CORRECTIONAL MANAGED HEALTH CARE

COMMITTEE

AGENDA

June 9, 2009

9:00 a.m.

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

CORRECTIONAL MANAGED HEALTH CARE COMMITTEE
June 9 , 2009
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, March 27, 2009

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. CMHCC FY 2009 Second Quarter Performance and Financial Status Report

EACH ITEM ABOVE INCLUDES DISCUSSION AND ACTION AS NECESSARY

VII. Funding Update and Approval

1. Review and Approval of Supplemental Funding Allocations FY 2008-2009

2. Review and Approval of FY 2010-2011 Budget Allocations

VIII. Summary of Critical Correctional Health Care Personnel Vacancies

1. Texas Department of Criminal Justice

2. Texas Tech University Health Sciences Center

3. The University of Texas Medical Branch

IX. Nursing Market Adjustment

X. Updates: Infection Control Manual Policies

1. B-14.11, Human Immunodeficiency Virus (HIV) Infection
2. B-14.13, Hepatitis Policy
3. B-14.13TR, Technical Reference for Hepatitis Policy

XI. Medical Director's Updates

1.Texas Department of Criminal Justice
- Health Services Division FY 09 Second Quarter Report

2. Texas Tech University Health Sciences Center

3. The University of Texas Medical Branch

XII. Presentation from Joint Work Group Committee: Joint Infection Control Committee

XIII. Suicide Prevention Efforts

XIV. Financial Reports

1. FY 2009 Second Quarter Financial Report
2. Financial Monitoring Update

XV. Public Comment

XVI. Date / Location of Next CMHCC Meeting

XVII. Adjourn

Consent Item 1

Approval of Minutes, March 27, 2009

MINUTES

CORRECTIONAL MANAGED HEALTH CARE COMMITTEE
March 27, 2009

Chairperson: James D. Griffin, M.D.

CMHCC Members Present: Elmo Cavin, Jeannie Frazier, Cynthia Jumper, Lannette Linthicum, M.D., Ben G. Raimer, M.D., Desmar Walkes, M.D.

CMHCC Members Absent: Bryan Collier, William Elger

Partner Agency Staff Present: Owen Murray, D. O., Joe Penn, M.D., Lauren Neumann, Steve Alderman, Stephanie Zepeda, Michael Rains, Sonny Wells, DDS (Retired) The University of Texas Medical Branch; Denise DeShields, M.D., Texas Tech University Health Sciences Center; Nathaniel Quarterman, Ron Steffa, Robert Williams, M.D., Dee Wilson, George Crippen, R.N., Shirley Nelson, Cathy Martinez, Texas Department of Criminal Justice; David Nelson, Janice Lord, Texas Board of Criminal Justice; Allen Hightower, David McNutt, Lynn Webb, Tati Buentello, CMHCC Staff.

Others Present: Cindi Carr, GSK

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

Agenda Topic / Presenter	Presentation	Discussion	Action
I. Call to Order - **James D. Griffin, M.D.**	Dr. Griffin called the CMHCC meeting to order at 9:05 a.m. then noted that a quorum was present and the meeting would be conducted in accordance with Chapter 551 of the Texas Government Code, the Open Meetings Act.		
II. Recognitions and Introductions - **James D. Griffin, M.D.**	Dr. Griffin next introduced Mr. David Nelson who was appointed to the Texas Board of Criminal Justice (TBCJ) in April 2008 and Chairs the TBCJ Health Care Committee. He is also a member of the TBCJ Community Corrections Committee, Education Committee, Management Information Systems and Legal Committee. Mr. Nelson is a partner in the law firm of Nelson and Nelson; a graduate of Texas Tech University School of Law and currently resides in Lubbock. Dr. Griffin welcomed and thanked Mr. Nelson for attending. Dr. Griffin then stated that David Callender, M.D. President, UTMB, appointed Mr. William Elger, Executive Vice-President and Chief Business and Finance Officer to serve as the non-physician member representing UTMB. Mr. Elger is filling in the position vacated by Mr. Larry Revill. Dr. Griffin further noted		

