-14.13 Hepatitis Attachment 3
Interferon and Ribavirin Dose Modification Guide

Note: this information is adapted from the package insert and is not expected to cover every case. This information does not preclude the exercise of clinical judgment.

Hematological Dose Modification Guide*		
Lab Value	**Dose Reduction**	**Discontinue When**
ANC < 750	Peginterferon 135 micrograms q week	ANC < 500
Platelets < 50,000	Peginterferon 90 micrograms q week	Platelets < 25,000
Hemoglobin < 10 **	Ribavirin 600 mg/day	Hemoglobin < 8.5 **
Hgb 2gm reduction in 4 weeks***	Ribavirin 600 mg/day	Hgb < 12 after 4 weeks at reduced dosage***

* See package insert for details and information on restarting drugs after discontinuation for hematological abnormalities

** Patients with no cardiac disease

*** Patients with stable cardiac disease

ANC = absolute neutrophil count

Depression Dose Modification Guide*	
Depression Severity	**Dose Reduction**
Mild	None
Moderate	Peginterferon 135 micrograms q week. May need to reduce dose to 90 micrograms.
Severe	Discontinue Peginterferon immediately and refer to psych

* See package insert for details and information on restarting drugs when discontinued

Increase frequency of clinical evaluations if patient develops depression. Evaluate depression weekly.

ALT Dose Modification Guide		
Lab Value	**Dose Reduction**	**Discontinue When**
ALT > 2x baseline	Peginterferon 135 micrograms q week	Continued ALT increase despite dose reduction, or elevation of bilirubin

CMHCC Infection Control Manual

DRAFT

B-14.13TR Technical Reference for Hepatitis Policy

The information given in this technical reference is not policy. It is intended to assist the provider in making clinical decisions by discussing treatment options and some of the considerations involved in determining the work-up and treatment of viral hepatitis and chronic liver disease.

BACKGROUND INFORMATION ON HEPATITIS AND END STAGE LIVER DISEASE

I. Hepatitis A

B. Infectious Agent – hepatitis A virus (HAV), a single strand RNA virus. The virus can persist in the environment for several weeks under ideal conditions. Disinfection of contaminated surfaces with a 1:10 dilution of household bleach or Double-D disinfectant diluted according to directions is effective.

C. Transmission – generally person to person by fecal-oral route. Can also be foodborne or waterborne by contamination from an infected food handler or contamination by raw sewage. High risk groups include men who have sex with men, injection drug users and persons who eat raw shellfish.

D. Diagnostic tests – laboratory confirmation of acute hepatitis A is by serum anti-HAV IgM antibody. Immunity is confirmed by serum anti-HAV total antibody (IgM+IgG). Note that a diagnosis of acute hepatitis A requires the IgM specific test. The total antibody test does not differentiate between acute infection and resolved previous infection.

E. Incubation period – average 4 weeks, range 15-50 days.

F. Infectious period of cases – from 2 weeks before onset of symptoms to 7 days after onset of jaundice or peak elevation of transaminases (approximate).

G. Symptoms – 50% or more of childhood cases are asymptomatic. Adult cases are more likely to be symptomatic, with fever, anorexia, nausea, and abdominal discomfort, followed in a few days by jaundice. Disease is generally self-limited lasting 1-2 weeks. 10-15% of cases may have several episodes of relapsing symptoms over 6-12 months, but chronic infection does not occur. Case-fatality rate is 0.1-0.3%, but is higher in patients over age 50 and those with chronic liver disease.

H. Prevention – hepatitis A vaccine is available. In TDCJ, the very low rate of HAV infection does not warrant hepatitis A vaccination except in patients who

are HIV positive or who have chronic liver disease including hepatitis C or chronic hepatitis B. Hepatitis A can be prevented after exposure by administering immune globulin within 14 days of the exposure. Hepatitis A is also prevented by practicing good personal hygiene, especially hand hygiene.

II. Hepatitis B

A. Infectious Agent – hepatitis B virus (HBV), a double strand DNA virus. It is able to persist for extended periods in the environment and can be detected in dried blood for several weeks. It remains infectious on environmental surfaces for at least a week. Disinfection of contaminated surfaces with a 1:10 dilution of household bleach or Double-D disinfectant diluted according to directions is effective in inactivating virus on cleaned surfaces, but may not inactivate virus that resides in organic matter such as visible dried blood.

B. Transmission – low infectious dose and typically large amount of virus in the bloodstream make this one of the most easily transmitted of the bloodborne pathogens. Percutaneous or permucosal exposure to blood or other potentially infectious materials (OPIM, see CMHC Policy B-14.5 for definition of OPIM) is the route of infection. HBV is transmitted efficiently through unprotected sexual contact and from mother to infant. Unlike most other bloodborne pathogens, saliva without visible blood is capable of transmitting infection, although no outbreaks have been associated with this. Sharing of toothbrushes and razors has been implicated in transmission. Risk factors for hepatitis B infection include history of injection drug use, history of male on male sex, history of jailhouse tattoos, history of sexually transmitted disease, HCV or HIV infection. Offenders who come from high prevalence areas, including Africa, Eastern Europe, Southeast Asia or the Western Pacific islands are also high risk.

C. Diagnostic tests. HBV surface antigen (HBsAg) indicates current infection and that the patient is infectious. Acute infection is confirmed by a positive HBsAg test with a positive HBV core antibody IgM (anti-HBc IgM) test, while chronic infection is confirmed by a positive HBsAg test and a negative anti-HBc IgM. Chronic infection can also be diagnosed if HBsAg persists for more than 6 months. Total HBV core antibody (anti-HBc total) does not differentiate between acute infection, chronic infection or resolved infection.

HBV surface antibody (anti-HBs) is protective antibody and is seen in resolved infection or in persons who have been vaccinated against hepatitis B.

Anti-HBs is not present in chronic hepatitis B. Vaccinated persons have a positive anti-HBs with a negative anti-HBc total antibody test. Persons with resolved hepatitis B will have a positive anti-HBs and a positive anti-HBc total antibody test.

Anti-HBc antibody persists longer at higher levels than does anti-HBs. Occasionally a person will be seen with a positive anti HBc and all other serum markers of HBV negative. This usually means they had hepatitis B several years previously that has resolved. If they have risk factors of HBV infection and normal liver enzymes this is usually the correct interpretation. If they have normal liver enzymes and no risk factors for HBV the result may be a false positive. An isolated positive anti-HBc result may also be seen in chronic infection if the rate of virus replication is so low that HBsAg is undetectable. This is sometimes seen in HCV-HBV coinfection.

The presence of hepatitis B e antigen (HBeAg) indicates a very high rate of viral replication and a highly infectious patient. HBeAg is not helpful for diagnosis but chronic HBV patients who are HBeAg positive are treated differently than those who are HBeAg negative, and the indications to consider treatment are a little different.

The HBV-DNA test is based on polymerase chain reaction technology. HBV-DNA can remain positive at low levels even in individuals who have serologically recovered from acute HBV infection (i.e., HBsAg has disappeared and anti-HBs is present). The level of 20,000 IU/ml that is currently used as a diagnostic criterion for chronic hepatitis B is an arbitrary value set at the 2000 National Institutes of Health conference on the management of hepatitis B. That value may change in the future as progressive liver disease has been observed in patients with lower levels of HBV-DNA (2,000 – 20,000 IU/mL). Levels of HBV-DNA in the 2,000-20,000 range coupled with evidence of active liver disease (i.e., elevated transaminases or liver function abnormalities) generally warrant further evaluation for treatment.

Interpretation of major hepatitis B serologic test patterns

HBsAg	Anti-HBs	Anti-HBc IgM	Anti-HBc Total	Interpretation
+	–	–	–	Very early infection or 1-2 weeks after first vaccine dose.
+	–	+	+	Acute hepatitis B, infectious
–	+ or –	+	+	Resolving acute infection
+	–	–	+	Chronic hepatitis B, infectious
–	–	–	–	Never infected or immunized. Susceptible.
–	+	–	–	Immunized, never infected. Immune if titer > 10 IU/mL
–	+	–	+	Resolved hep B. Immune.
–	–	–	+	Several possibilities: 1. Lab error 2. Remote infection with undetectable anti-HBs; immune 3. Chronic infection with undetectable HBsAg (concurrent HCV infection can suppress HBsAg expression); infectious potential is low.

D. Incubation period – 6 weeks to 6 months

E. Infectious period – for acute cases, from about 3 weeks before the onset of symptoms throughout the course of clinical illness, until HBsAg disappears. For chronic cases, indefinite, as long as HBsAg is positive.

F. Clinical course – childhood cases are more frequently asymptomatic and anicteric. Adult cases are more likely to be symptomatic, with fever, anorexia, nausea, and abdominal discomfort, followed in a few days by jaundice. Acute infection is treated symptomatically and is usually self-limited. Fulminant hepatitis may occur; the case-fatality ratio in patients over 40 is 1 percent. 1-10 percent of acute infections persist and become chronic. Patients with chronic hepatitis B are at risk for hepatocellular carcinoma even in the absence of cirrhosis. HBV infection is the underlying cause of up to 80% of hepatocellular carcinoma cases worldwide. 15-25% of patients with chronic hepatitis B will develop cirrhosis over a period of 10-30 years.

G. Prevention – hepatitis B vaccine is available. Hepatitis B can be prevented after exposure by administering hepatitis B immune globulin (HBIG) within 7 days of a percutaneous exposure (it is preferable to administer HIBG within 24 hours of exposure) or within 14 days of sexual exposure. Hepatitis B is also prevented by avoiding high risk behaviors such as sharing needles or personal grooming items, exposure to blood and other potentially infectious materials, and unsafe sexual practices.

H. Treatment – chronic hepatitis B can be treated with interferon alfa (IFN) or with nucleoside analogs (NA). FDA approved NA available in the United States as of April 2007 include lamivudine, adefovir, entecavir and telbivudine. Several other drugs are in clinical trials so this list is likely to change. NAs are usually administered for an indefinite period until a specific endpoint is reached. For HBeAg positive patients this endpoint is 6 months after the disappearance of HBeAg. For initially HBeAg negative patients treatment may continue for several years, with the endpoint being normalization of ALT levels and undetectable HBV-DNA for one year. One problem with the use of NAs includes the development of drug resistance. Of the drugs available in April, 2007, lamivudine has the highest rate of drug resistance developing during treatment while entecavir has the lowest. Combination therapy has not yet been shown to reduce the risk of resistance. Another problem with NAs is the possibility of a hepatitis flare if the drug is stopped abruptly. This could happen in a patient who is released while on treatment and does not have follow-up in the community.

   If a patient has coinfection with HBV and HIV it is very important that the treatment regimen take into account both infections, as a poorly conceived drug regimen for one infection may adversely impact the ability to treat the other.

   FDA approved interferons for treatment of chronic hepatitis B include interferon alfa 2b and peginteferon alfa 2a. IFN is administered for a defined period that differs for HBeAg positive and HBeAg negative patients. Interferon may cause decompensation in cirrhotic patients and is currently contraindicated in those patients.