Agenda Topic / Presenter	Presentation	Discussion	Action
Introductions / Recognitions Cont.	that Mr. Elger was unable to attend this meeting due to prior commitments but will be officially introduced and welcomed at the next meeting.		
III. Approval of Excused Absence - **James Griffin, M.D.**	Dr. Griffin next noted that Mr. Bryan Collier and Mr. Larry Revill were absent from the December 9, 2008 CMHCC meeting due to scheduling conflicts. He then stated that he would entertain a motion to excuse their absence.		Ms. Jeannie Fraizer moved to approve Mr. Bryan Collier and Mr. Larry Revill's absence from the December 9, 2008 CMHCC meeting. Dr. Ben Raimer seconded the motion. The motion passed by unanimous vote.
IV. Consent Items - **James Griffin. M.D**.	Dr. Griffin then stated next on the agenda was the approval of the consent items to include the Minutes from the December 9, 2008 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 the members if they had any specific consent item(s) to pull for separate discussion. Hearing no further comments, Dr. Griffin stated that he would entertain a motion on approving the consent items as presented in the agenda booklet.		Mr. Elmo Cavin moved to approve the consent items as presented at Tab A of the agenda packet. Dr. Ben Raimer seconded the motion. The motion passed by unanimous vote.
	Dr. Griffin acknowledged that Ms. Janice Lord, Member, TBCJ just joined the meeting and stated that he would like to take the opportunity to introduce Ms. Lord. Dr. Griffin stated that Ms. Lord was appointed to the TBCJ in December, 2007 and Chairs the TBCJ Victim Services Committee and is also a member of the Education, Human Resources, Management Information Systems and Rehabilitation and Re-Entry Programs Committees. Ms. Lord is a national consultant on crime victims and received her Masters degree in social work from the University of Texas at Arlington. Dr. Griffin on behalf of the Committee welcomed Ms. Lord.		
V. Executive Director's Report - **Allen Hightower**	Dr. Griffin then called on Mr. Hightower to provide the Executive Director's Report. Mr. Hightower noted that the Executive Director's report is provided at Tab B of the agenda packet.		

Agenda Topic / Presenter	Presentation	Discussion	Action
Executive Director's Report (Cont.)	Mr. Hightower reported that the CMHCC staff continues to work with the partner agencies and the appropriate legislative staff on supporting the FY 2010-2011 Legislative Appropriations Request (LAR). He further stated that the CMHC appropriations request has been presented to both the full Senate Finance Committee and the full House Appropriations Committee. He thanked Dr. Lannette Linthicum for testifying at the Legislative Hearings and both UTMB and TTUHSC for being available as resource witnesses. Mr. Hightower then noted that a handout was passed out on the status of the exception item request (Attachment 1). The CMHCC requested $181.1M which include in priority order, the adjustment to base to reflect current cost at $56.8M; market adjustment to retain and hire staff at $46.2M; increase hospital / specialty care costs at $29.4M; critical capital equipment replacement cost at $5.7M; Hepatitis biopsy cost at $4.4M; phased in implementation of staffing study at $35.2M and new initiatives at $3.2M. Mr. Hightower thanked Dr. Linthicum and her staff for doing an excellent job with the staffing study. Mr. Hightower stated that there are ten Articles within the Legislative process and the CMHCC and TDCJ falls under Article V and Article XI. He further clarified that Article XI used to be for items in the wish list but for this Legislative Session it is where those item requests are in the "hold-over" status. For the exception item requests, Mr. Hightower noted that the Senate has $86.8M in Article V and $25.6M in Article XI for a total of $112.4M. The House version shows $5.7M in Article V and $111.1M in Article XI for a total of $116.9M. Mr. Hightower further noted that the decision as to which version of the budget will be approved is still pending until the state leadership works through the stimulus package. Mr. Hightower however noted that he does not foresee any more public testimony made on the budget at this point.	Ms. Frazier asked if he was considered public testimony? Mr. Hightower responded that anyone who is not a member of the Legislature or the staff of the Legislative Budget Board and the State Auditor's Office is considered public testimony.	

Agenda Topic / Presenter	Presentation	Discussion	Action
- **Executive Director's Report (Cont.)**	Mr. Hightower then reported on the Supplemental Appropriation Request (SAR) which are for funds already expended for health care in the last biennium that were above what was budgeted. He further stated that the SAR request were made based on the amount that each universities provided for the actual loss for the first year of the biennium (FY 2008) and the projected losses for the FY 2009.	Mr. Nelson asked if the $181M was in addition to the base? Mr. McNutt responded that the Legislative Budget Board recommended in SB 1 and HB 1 for the medical side the amount of $375M per each year of the biennium and for the psychiatric side the amount of $43M for the first year and $47.7M for the second year. Mr. Nelson then asked how that compared in the process? Mr. McNutt stated that the medical base should have been closer to $379M . Dr. Raimer added that UTMB takes care of 80% of the offender population and in particular, those with high acuity cases such as cancer patients. He noted that they have been under-funded for the last couple of sessions and even if they submit for SAR; both universities still have to post their year end budget sheet as losses incurred for the first year of the biennium. Dr. Raimer further noted that one item being looked at this year is the spend forward authority where money can be taken from the 2011 budget and expended in 2010 if in a deficit situation. This would allow the universities to be within budget for the even numbered years and be able to go back to the legislators for the odd numbered years. Dr. Griffin stated the spend forward authority would change the expectations and increase the responsibility of regulating the parameters as to the health care activities.	

Agenda Topic / Presenter	Presentation	Discussion	Action
- Executive Director's Report (Cont.)		Mr. Hightower noted that most Riders such as this would require action taken by the universities to notify the Committee of the budget shortfall, then the Committee would vote to ask the Legislative Budget Board and / or the Governor's Office for the spend forward authority. Dr. Walkes asked why there was such a discrepancy between the House and the Senate on their assessment of what the budget amount should be allocated? Mr. Hightower responded that the Senate and the House are two totally different institutions until they act as single bodies during Conference Committee. Dr. Walkes noted that both the House and Senate recognize the need for critical capital equipment and asked if the numbers were the same? Mr. McNutt responded that they are the same once Article V and Article XI are combined. Mr. Hightower also explained that the stimulus money is available for use as a one time purchase of capital equipment and this would not affect the flow of the General Revenue. Dr. Walkes further asked if that purchase of capital equipment money can be used for telemedicine services which may help with the staffing shortages? Mr. McNutt responded that capital equipment replacement monies are for such items as dental chairs; dialysis, imaging and x-ray machines. Dr. Linthicum added there are telemedicine services available on every unit now and the only cost associated may be on the infrastructure for updating lines. She further noted that staffing shortages are still a big issue as most of their units are operating on modified schedules without the appropriate health care providers.	

Agenda Topic / Presenter	Presentation	Discussion	Action
VI. Performance and Financial Status - David McNutt	Hearing no further discussions, Dr. Griffin thanked Mr. Hightower for the update then called on Mr. McNutt to present the financial and performance update. Mr. McNutt noted that the Performance and Financial Status Report is provided at Tab C of the agenda packet. For the first quarter of FY 2009, Mr. McNutt reported that the average population served was 150,760 compared to 151,638 this time last year. The aging offenders population continue to increase with the over 55+ population at the end of this quarter averaging at 10,724 compared to 10,120 a year ago which is approximately a 6% growth. Mr. McNutt further reported that the psychiatric inpatient census remained stable averaging at 1,950 compared to 1,959 in November of 2007 which he again noted is limited by the number of available inpatient beds. The psychiatric outpatient census at the end of November of this quarter averaged at 18,964 representing 12.6% of the service population. Mr. McNutt then recalled at the last CMHCC meeting, he was asked to provide the definitions to the access to care indicators which is now included in the report on page 88 of the agenda packet. The medical access to care indicator #7, #8 & #9 remained consistent within the 96% - 98% range. The mental healthcare and dental access to care indicators were also stable staying within the 97%-99% range. Mr. McNutt next reported that the average UTMB physician vacancy rate for the first quarter FY 2009 was 16.92%; mid-level practitioners at 9.17%; RN's at 11.2%; LVN's at 15.46%; Dentists at 12.50% and Psychiatrists at 13.3%.	Dr. Murray again noted that both UTMB and TTUHSC face the challenges of getting the qualified health care provider positions filled in certain geographical areas which affects the access to care indicators. Mr. McNutt added that TDCJ also have the same challenges of recruiting and retaining security staff in those same remote areas.	