   Criteria for consideration for treatment are given in the Hepatitis Policy in sections II.D.5 and II.D.6. Although they are complicated, in general, a HBV-DNA level over 20,000 is considered confirmatory for HBV infection and coupled with ALT levels ≥ 2x ULN, an indication of immediate referral for treatment. These patients will often be treated without a liver biopsy. If the e-

antigen is negative, treatment should be considered if the HBV-DNA is over 2,000 and the ALT is ≥ 2x ULN. However, if the HBV-DNA level is in the 2,000 – 20,000 range, a liver biopsy may be needed before treatment to verify the presence of active liver disease.

After the initial evaluation, if there is evidence of active liver disease (HBV-DNA persistently over 2,000 and ALT levels persistently elevated) then treatment should be considered, but, again, a liver biopsy may be needed to verify active liver disease before treatment is initiated.

I. Contraindications to treatment – see Attachment 1 for contraindications to IFN and other drugs used to treat chronic hepatitis B. In addition to the absolute contraindications, the following relative contraindications should be considered.
   1. If interferon treatment is being considered, evaluate the patient for history of serious mental illness. These patients may need evaluation by a psychologist or psychiatrist prior to treatment. If they have symptoms of mental illness, they should be treated and stabilized before pursuing a work-up for treatment.
   2. Ability to complete treatment before release, or to assure continuation of treatment after release. The latter is particularly important for HBeAg negative offenders for whom long term therapy with a NA is anticipated.
   3. Ongoing substance or alcohol abuse. Inability to abstain during incarceration raises questions about their ability to adhere to the treatment regimen and to abstain from high risk behaviors after their release.
   4. Co-morbidity that may affect life expectancy independent of their chronic hepatitis infection.

III. Hepatitis C

A. Infectious Agent – hepatitis C virus (HCV), an enveloped RNA virus. The virus exists in at least 6 distinct genotypes, with the most common genotype in TDCJ offenders being genotype I. Approximately 70 percent of cases in TDCJ are genotype I and 30 percent genotypes 2 or 3. The virus can persist in the environment for several hours. Although few, if any, disinfectants are registered with the EPA to be virucidal against HCV, a 1:10 dilution of household bleach or properly diluted Double-D disinfectant are effective.

B. Transmission – HCV is a bloodborne pathogen. The most common mode of transmission is through shared needles, such as with injection drug use. There is some evidence that jail tattoos may be responsible for transmission of HCV. Sexual transmission may occur, but it is much less efficient than needle sharing. In the past, HCV was commonly acquired through blood transfusion, but since July, 1992, the test used to screen donated blood has nearly eliminated this mode of transmission in the United States. Risk factors for hepatitis C infection include current or previous injection drug use, unprotected sex with multiple partners, blood transfusion before July 1992, receipt of clotting factor concentrates before 1987, history of chronic hemodialysis, and possibly having a jailhouse or street tattoo. There is evidence that the majority of HCV infections related to injection drug use occur within the first year of beginning to engage in this behavior.

C. Diagnostic Tests – Screening for hepatitis C infection is done by a serum anti-HCV antibody test (EIA). This test does not differentiate between acute, chronic or resolved hepatitis C. Confirmation by an immunoblot (RIBA) test is not required; RIBA should only be ordered in exceptional circumstances. If confirmation of the diagnosis is required, current (acute or chronic) HCV infection can be verified with a HCV-RNA assay. However, confirmation of the diagnosis with HCV-RNA is not required for offenders with risk factors for HCV infection. (Note that a positive HCV-RNA is still required before initiating treatment) A positive HCV-RNA assay is conclusive for current infection, but a single negative result does not rule out infection, as the degree of viremia fluctuates during infection and may be undetectable at times. Chronic infection can be diagnosed by demonstrating persistent viremia or elevation of transaminases over 6 months or longer. If the offender has a clinical history that suggests infection was most likely acquired in the past (for example, injection drug use more than 1 year previously) a diagnosis of chronic infection may be reasonably made at the time of the initial diagnosis of HCV infection.

D. Incubation Period – two to 26 weeks, averaging about 6-7 weeks. ALT elevation usually begins 1-3 months after infection. Anti-HCV antibody may not be present when acute symptoms or the initial rise in ALT occur, but the antibody usually is detectable within 3 months of exposure and infection.

E. Infectious period – patients must be considered infectious unless they have demonstrated persistent normal ALT levels and undetectable HCV-RNA by qualitative testing.

F. Symptoms – most cases of acute HCV infection are asymptomatic or do not have symptoms that would suggest hepatitis. The minority of acute infections that do have symptoms will have those typical of acute hepatitis. 50-85% of acute infections will become chronic. Chronic hepatitis C is generally asymptomatic. Chronic hepatitis C is characterized by fluctuations in viremia and ALT levels.

G. Treatment – In 2007, pegylated interferon and ribavirin in combination is the accepted form of treatment. There are a number of warnings and contraindications to these drugs and the prescriber should be familiar with them. The decision who to treat must be individualized, but currently the best candidates are considered to be those with elevated ALT, positive HCV-RNA and moderate to severe fibrosis (METAVIR or Ludwig-Batts score of 2 or higher) on liver biopsy. Some individuals with advanced liver disease may have normal ALT levels. One must also consider absolute and relative contraindications to treatment, the patient's commitment and consent to pre-treatment evaluation and to treatment, comorbid conditions and other clinical considerations in making a decision about referral for treatment.

H. Retreatment. The chance of achieving a sustained viral response in a patient who initially responded to treatment and then relapsed after completion of therapy may be as high as 40-50 percent if a more effective treatment regimen is used. Patients who relapse after standard interferon with or without ribavirin should be considered for retreatment with pegylated interferon and ribavirin. Retreatment with a longer duration or therapy in patients who relapse after a 12 month course of pegylated interferon and ribavirin is of unproven benefit. Retreatment of non-responders to standard interferon monotherapy with pegylated interferon can achieve SVR in up to 20 percent of patients; response to retreatment of non-responders to standard interferon with ribavirin is only about 10 percent.

I. The APRI (aspartate aminotransferase to platelet ratio index) is the ratio of the AST level, expressed as a percentage of the upper limit of normal, divided by the platelet count in thousands per cubic millimeter. It is somewhat predictive of liver fibrosis but cannot replace the liver biopsy in all cases. An APRI score of less than 0.42 has a 93% predictive value for a Ludwig-Batts score of 0 or 1 on liver biopsy, and a score of over 1.2 has a predictive value of 93% for a Ludwig-Batts score of 2-4. The APRI may be less predictive when there are comorbid conditions other than liver disease that may affect the platelet count or AST level.

An APRI score calculator is available on CMCWEB under the Tools submenu.

IV. Advanced Liver Disease

A. Approximately 10-25 percent of chronic hepatitis C and chronic hepatitis B infections will progress to cirrhosis over a period of 10-30 years. The proportion progressing and the rate of progression may be increased by cofactors such as alcohol ingestion and co-infection.

B. Laboratory evidence suggestive of cirrhosis includes AST/ALT ratio greater than 1, elevated alkaline phosphatase, low albumin level, elevated bilirubin, low platelet count or prolonged prothrombin time. Of course, other conditions can cause some or all of these abnormalities so the laboratory results must be interpreted in the context of the overall clinical picture.

C. Laboratory results consistent with uncompensated cirrhosis are albumin < 3.0, bilirubin > 1.5, platelet count < 70,000, or prothrombin time > 2 seconds longer than control.

D. Clinical evidence of uncompensated cirrhosis includes ascites, history of bleeding esophageal varices and history of hepatic encephalopathy.

E. Each year about 1-4 percent of patients with cirrhosis will progress to end stage liver disease or develop hepatocellular carcinoma.

F. The treatment of choice for liver failure secondary to chronic HCV or HBV infection is liver transplantation. The American Association for the Study of Liver Disease recommends that patients with chronic hepatitis C or chronic hepatitis B be referred for evaluation for liver transplant if they have decompensated cirrhosis. However, the decision to refer to be considered for transplant must be made on a case-by-case basis.

G. Patients with cirrhosis are at risk of developing hepatocellular carcinoma or esophageal varices. There is no consensus on frequency or modality of screening for varices, but recent evidence suggests periodic surveillance for hepatocellular carcinoma is cost-effective in selected patients. These patients include those with cirrhosis related to hepatitis B, hepatitis C or other causes of liver disease, as well as some patients with chronic hepatitis B without evidence of cirrhosis, as listed below:
   1. Asian males age 40 and older

2. Asian females age 50 and older
3. Patients with confirmed cirrhosis or lab results suggestive of cirrhosis (compensated or uncompensated)
4. Patients with a family history of HCC
5. Africans over age 20

H. Patients with ascites are at increased risk for spontaneous bacterial peritonitis. Certain high-risk patients (eg., GI bleed) may benefit from prophylactic antibiotics.

I. Primary treatment for ascites is dietary sodium restriction (2 Gm/day) and diuretics, although the initial presentation of tense ascites may require therapeutic paracentesis followed by salt restriction and diuretics. Some patients may be diuretic resistant and require second line therapy, such as serial therapeutic paracentesis, transjugular intrahepatic portasystemic shunt (TIPS), liver transplant or peritoneovenous shunt. Before concluding a patient is refractory to diuretics, make sure they are following the sodium restriction and are not taking NSAIDS or other drugs that can reduce urinary sodium excretion. If a random spot urine has a sodium/potassium ratio greater than 1 or if a 24 hour urine sodium is less than 78 mmol/day (on diuretics) and the patient is not losing weight, they should be counseled about adhering to the salt restriction.

J. Patients with esophageal varices are at risk for gastrointestinal hemorrhage. Primary prevention of gastrointestinal hemorrhage with beta blockers may be considered for patients with severe liver failure or those who have had endoscopy findings of large esophageal varices. Secondary prevention (i.e., prevention of rebleeding after an initial bleed) may include variceal ligation or sclerotherapy, both of which require multiple sessions to eradicate varices. Non-selective beta blockers used for secondary prevention have comparable rates of rebleeding and survival to sclerotherapy. Portosystemic shunt, including Transjugular Intrahepatic Portosystemic Shunt (TIPS) may also be considered for a patient who has had a GI bleed from esophageal varices.