Agenda Topic / Presenter	Presentation	Discussion	Action
- Financial and Performance Status Report (Cont.)	Mr. McNutt continued by stating that TTUHSC sector physician vacancy rate for the same quarter averaged at 22.84%; mid-level practitioners at 9.53%; RN's at 20.55%; LVN's at 25.89%; Dentists at 18.71%, and Psychiatrists at 21.90%. He then noted that due to Hurricane Ike, the timelines for the medical summaries for MRIS in September dropped to 85% but came back up to 96% in October and 97% for November. Mr. McNutt next reported that the overall health care costs through the First Quarter of FY 2009 totaled $117.1M. On a combined basis, this amount is below overall revenues earned by the university providers by approximately $1.6M. He concluded by noting that this is only the data up through the first quarter of FY 2009. Dr. Griffin asked if there were any comments or questions for Mr. McNutt?	Dr. Walkes stated that the challenges of recruiting and retaining staff remains to always be an issue and asked if the partner agencies were looking at specific recruiting methods targeted for those kinds of staffing vacancies? Dr. Griffin responded that as part of his testimony at the House Corrections Subcommittee Hearing, he testified about looking into new initiatives or programs such as tuition reimbursement programs; the possibility of forming agreements with perspective students to spend some time in the correctional facilities as they do in the military setting. Dr. Walkes asked if it was feasible to ask the state leadership to reconsider and bring the amount back to the $46M requested for the market adjustment to retain and hire staff? Mr. Hightower responded that the state leadership would not put any additional amount into the overall budget but that the universities have the flexibility to use the monies they do get funded for recruiting purposes.	

Agenda Topic / Presenter	Presentation	Discussion	Action
- Performance and Financial Status Report (Cont.)	Hearing no further comments, Dr. Griffin thanked Mr. McNutt for the update.	Dr. Raimer added that incentives such as loan repayment programs and scholarships would also help recruit people into working at those underserved areas as they are unable to compete with the free-world salaries which may include sign-on bonuses. He further added that they are still trying to recover from the 2003 cuts and have not been able to catch up from that to compete. Dr. DeShields stated that the Tech sector is looking at close to a 38% vacancy rate strictly at the Montford Unit as of December. They have filled some of the 45 vacancies with 26 agency staff. She did note that this doubles the cost as a full time nurse would on the average have a salary range between $50,000 to $55,000 compared to an agency nurse at $110,000. Dr. Linthicum then noted that the staffing study looked at current staffing levels on each of the units; looked also at the mission and the recommended staff for each facilities. She further added that the offsite costs in part are due to not having health care staff on the unit to make appropriate assessment. Instead they are relying on the security staff to contact the on-call nurse to make or relay the situation which in most case results in information that is lost in translation. Dr. Raimer acknowledged that Dr. Linthicum spent over two years working on the staffing study and stated that she and her staff did an extraordinary job putting it together and hoped that the Legislature would re-consider this item request.	

Agenda Topic / Presenters	Presentation	Discussion	Action
VII. UTMB Audit Report **- David McNutt**	Dr. Griffin then asked Mr. McNutt to present the UTMB Audit Report. Mr. McNutt noted that the entire UTMB Audit Report on the Correctional Managed Care (CMC) Pharmacy Review is provided at Tab D of the agenda packet. As part of the contract agreement, both universities internal auditors are to provide a certain number of audit hours on services pertaining to correctional managed health care. UTMB is required to provide 500 hours and TTUHSC is to provide 200 hours. Mr. McNutt recalled that the Texas Tech's required audit report was provided at the last CMHCC meeting. The UTMB audit that he is presenting took over 600 hrs to conduct. The primary objective of this audit was to review the internal control process and operational activities related to CMC Central Pharmacy operations and select TDCJ units. Mr. McNutt further reported that the audit methodology included conducting risk assessments; interviewing key CMC finance operations central pharmacy and unit personnel; observing current operations; reviewing policies and procedures, reviewing supporting documents; and, limited testing of TDCJ billing and Central Pharmacy expenditures, purchases and receiving information. Mr. McNutt stated that Stephanie Zepeda, Director of Pharmacy has already implemented most of the actions required and that the audit met the contract requirements. He concluded by stating that he would entertain any questions along with Ms. Zepeda who was also at the meeting. Hearing none, Dr. Griffin thanked Mr. McNutt for the update. Dr. Griffin next called on Ms. Zepeda to present the Joint Pharmacy and Therapeutics Committee Overview.		
VIII. Update on Joint Pharmacy & Therapeutic (P & T) Committee	Ms. Zepeda thanked the Committee for the opportunity to provide an update on the Joint Pharmacy & Therapeutics (P & T) Committee and the Overview of Pharmacy Operation. She then noted that her presentation is provided at Tab G.		

Agenda Topic / Presenter	Presentation	Discussion	Action
- Joint P & T Committee Update - Stephanie Zepeda	Ms. Zepeda stated that some of the primary functions of the Joint Pharmacy & Therapeutics Committee include developing medication formularies; developing drug use policies and procedures; to ensure safe and cost effective drug therapy; and to develop educational programs and quality programs related to drug use. The P & T Committee consists of representatives from TDCJ, UTMB, TTUHSC and is a multidisciplinary team which includes physicians, psychiatrists, dentist, nurses and pharmacists. The Chair of the Committee is appointed by Dr. Linthicum, TDCJ Health Services Division Medical Director and serves a two year term. Ms. Zepeda added that the Committee will occasionally appoint an Ex-officio or a non-voting member whose term may not exceed the tenure of the Chairperson who have particular expertise in the area that they are working on. Ms. Zepeda further reported that the 340B Drug Pricing Program is one of the most significant cost containment strategies that UTMB implemented. This is a Federal drug pricing discount program that the university was able to gain access to with their status as a disproportionate share hospital. Federal approval was granted in April and the program began on May 2002. This reduced the CMC pharmacy costs from prior years by as much as a third, depending on drug class. The graph on page 151 of the agenda packet shows the trend data of what was spent if UTMB had not qualified for the 340B pricing program since implementing this back in 2002. She noted that this is a savings of about $12M per year. The graph on page 152 shows the comparison of drugs as percentage of the total TDCJ health care expenses versus the National HMO expenses and the national expenses published by the Centers for Medicare and Medicaid Services (CMS). Ms. Zepeda further noted that TDCJ expenses are less than 10% which is equivalent to the national CMS expenses but well below the national HMO expenses which are being reported at 14%. Ms. Zepeda next reported that the major pharmacy cost drivers are medications to treat HIV which represents 48% of the total drug budget; chronic Hepatitis C at 4.6%; and psychotropic agents representing less than 8% of the total drug costs. Other major cost drivers include chronic care medication such as cardiovascular agents used to reduce high cholesterol and the prevention of cardiovascular disease; for	Dr. Linthicum asked for clarification of what PHS is for the non-health care related staff present. Ms. Zepeda responded that PHS stood for Public Health Services pricing which is another acronym for 340B drug discount program. Dr. Linthicum asked how much is being spent on HIV medication per month? Ms. Zepeda responded approximately $1.5M.	