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TEXAS CORRECTIONAL OFFICE ON OFFENDERS WITH MEDICAL OR MENTAL IMPAIRMENTS
CONTINUITY OF CARE STATISTICAL REPORT
FISCAL YEAR 2007

I. REFERRALS / SOURCES

A. Offenders Referred by Referral Source

Monthly I.T. Data Report		2576
Parole Division (HV Placement; ISF)		43
BPP Condition "P"		513
TCOOMMI - MRIS		19
Unit Staff (classification, medical, psych)		112
Family/Self		0
Regional COC Worker		31
OD Field Services		5
Health Services Liaison		7
Flat/State Jail discharge post card		1836
	TOTAL	**5142**

II. RELEASES BY RELEASE TYPE/DIAGNOSIS

Mandatory Supervision		1105
Parole		1054
Flat Discharge		572
State Jail Discharge		1286
	TOTAL	**4017**

Medical

HIV		327
Dialysis		51
Other		46
	TOTAL	**424**

Psychiatric

Bipolar		948
Major Depression		1385
Schizophrenia		968
Mentally Retarded / other		33
BPP imposed "P"		259
	TOTAL	**3593**

III. SAFP RELEASES BY DIAGNOSIS

Bipolar		213
Major Depression		136
Schizophrenia		84
Mentally Retarded		4
Other		3
	TOTAL	**440**

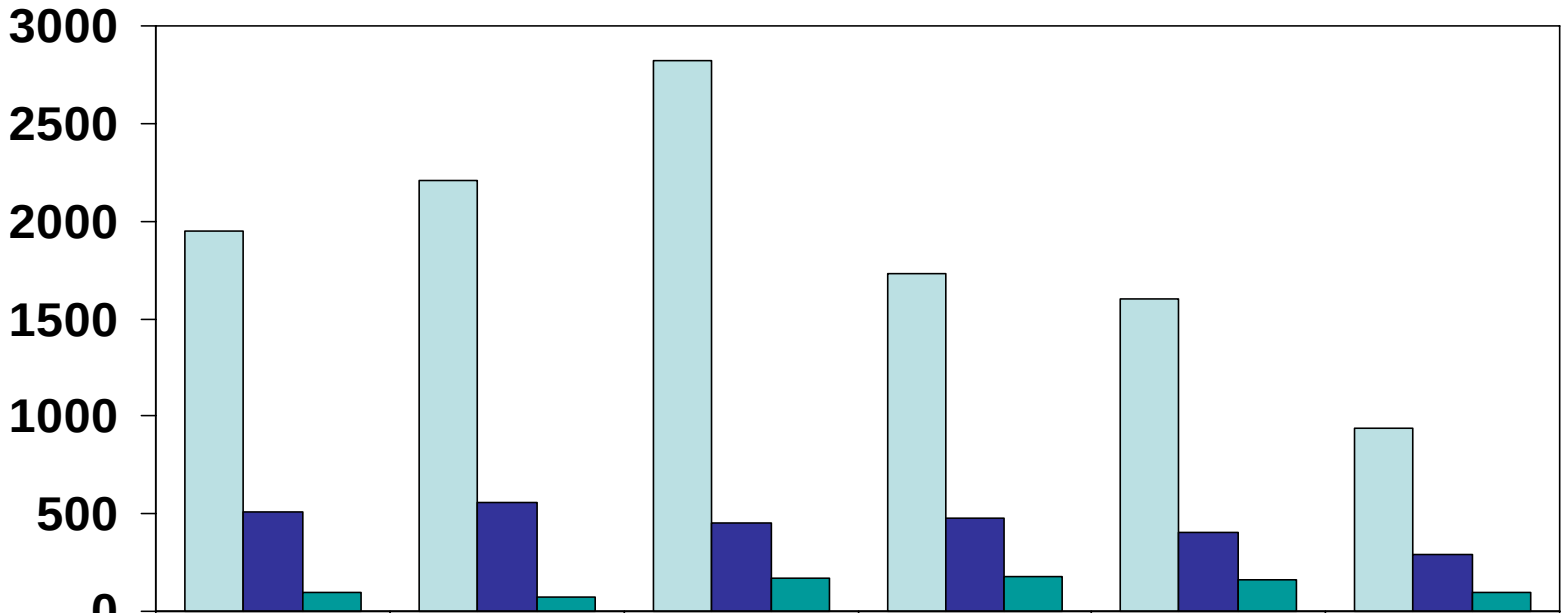
Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI)

Medically Recommended Intensive Supervision (MRIS)

FY07 Annual Report

The MRIS program provides for the early parole review and release of certain categories of offenders who are mentally ill, mentally retarded, elderly, terminally ill, long term care or physically handicapped. The purpose of MRIS is to release inmates, who pose minimal public safety risk, from incarceration to more cost effective alternatives.

MRIS Data Comparison (by fiscal year)



	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Screened**	1952	2211	2821	1729	1600	941
Presented	510	560	453	475	401	290
Approved	97	75	167	174	161	101

**Includes ineligible referrals such as sex offenders, ineligible 3g or inmates with no qualifying medical condition.

MRIS FY07 Referral Status

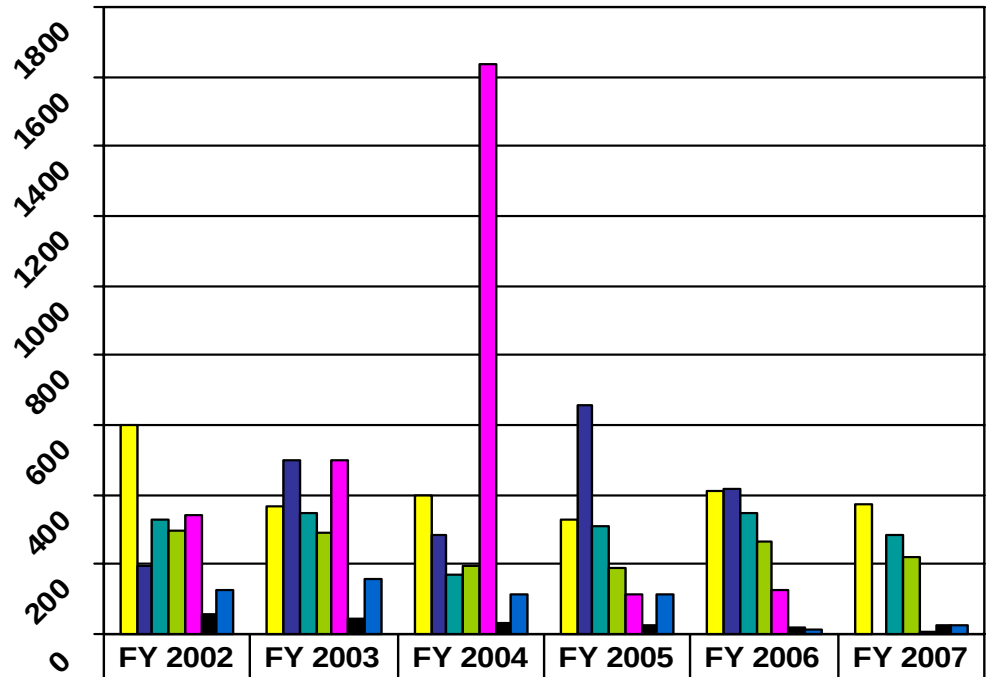
Eligible

Presented to BPP	290
Clinical Criteria Not Met	182
Offender Referred to Unit Medical	127
Deceased Prior to BPP Presentation	35
Pending Presentation to BPP at close of FY07	14
Pending Response from Unit Medical at close of FY07	12
Refused MRIS	6
Active Detainer	6
Total Eligible Referrals	672

Ineligible

Sex Offender	179
Parole Approved	49
Not an Inmate (State Jail or SAFPF)	26
3G / Not Long Term Care or Terminally Ill	15
Total Ineligible Referrals	269

MRIS Referral Sources (Comparison by fiscal year)



	FY 2002 Total 1952	FY 2003 Total 2211	FY 2004 Total 2821	FY 2005 Total 1729	FY 2006 Total 1600	FY 2007 Total 941
Unit Medical Staff	599	367	395	327	409	372
Data Report	198	502	282	655	414	0
Family	331	350	169	311	350	286
Offender	298	289	197	189	268	223
Re-reviews	340	501	1636	112	126	9
Attorney/Advocacy	58	45	29	23	21	25
State Agencies	128	157	113	112	12	26

MRIS FY07
Presented to BPP by Diagnosis

Terminally Ill	106
Physically Handicapped	17
Elderly	5
Long Term Care	152
Mentally Ill	10
Mentally Retarded	0
Total Presented	290

MRIS Approval Rates by Diagnosis (Comparison by fiscal year)

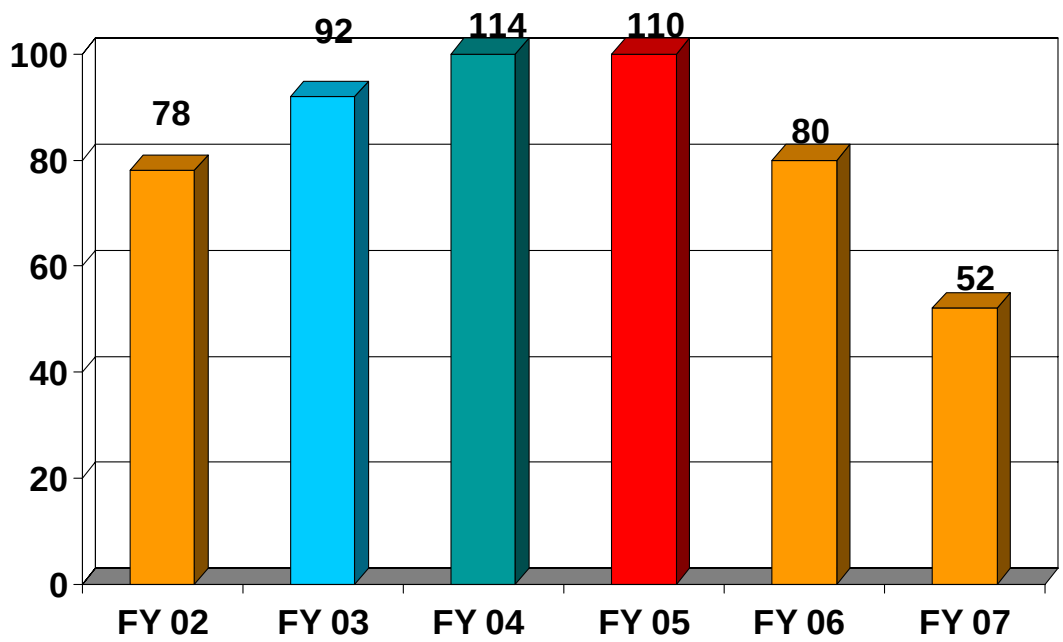
	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Terminally Ill	54	37	92	79	84	58
Physically Handicapped	4	6	7	2	0	0
Elderly	9	3	9	2	1	0
Long Term Care	29	25	55	90	75	42
Mentally Ill	1	4	4	1	1	1
Mentally Retarded	0	0	0	0	0	0
Total Approvals	**97**	**75**	**167**	**174**	**161**	**101**

Status of FY07 Approved Cases

Released	81
Deceased Prior to Release	11
Pending Release	6
MRIS Vote Withdrawn	3
Total Approved	**101**

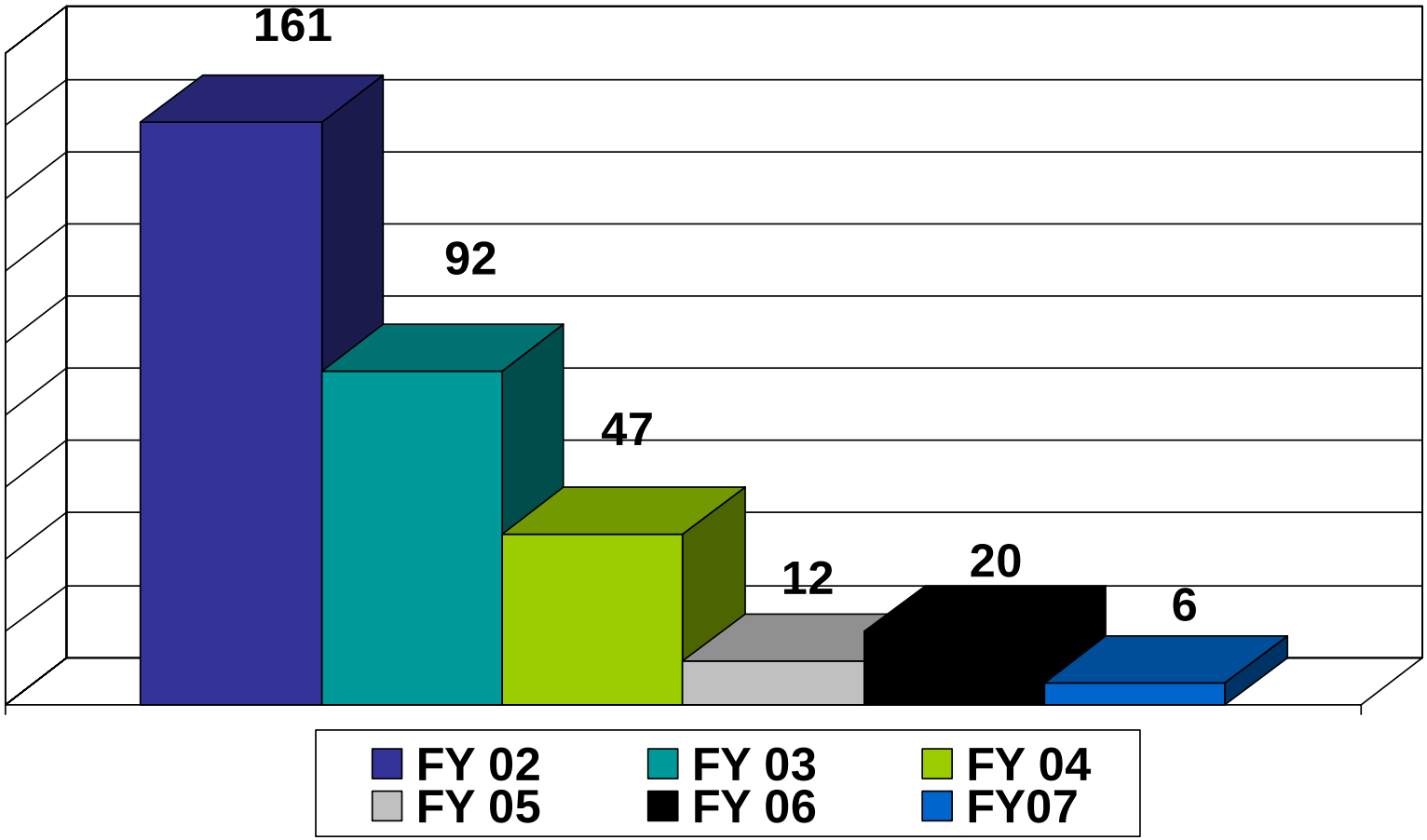
Reflects status of approved cases as of 08/31/2007

Deaths During the MRIS Process (Comparison by fiscal year)

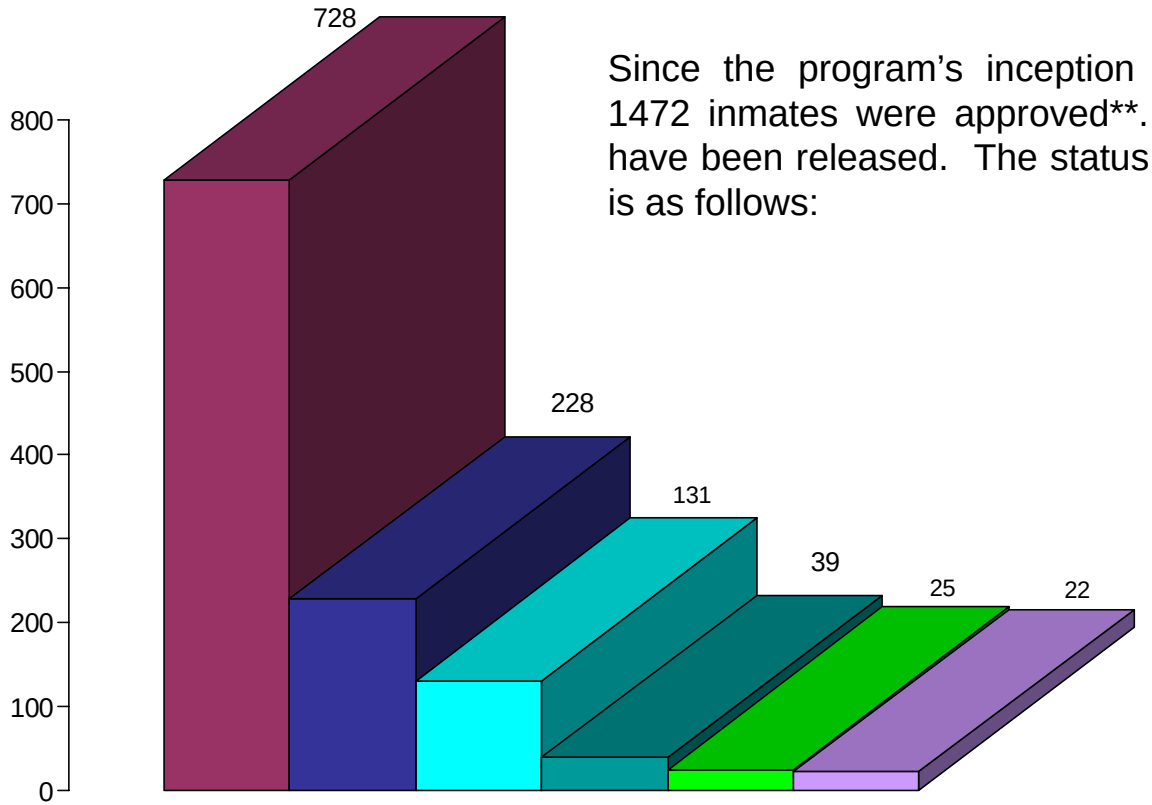


FY 07:	
•After Referral ~ Prior to Receipt of MRIS Medical Summary	0
•After Receipt of MRIS Medical Summary ~ Processing for Presentation to Parole Board	35
•Pending Parole Panel Decision	5
•Approved, Pending Placement/Release	12

Inmate Refusals for MRIS Consideration (Comparison by fiscal year)



MRIS Total Program Releases to Date



Since the program's inception on December 1, 1991, 1472 inmates were approved**. Of this, 1173 Inmates have been released. The status of these released cases is as follows:

- Deceased Post Release - 62%
- Currently On Supervision - 20%
- Discharged Parole - 11%
- Currently in TDCJ Custody - 3%
- Returned toTDCJ; Departed Other - 2%
- Other (Absconder, Deported, FCI, Other State Custody) - 2%

**	243	Deceased Prior to Release
	44	MRIS Vote Withdrawn Prior to Release
	6	Approved - Still Pending Release as of 8/31/2007
	6	Approved Twice After Returning to Custody

Article V Rider
related to
TCOOMMI and TDCJ

74. Medically Recommended Intensive Supervision. It is the intent of the Legislature that the Texas Department of Criminal Justice (TDCJ) develop an automated report to assist in identifying offenders eligible for medically recommended intensive supervision (MRIS). TDCJ should work with the University of Texas Medical Branch and the Texas Tech University Health Sciences Center to develop uniform diagnosis codes to signal offenders eligible for release on MRIS.

It is also the intent of the Legislature that the TDCJ expedite its screening process for MRIS by requesting an offender's board file at the same time it assigns a caseworker to complete an interview of the offender.

An Overview of the Joint Mortality Review Committee

For the Correctional Managed Health Care Committee March 25, 2008

Joint Mortality Review Committee Functions

- Medical record review of every offender death, except executions
  - Nursing and provider quality of care
  - Systemic issues that affect care
  - Security issues that affect care
- Refer quality of care issues to university peer review functions for further review
- Refer other issues to the appropriate party
- Develop Committee consensus on cause of death, based on chart review and, when available, autopsy results.

Joint Mortality Review Committee Authorization

- Functions as a medical committee as defined in the Texas Health and Safety Code (§161.031)
- Proceedings are confidential and not subject to subpoena or open records request
- Meetings are not subject to Open Meetings Law

Record Review Process

- Unit medical director writes death summary
- Records sent to Medical Records Archive
- When all records are received, including autopsy, if done
  - Cases assigned to Committee members and records distributed
  - Death certificate may not be available
- Cases reviewed by MD/DO, PA, ANP or RN
  - Average 2-3 cases/member/month
  - Entire record reviewed, not just events leading to death
  - Presented at monthly meeting with recommendation for/against referral to peer review

Referrals for Further Review

- Committee determines case has quality, systemic or security issues
  - Low threshold for referral – "could it have been significantly better" rather than "was it within the standard of care?"
- Peer review referral written by Chair
  - Nursing (including ANP) to Nursing Peer Review
  - MD/DO, PA to Provider Peer Review
  - Allied Mental Health to Joint Mental Health Committee
- Systemic issues usually sent to Provider Peer Review
- Security issues sent to CID Division Director

2007 Activities

- 402 cases presented to Joint Mortality Review Committee
- 28 cases referred to Provider Peer Review
  - 16 to both Provider and Nursing
  - 1 case to free world facility peer review
  - 11 cases to Provider Peer Review only
- 20 cases referred to Nursing Peer Review
  - 16 to both Provider and Nursing
  - 2 to Nursing and Allied Mental Health
  - 2 to Nursing Peer Review only
- 4 cases referred to Allied Mental Health
  - 2 also referred to Nursing Peer Review
- Overall, 35 cases referred to peer review

2007 Activities

- 4 cases referred for systemic issues
- 1 case referred for security issues
- 4 cases referred for other issues
  - Specialty clinic scheduling
  - Ambulance dispatch
  - Facility processes

Backlog

- 208 cases not assigned (out of 3562 deaths)
  - 9 from 2005
  - 42 from 2006
  - 28 from Jan-Jun 2007
  - 89 from Jul-Dec 2007
  - 40 from 2008
- 69 charts assigned but not presented
  - 14 assigned in 2007

Process Improvement

- Average time from death to committee review by year of review
  - 2005– 237 days
  - 2006– 232 days
  - 2007– 203 days
- Average time from death to review by year of death
  - 2005 – 220 days
  - 2006 – 202 days
  - 2007 – 153 days
- Time from death to case assignment is about 2/3 of the gap

Correctional Managed Health Care

Quarterly Report
FY 2008 First Quarter

September 2007 – November 2007

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 2008. Following this summary are individual data tables and charts supporting this report.

Background

During Fiscal Year 2008, approximately $412.5 million within the TDCJ appropriation has been allocated for funding correctional health care services. This funding included:

- $369.4M in general revenue appropriations in strategy C.1.8 (Managed Health Care, medical services)
- $43.1M in general revenue appropriations in strategy C.1.7. (Psychiatric Care).

Of this funding, $411.9M (99.9%) was allocated for health care services provided by UTMB and TTUHSC and $586K (0.1%) for the operation of the Correctional Managed Health Care Committee.

In addition and based on the 80th Legislative Session, UTMB is to receive $10.4M in General Obligation Bonds for repairs to the TDCJ Hospital in Galveston in FY 2008. Funding in the amount of $4.8M for year FY 2009 is appropriated for psychiatric care at the Marlin VA Hospital contingent upon transfer of the facility to the State. 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 2008 was 151,638. Through this same quarter a year ago (FY 2007), the average daily population was 151,838, a decrease of 200 (0.1%). 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 2008, the average number of older offenders in the service population was 10,120. Through this same quarter a year ago (FY 2007), the average number of offenders age 55 and over was 9,488. This represents an increase of 632 or about 6.6% 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 2,471 (or about 1.6% of the population served).
  - Two mental health caseload measures have also remained relatively stable:
    - The average number of psychiatric inpatients within the system was 1,959 through the first quarter of FY 2008, as compared to 2,002 through the same quarter a year ago (FY 2007). The inpatient caseload is limited by the number of available inpatient beds in the system.
    - Through the first quarter of FY 2008, the average number of mental health outpatients was 20,567 representing 13.5% of the service population.

Health Care Costs

- Overall health costs through the first quarter of FY 2008 totaled $111.2M. This amount was below overall revenues earned by the university providers by $1.9M or 1.7%.
  - UTMB's total revenue through the quarter was $89.1M. Their expenditures totaled $87.7M, resulting in a net gain of $1.4M. On a per offender per day basis, UTMB earned $8.14 in revenue, but expended $8.01 resulting in an overage of $0.13 per offender per day.

- TTUHSC's total revenue through the first quarter was $23.9M. Expenditures totaled $23.4M, resulting in a net gain of $0.5M. On a per offender per day basis, TTUHSC earned $8.40 in revenue, but expended $8.23 resulting in an overage of $0.17 per offender per day.

- Examining the health care costs in further detail indicates that of the $111.2M in expenses reported through the first quarter of the year:
  - Onsite services (those medical services provided at the prison units) comprised $54.3M representing about 48.9% of the total health care expenses:
    - Of this amount, 79.7% was for salaries and benefits and 20.3% for operating costs.
  - Pharmacy services totaled $10.7M representing approximately 9.6% of the total expenses:
    - Of this amount 15.0% was for related salaries and benefits, 3.9% for operating costs and 81.1% for drug purchases.
  - Offsite services (services including hospitalization and specialty clinic care) accounted for $31.7M or 28.5% of total expenses:
    - Of this amount 76.1% was for estimated university provider hospital, physician and professional services; and 23.9% for Freeworld (non-university) hospital, specialty and emergency care.
  - Mental health services totaled $10.3M or 9.3% of the total costs:
    - Of this amount, 96.3% was for mental health staff salaries and benefits, with the remaining 3.7% for operating costs.
  - Indirect support expenses accounted for $4.2M and represented 3.7% of the total costs.

- The total cost per offender per day for all health care services statewide through the first quarter of FY 2008 was $8.06. The average cost per offender per day for the prior four fiscal years was $7.56.
    - For UTMB, the cost per offender per day was $8.01. This is higher than the average cost per offender per day for the last four fiscal years of $7.67.
    - For TTUHSC, the cost per offender per day was $8.23, significantly higher than the average cost per offender per day for the last four fiscal years of $7.18.
    - 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 2008 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 $835 per offender. The same calculation for offenders under age 55 totaled about $141. 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 6.7% of the overall service population, offenders age 55 and over account for more than 29.8% 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 $22K per patient per year. Providing medically necessary dialysis treatment for an average of 185 patients through the first quarter of FY2008 cost $1.0M.

Drug Costs

- Total drug costs through the first quarter of FY 2008 totaled $10.1M.
    - Pharmaceutical costs related to HIV care continue to be the largest single component of pharmacy expenses.
        - Through this quarter, $4.8M in costs (or just over $1.6M per month) for HIV antiretroviral medication costs were experienced. This represents 47.4% of the total drug cost during this time period.
        - Expenses for psychiatric drugs are also being tracked, with approximately $0.5M being expended for psychiatric medications through the first quarter, representing 5.3% of the overall drug cost.
        - Another pharmacy indicator being tracked is the cost related to Hepatitis C therapies. These costs were $0.4M and represented about 3.6% 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 net gain of $1,429,391 through this quarter. TTUHSC reports that they hold no such reserves and report a total net gain of $481,722.

- 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, 2007 was <$24,343.30> due to CMHCC Operating Account personnel changes as compared to budget allocations.

- The FY 2007 unencumbered ending fund balance, as of August 31, 2007, was $35,601.16. The total amount of the FY 2007 fund balance was lapsed back to the State General Revenue Fund in November 2007, as required by Rider 69.

- UTMB and TTUHSC has indicated that their operating gains this first quarter of FY 2008 does not reflect the market adjustments for retention of staff as appropriated by the legislature on the expense side until the second quarter of FY 2008.

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 and October, 2007, resulted in one discrepancy in recording unallowable relocation expense requiring correction or adjustment.

The preliminary testing of detail transactions performed on UTMB's financial information for September and October, 2007, resulted in two discrepancies in recording unallowable relocation expenses requiring correction or adjustment.

Concluding Notes

The combined operating gain for the university providers through the first quarter of FY 2008 is $1.9M. The university providers are continuing to monitor their expenditures closely, while seeking additional opportunities to reduce costs in order to minimize any future operating losses.

Listing of Supporting Tables and Charts

Table 1

Correctional Managed Health Care

FY 2008 Budget Allocations

Distribution of Funds

Allocated to	FY 2008
University Providers	
The University of Texas Medical Branch	
Medical Services	$296,042,567
Mental Health Services	$25,619,350
Subtotal UTMB	$321,661,917
Texas Tech University Health Sciences Center	
Medical Services	$77,909,117
Mental Health Services	$12,337,000
Subtotal TTUHSC	$90,246,117
SUBTOTAL UNIVERSITY PROVIDERS	$411,908,034
Correctional Managed Health Care Committee	$585,718
TOTAL DISTRIBUTION	**$412,493,752**

Source of Funds

Source	FY 2008
Legislative Appropriations	
HB 1, Article V, TDCJ Appropriations	
Strategy C.1.8. Managed Health Care	$369,399,163
Strategy C.1.3 Psychiatric Care	$43,094,589
TOTAL	**$412,493,752**

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

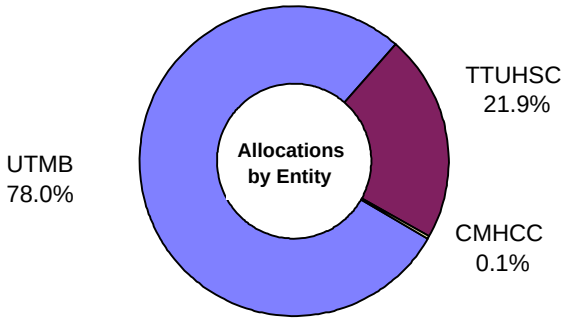


Table 2
FY 2007
Key Population Indicators
Correctional Health Care Program

Indicator	Sep-07	Oct-07	Nov-07	Population Year to Date Avg.
Avg. Population Served by CMHC:				
UTMB State-Operated Population	108,399	108,504	108,781	108,561
UTMB Private Prison Population*	11,797	11,793	11,757	11,782
UTMB Total Service Population	120,196	120,296	120,538	120,343
TTUHSC Total Service Population	31,409	31,293	31,183	31,295
CMHC Service Population Total	**151,605**	**151,589**	**151,721**	**151,638**
Population Age 55 and Over				
UTMB Service Population Average	8,253	8,351	8,356	8,320
TTUHSC Service Population Average	1,821	1,786	1,794	1,800
CMHC Service Population Average	**10,074**	**10,137**	**10,150**	**10,120**
HIV+ Population	**2,491**	**2,462**	**2,459**	**2,471**
Mental Health Inpatient Census				
UTMB Psychiatric Inpatient Average	1,050	1,021	1,014	1,028
TTUHSC Psychiatric Inpatient Average	912	931	950	931
CMHC Psychiatric Inpatient Average	**1,962**	**1,952**	**1,964**	**1,959**
Mental Health Outpatient Census				
UTMB Psychiatric Outpatient Average	16,041	17,303	15,563	16,302
TTUHSC Psychiatric Outpatient Average	3,831	4,617	4,347	4,265
CMHC Psychiatric Outpatient Average	**19,872**	**21,920**	**19,910**	**20,567**

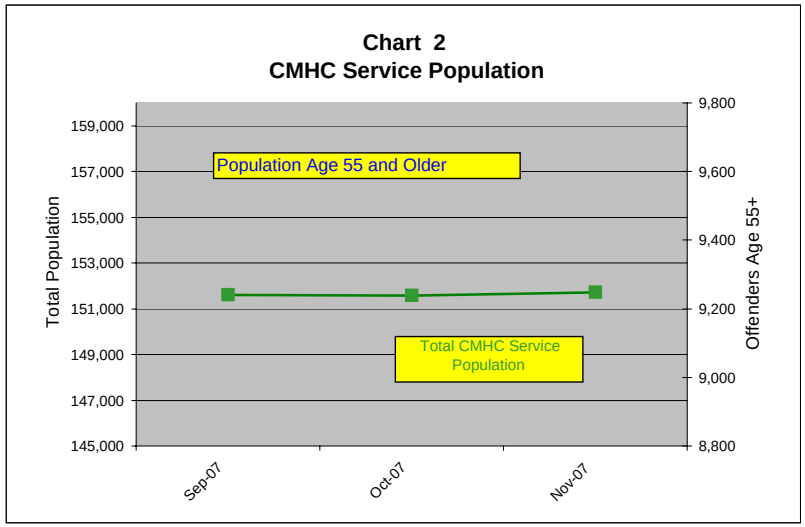


Chart 2
CMHC Service Population
Total Population
Offenders Age 55+
159,000
157,000
155,000
153,000
151,000
149,000
147,000
145,000
9,800
9,600
9,400
9,200
9,000
8,800
Population Age 55 and Older
Total CMHC Service Population
Sep-07
Oct-07
Nov-07

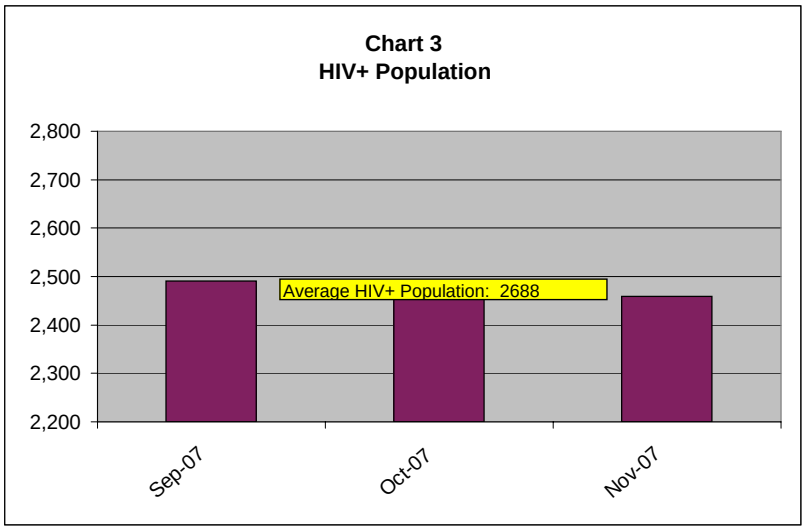


Chart 3
HIV+ Population
2,800
2,700
2,600
2,500
2,400
2,300
2,200
Average HIV+ Population: 2688
Sep-07
Oct-07
Nov-07

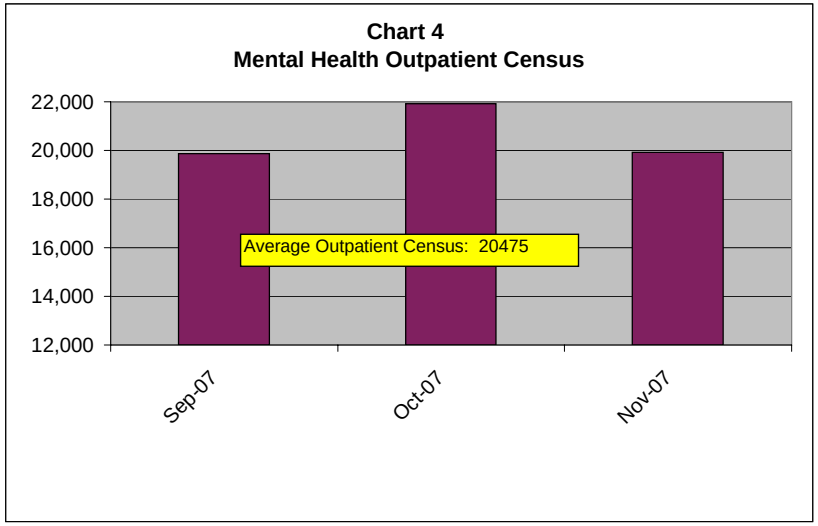


Chart 4
Mental Health Outpatient Census
22,000
20,000
18,000
16,000
14,000
12,000
Average Outpatient Census: 20475
Sep-07
Oct-07
Nov-07

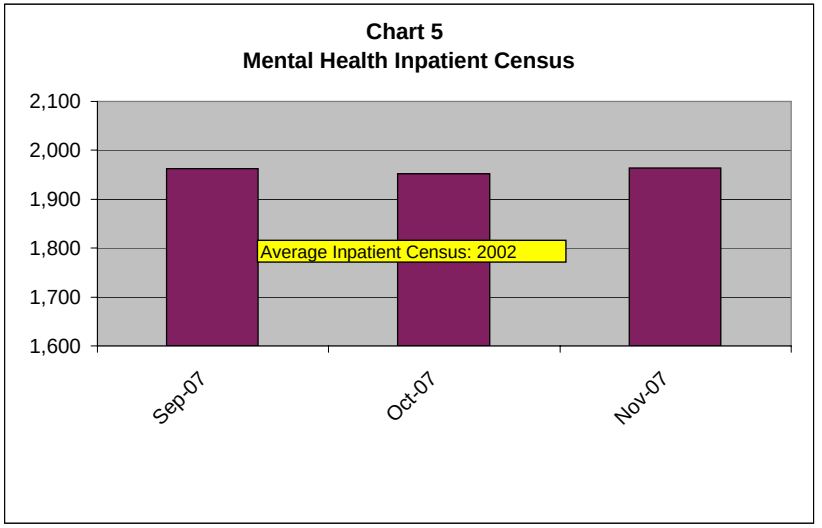


Chart 5
Mental Health Inpatient Census
2,100
2,000
1,900
1,800
1,700
1,600
Average Inpatient Census: 2002
Sep-07
Oct-07
Nov-07

Table 3
Summary Financial Report: Medical Costs
Fiscal Year 2008 through Quarter 1 (Sep 2007 - Nov 2007)

Days in Year: 91

	Medical Services Costs			Medical Cost Per Day Calculations		
	UTMB	**TTUHSC**	**TOTAL**	**UTMB**	**TTUHSC**	**TOTAL**
Population Served	**120,343**	**31,295**	**151,638**			
Revenue						
Capitation Payments	$72,194,986	$19,495,846	$91,690,832	$6.59	$6.85	$6.64
State Reimbursement Benefits	$9,158,109	$889,876	$10,047,985	$0.84	$0.31	$0.73
Non-Operating Revenue	$110,137	$391	$110,528	$0.01	$0.00	$0.01
Total Revenue	**$81,463,232**	**$20,386,113**	**$101,849,345**	**$7.44**	**$7.16**	**$7.38**
Expenses						
Onsite Services						
Salaries	$31,723,053	$2,704,266	$34,427,319	$2.90	$0.95	$2.49
Benefits	$8,262,766	$627,229	$8,889,995	$0.75	$0.22	$0.64
Operating (M&O)	$3,971,802	$277,513	$4,249,315	$0.36	$0.10	$0.31
Professional Services	$0	$630,748	$630,748	$0.00	$0.22	$0.05
Contracted Units/Services	$0	$5,673,789	$5,673,789	$0.00	$1.99	$0.41
Travel	$264,567	$20,809	$285,376	$0.02	$0.01	$0.02
Electronic Medicine	$0	$86,891	$86,891	$0.00	$0.03	$0.01
Capitalized Equipment	$73,870	$26,943	$100,813	$0.01	$0.01	$0.01
Subtotal Onsite Expenses	$44,296,058	$10,048,188	$54,344,246	$4.04	$3.53	$3.94
Pharmacy Services						
Salaries	$989,210	$289,423	$1,278,633	$0.09	$0.10	$0.09
Benefits	$315,217	$9,987	$325,204	$0.03	$0.00	$0.02
Operating (M&O)	$242,758	$161,231	$403,989	$0.02	$0.06	$0.03
Pharmaceutical Purchases	$6,731,948	$1,931,565	$8,663,513	$0.61	$0.68	$0.63
Professional Services	$0	$0	$0	$0.00	$0.00	$0.00
Travel	$4,520	$3,296	$7,816	$0.00	$0.00	$0.00
Subtotal Pharmacy Expenses	$8,283,653	$2,395,502	$10,679,155	$0.76	$0.84	$0.77
Offsite Services						
University Professional Services	$3,263,395	$217,292	$3,480,687	$0.30	$0.08	$0.25
Freeworld Provider Services	$2,187,606	$3,012,898	$5,200,504	$0.20	$1.06	$0.38
UTMB or TTUHSC Hospital Cost	$17,989,835	$2,635,812	$20,625,647	$1.64	$0.93	$1.49
Estimated IBNR	$1,980,287	$391,015	$2,371,302	$0.18	$0.14	$0.17
Subtotal Offsite Expenses	$25,421,123	$6,257,017	$31,678,140	$2.32	$2.20	$2.30
Indirect Expenses	$2,548,497	$1,202,001	$3,750,498	$0.23	$0.42	$0.27
Total Expenses	**$80,549,331**	**$19,902,708**	**$100,452,039**	**$7.36**	**$6.99**	**$7.28**
Operating Income (Loss)	**$913,901**	**$483,405**	**$1,397,306**	**$0.08**	**$0.17**	**$0.10**

Table 3 (Continued)
Summary Financial Report: Mental Health Costs
Fiscal Year 2008 through Quarter 1 (Sep 2007 - Nov 2007)

Days in Year: 91

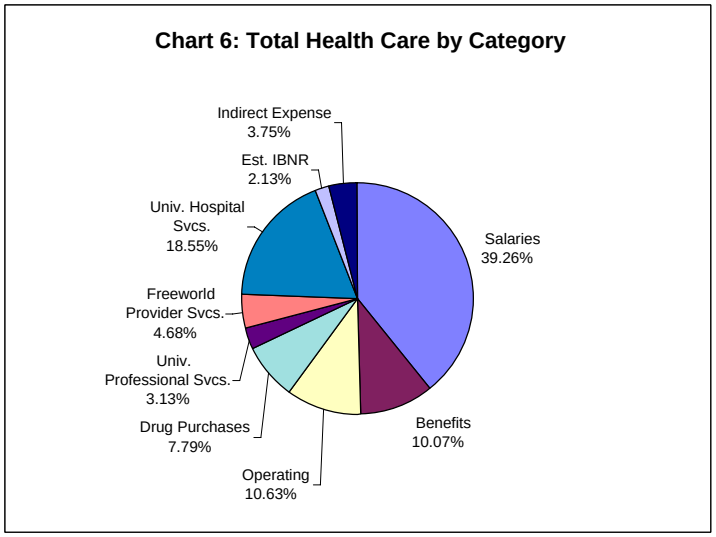
	Mental Health Services Costs			Mental Health Cost Per Day Calculations		
	UTMB	TTUHSC	TOTAL	UTMB	TTUHSC	TOTAL
Population Served	**120,343**	**31,295**	**151,638**			
Revenue						
Capitation Payments	$6,387,290	$2,942,396	$9,329,686	$0.58	$1.03	$0.68
State Reimbursement Benefits	$1,303,399	$599,848	$1,903,247	$0.12	$0.21	$0.14
Other Misc Revenue	$0	$0	$0	$0.00	$0.00	$0.00
Total Revenue	**$7,690,689**	**$3,542,244**	**$11,232,933**	**$0.70**	**$1.24**	**$0.81**
Expenses						
Mental Health Services						
Salaries	$5,374,749	$2,565,758	$7,940,507	$0.49	$0.90	$0.58
Benefits	$1,331,707	$643,524	$1,975,231	$0.12	$0.23	$0.14
Operating (M&O)	$181,256	$42,279	$223,535	$0.02	$0.01	$0.02
Professional Services	$0	$101,368	$101,368	$0.00	$0.04	$0.01
Contracted Units/Services	$0	$0	$0	$0.00	$0.00	$0.00
Travel	$49,819	$6,954	$56,773	$0.00	$0.00	$0.00
Electronic Medicine	$0	$0	$0	$0.00	$0.00	$0.00
Capitalized Equipment	$0	$0	$0	$0.00	$0.00	$0.00
Subtotal Mental Health Expenses	$6,937,531	$3,359,883	$10,297,414	$0.63	$1.18	$0.75
Indirect Expenses	$237,668	$184,044	$421,712	$0.02	$0.06	$0.03
Total Expenses	**$7,175,199**	**$3,543,927**	**$10,719,126**	**$0.66**	**$1.24**	**$0.78**
Operating Income (Loss)	**$515,490**	**($1,683)**	**$513,807**	**$0.05**	**($0.00)**	**$0.04**

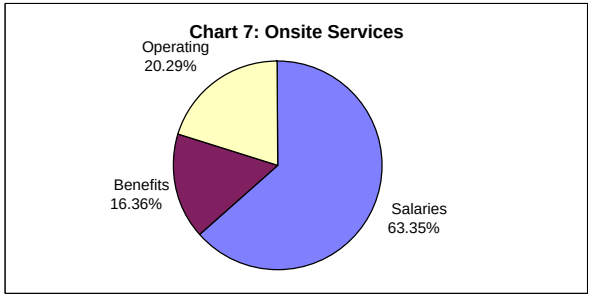
All Health Care Summary

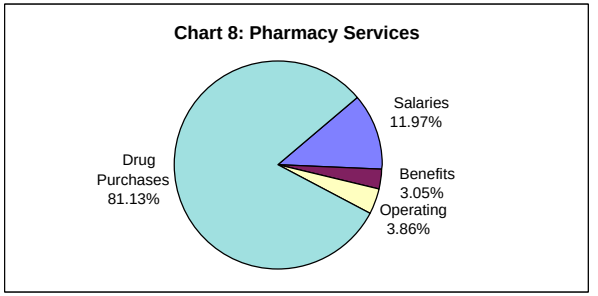
	All Health Care Services			Cost Per Offender Per Day		
	UTMB	TTUHSC	TOTAL	UTMB	TTUHSC	TOTAL
Medical Services	$81,463,232	$20,386,113	$101,849,345	$7.44	$7.16	$7.38
Mental Health Services	$7,690,689	$3,542,244	$11,232,933	$0.70	$1.24	$0.81
Total Revenue	**$89,153,921**	**$23,928,357**	**$113,082,278**	**$8.14**	**$8.40**	**$8.19**
Medical Services	$80,549,331	$19,902,708	$100,452,039	$7.36	$6.99	$7.28
Mental Health Services	$7,175,199	$3,543,927	$10,719,126	$0.66	$1.24	$0.78
Total Expenses	**$87,724,530**	**$23,446,635**	**$111,171,165**	**$8.01**	**$8.23**	**$8.06**
Operating Income (Loss)	**$1,429,391**	**$481,722**	**$1,911,113**	**$0.13**	**$0.17**	**$0.14**

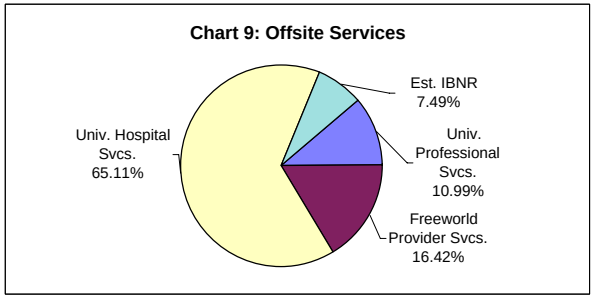
Table 4
FY 2008 1st Quarter
UTMB/TTUHSC EXPENSE SUMMARY

Category	Expense	Percent of Total
Onsite Services	**$54,344,246**	**48.88%**
Salaries	$34,427,319	
Benefits	$8,889,995	
Operating	$11,026,932	
Pharmacy Services	**$10,679,155**	**9.61%**
Salaries	$1,278,633	
Benefits	$325,204	
Operating	$411,805	
Drug Purchases	$8,663,513	
Offsite Services	**$31,678,140**	**28.49%**
Univ. Professional Svcs.	$3,480,687	
Freeworld Provider Svcs.	$5,200,504	
Univ. Hospital Svcs.	$20,625,647	
Est. IBNR	$2,371,302	
Mental Health Services	**$10,297,414**	**9.26%**
Salaries	$7,940,507	
Benefits	$1,975,231	
Operating	$381,676	
Indirect Expense	**$4,172,210**	**3.75%**
Total Expenses	**$111,171,165**	**100.00%**









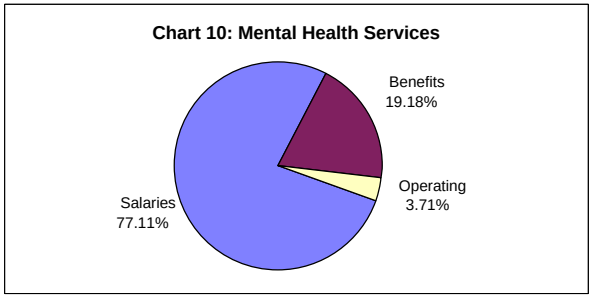


Table 5
Comparison of Total Health Care Costs

	FY 04	FY 05	FY 06	FY 07	4-Year Average	FYTD 08 1st Qtr	Less State Paid Bene. FYTD 08 1st Qtr
Population							
UTMB	113,729	119,322	119,835	120,235	118,280	120,343	120,343
TTUHSC	31,246	31,437	31,448	31,578	31,427	31,295	31,295
Total	144,975	150,759	151,283	151,813	149,708	151,638	151,638
Expenses							
UTMB	$313,875,539	$330,672,773	336,934,127	342,859,796	331,085,559	87,724,530	77,263,022
TTUHSC	$78,548,146	$80,083,059	83,467,550	87,147,439	82,311,549	23,446,635	21,956,911
Total	$392,423,685	$410,755,832	420,401,677	430,007,235	413,397,107	111,171,165	99,219,933
Cost/Day							
UTMB	$7.56	$7.59	$7.70	$7.81	$7.67	$8.01	$7.06
TTUHSC	$6.89	$6.98	$7.27	$7.56	$7.18	$8.23	$7.71
Total	**$7.40**	**$7.46**	**$7.61**	**$7.76**	**$7.56**	**$8.06**	**$7.19**

* 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

Chart 11: UTMB Cost Per Day

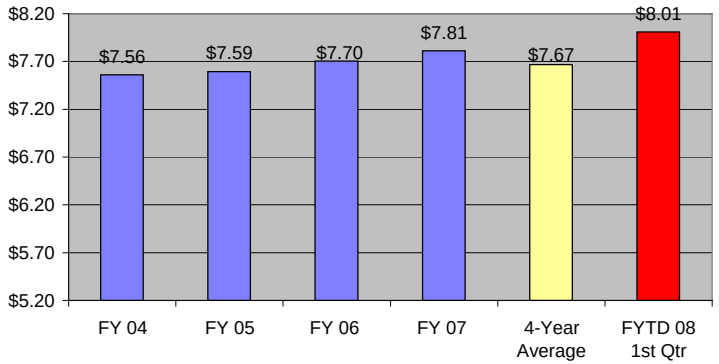


Chart 12: TTUHSC Cost Per Day

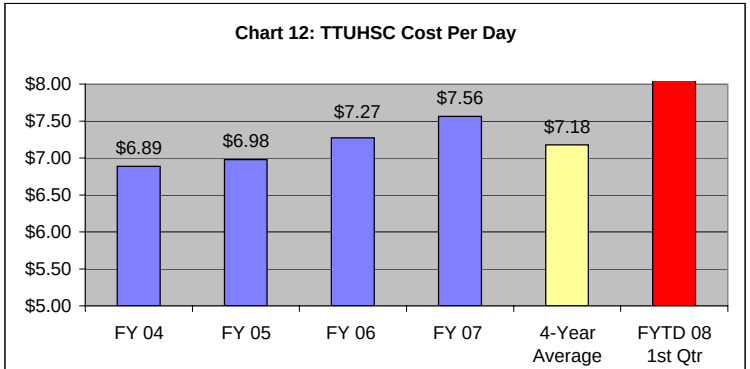


Chart 13: STATEWIDE Cost Per Day

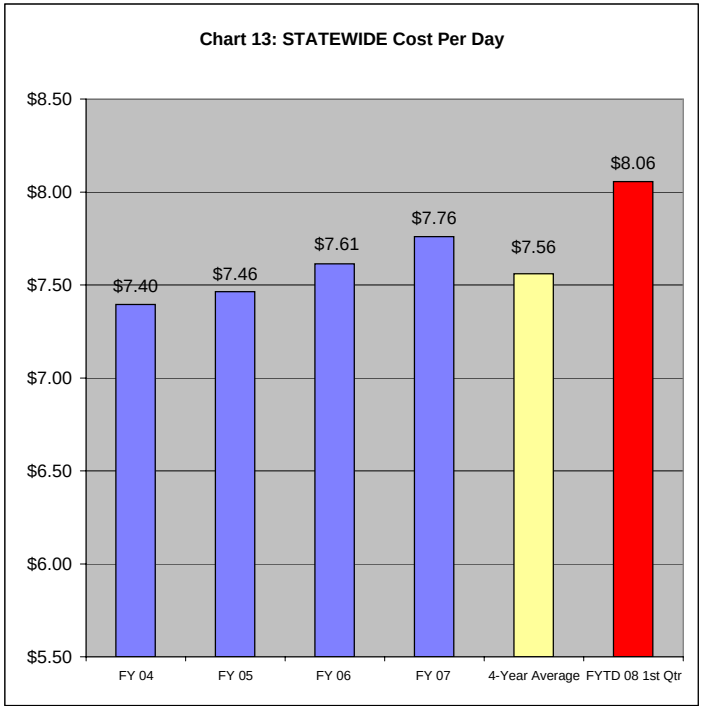


Table 6
Medical Encounter Statistics* by Age Grouping

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-07	35,284	160,052	195,336	8,253	111,943	120,196	4.28	1.43	1.63
Oct-07	41,408	183,045	224,453	8,351	111,945	120,296	4.96	1.64	1.87
Nov-07	37,339	159,731	197,070	8,356	112,182	120,538	4.47	1.42	1.63
Average	38,010	167,609	205,620	8,320	112,023	120,343	4.57	1.50	1.71

*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

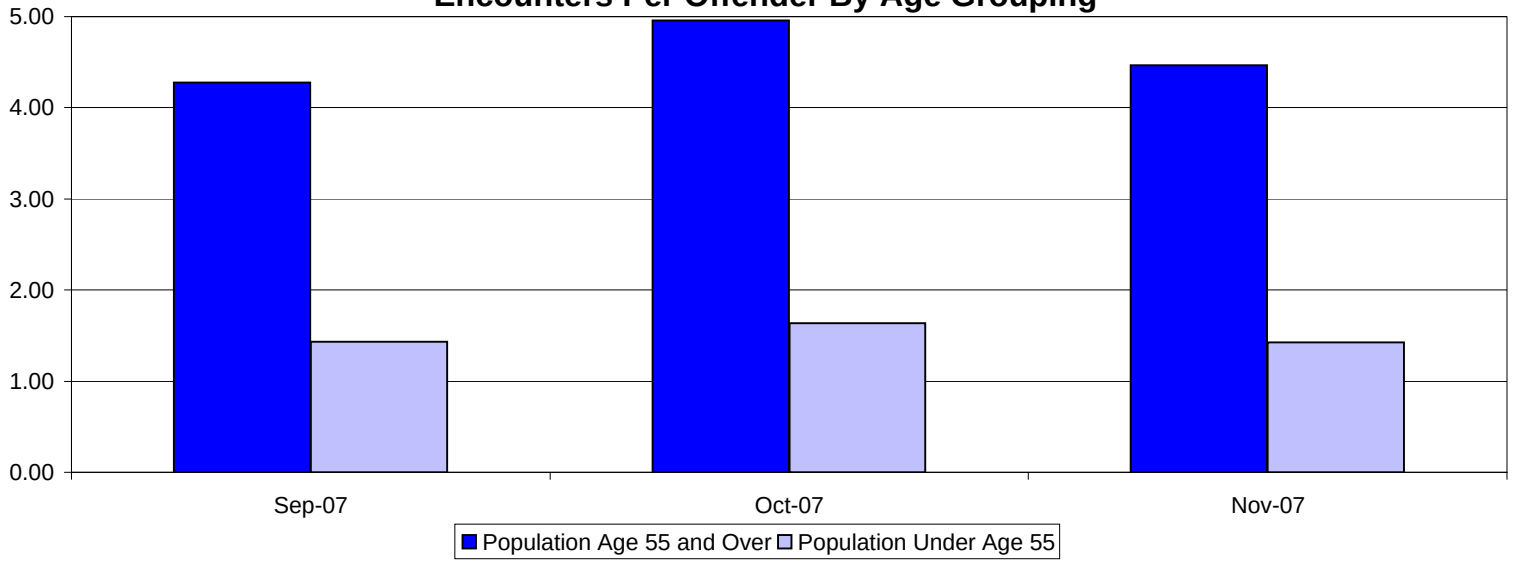


Table 7
FY 2008 1st Quarter
Offsite Costs* To Date by Age Grouping

Age Grouping	Cost Data	Total Population	Total Cost Per Offender
Age 55 and Over	$8,454,407	10,120	$835.39
Under Age 55	$19,912,365	141,518	$140.71
Total	**$28,366,772**	**151,638**	**$187.07**

**Figures represent repricing of customary billed charges received to date for services to institution's a which includes any discounts and/or capitation arrangements. Repriced charges are compared again 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

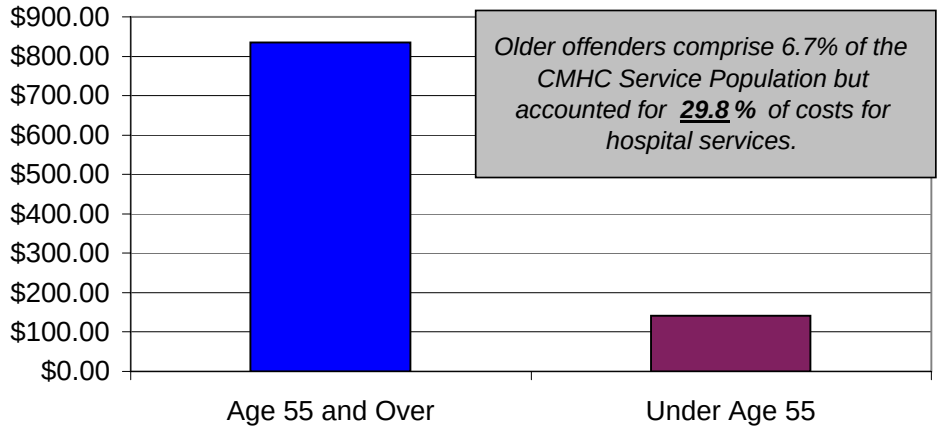
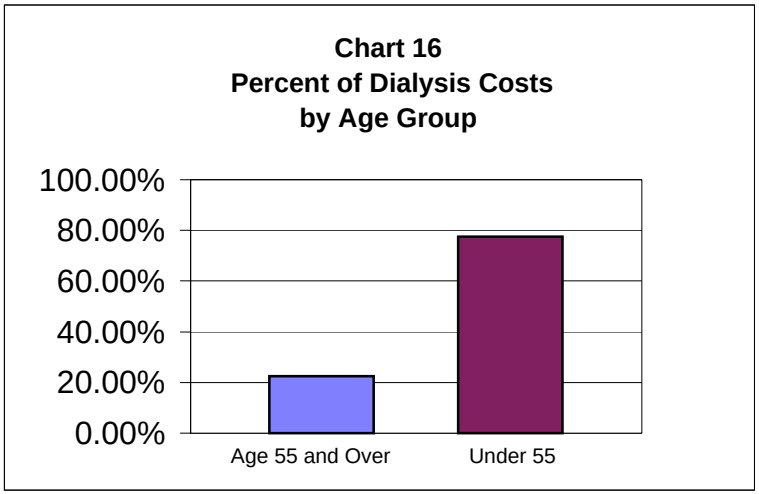


Table 8
Through FY 2008 1st Quarter
Dialysis Costs by Age Grouping

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	$228,579	22.44%	10,120	6.67%	40	0.39%
Under Age 55	$789,854	77.56%	141,518	93.33%	146	0.10%
Total	**$1,018,433**	**100.00%**	**151,638**	**100.00%**	**185**	**0.12%**

Projected Avg Cost Per Dialysis Patient Per Year: $21,981



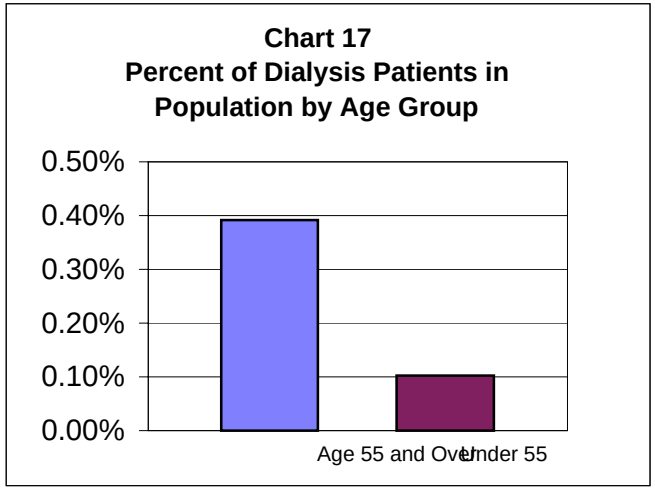


Table 9
Selected Drug Costs FY 2008

Category	Sep-07	Oct-07	Nov-07	Total Year-to-Date
Total Drug Costs	$3,590,199	$3,400,085	$3,148,925	$10,139,209
HIV Medications				
HIV Drug Cost	$2,197,685	$1,495,756	$1,117,502	$4,810,942
HIV Percent of Cost	61.21%	43.99%	35.49%	47.45%
Psychiatric Medications				
Psych Drug Cost	$31,560	$122,726	$384,064	$538,350
Psych Percent of Cost	0.88%	3.61%	12.20%	5.31%
Hepatitis C Medications				
Hep C Drug Cost	$118,158	$143,365	$105,257	$366,780
Hep C Percent of Cost	3.29%	4.22%	3.34%	3.62%
All Other Drug Costs	$1,242,797	$1,638,238	$1,542,102	$4,423,137

Chart 18
Drug Costs by Selected Categories

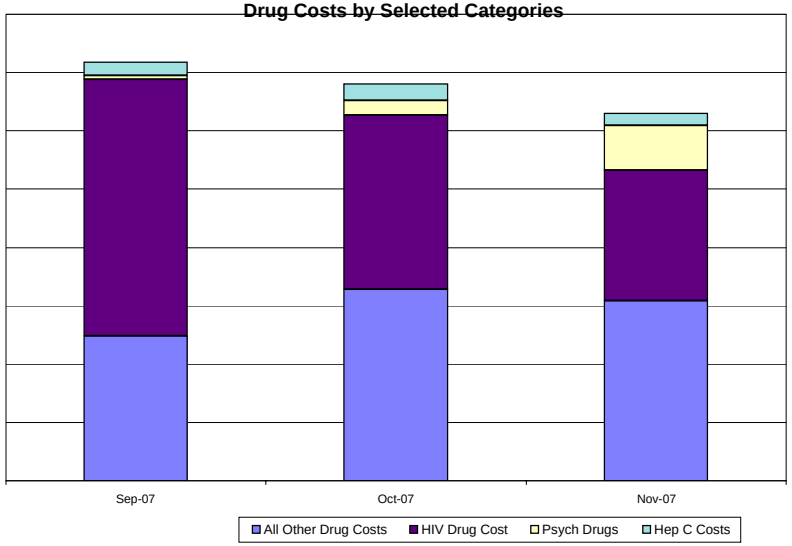


Table 10
Ending Balances 1st Qtr FY 2008

	Beginning Balance September 1, 2007	Net Activity FY 2008	Ending Balance November 30, 2007
CMHCC Operating Funds	$22,979.40	$176,441.25	$199,420.65
CMHCC Medical Services	$12,579.46	($12,579.46)	$0.00
CMHCC Mental Health	$42.30	($42.09)	$0.21
Ending Balance All Funds	**$35,601.16**	**$163,819.70**	**$199,420.86**
2nd QTR Advance Payments			
From TDCJ - CMHCC			($223,763.95)
Total Unencumbered Fund Balance			($24,343.09)

SUPPORTING DETAIL

CMHCC Operating Account	
Beginning Balance	$22,979.40
FY 2007 Funds Lapsed to State Treasury	($22,979.40)
Revenue Received	
1st Qtr Payment	$119,773.95
2nd Qtr Advance Payment	$223,763.95
Interest Earned	$480.69
Subtotal Revenue	$344,018.59
Expenses	
Salary & Benefits	($108,961.17)
Operating Expenses	($35,636.77)
Subtotal Expenses	**($144,597.94)**
Net Activity thru this Qtr	**$176,441.25**
Total Fund Balance CMHCC Operating	**$199,420.65**

RECONCILIATION:	
Less: 2nd Qtr Advance Payment from TDCJ	($223,763.95)
Total Unencumbered Fund Balance	($24,343.30)

SUPPORTING DETAIL

CMHCC Capitation Accounts	**Medical Services**	**Mental Health**
Beginning Balance	$12,579.46	$42.30
FY 2007 Funds Lapsed to State Treasury	($12,579.46)	($42.30)
Revenue Detail		
1st Qtr Payment FY 2008 from TDCJ	$92,977,058.00	$9,463,090.00
2nd Qtr Advance Payment from TDCJ	$0.00	$0.00
Interest Earned	$0.00	$0.21
Revenue Received	**$92,977,058.00**	**$9,463,090.21**
Payments to UTMB		
1st Qtr Payment FY 2008 to UTMB	($73,606,212.00)	($6,387,290.00)
2nd Qtr Advance Payment to UTMB	$0.00	$0.00
Subtotal UTMB Payments	**($73,606,212.00)**	**($6,387,290.00)**
Payments to TTUHSC		
1st Qtr Payment FY 2008 to TTUHSC	($19,370,846.00)	($3,075,800.00)
Subtotal TTUHSC Payments	**($19,370,846.00)**	**($3,075,800.00)**
Total Payments Made thru this Qtr	**($92,977,058.00)**	**($9,463,090.00)**
Net ActivityThrough This Qtr	**($12,579.46)**	**($42.09)**
Total Fund Balance	**$0.00**	**$0.21**