Agenda Topic / Presenter	Presentation	Discussion	Action
- P & T Joint Committee (Cont.)	drugs used to treat diabetes; and, for respiratory agents such as asthma. She further noted that the total number of prescription orders filled per year has increased 123.95% over the last 14 years and the pharmacy currently fills an average of 17,000 orders per day. Ms. Zepeda added that the number of orders filled per patient per year has also increased 49.8% over the last 14 years. Ms. Zepeda next reported that one of the major staffing challenges faced is the workload demands on the pharmacists. She stated that 500 prescriptions to fill per day is the ideal number for a pharmacist. The graph on page 159 shows that amount has increased up to 937 prescriptions to fill per day in FY 2005, but noted that number dropped back down to 852 per day over the next three years. In FY 2009, four new positions were added in June as the number of prescriptions being filled were on the rise again. Based on the 5.5% annual growth trend, the projection for FY 2012 she noted, would be up to 866 prescriptions per day. Ms. Zepeda then stated that as the workload increases, the number of interventions that the pharmacist have made per 10,000 orders have decreased which shows there is an opportunity that some of the drug interactions may have been missed. Ms. Zepeda next reported that some of the recent action items of interest includes a bid for Hepatitis B vaccine and a change in lipid lowering formulary agent to generic. She also noted that some new practice tools were developed to include non-formulary conversion chart, wound care assessment forms being added to	Dr. Linthicum stated that the total HIV+ population is approximately 2,449 and of those 841 are AIDS patients; she then asked how many were being treated? Ms. Zepeda responded about 1,800 were on medications. Dr. Linthicum asked what portion of the prescription orders filled is for TDCJ as the pharmacy also provides services for the Texas Youth Commission and Federal Bureau of Prisons. Ms. Zepeda stated that TDCJ accounts for 93%.	

Agenda Topic / Presenter	Presentation	Discussion	Action
- P & T Committee Updates (Cont.)	EMR; revision of key policies to strengthen inventory controls; and a checklist for secondary prevention of coronary artery disease. Ms. Zepeda concluded by stating that she would be happy to answer any questions.	Dr. Griffin recalled that a presentation was made to the Committee about a year ago on Pandemic Flu and there was a discussion on the limited shelf-life for the Pandemic Flu vaccine and asked if Ms. Zepeda would provide an update on this. Ms. Zepeda responded that TDCJ as well as UTMB purchased a stock-pile of Tamiflu which is an antiviral medication in preparation of the pandemic flu. She further stated that the shelf-life for Tamiflu is five years. The medication currently is centralized with the prescription labels pre-printed and ready to ship overnight if necessary. The goal is to treat patients, healthcare providers and correctional officers to prevent an outbreak while the area remains secure. Ms Zepeda added that there are no replacements once the shelf-life expires in five years. She again noted that Tamiflu was purchased at a special Federal discounted price at a cost of $1.98 per dose compared to the market cost of $6.00 per dose. Dr. Linthicum also recalled that the State Health Commissioners sent out a letter to all state agencies and received this stock-pile after being qualified. She added that the Center for Disease Control and the State Health Department will be in control in the invent of an outbreak. Dr. Griffin then asked whether there was a way to negotiate a renewal so that it can be kept longer? Ms. Zepeda responded that it was her understanding that there is not a replacement clause.	

Agenda Topic / Presenter	Presentation	Discussion	Action
- P & T Committee Report (Cont.)		Dr. Linthicum asked when the five years expires?	
	Hearing no further discussions, Dr. Griffin thanked Ms. Zepeda for the report.	Ms. Zepeda stated that currently it is about a year into the five years.	
	Dr. Griffin next called on Dr. Murray to provide the critical correctional health care personnel vacancies for UTMB.		
IX. Summary of Critical Correctional Healthcare Personnel Vacancies **- Owen Murray, D. O. (UTMB)**	Dr. Murray stated as discussed earlier, staff vacancies continues to be an issue in certain geographical regions such as Beeville, Palestine, Gatesville and the Beaumont areas. There are not enough healthcare personnel available to cover the number of offenders that are housed in those regions. The full time employee on the unit are overworked and burned out after being asked to work overtime due to the staffing shortages. Dr. Murray added that UTMB continues to utilize temporary services as well as telemedicine but that is not the same as having the health care provider onsite. They continue to look at innovative ways to recruit and retain staff but that it was difficult without being able to offer salaries that is more competitive with the current market value.		
	Dr. Griffin thanked Dr. Murray for the report then called on Dr. DeShields to provide the update for TTUHSC.		
- Denise DeShields, M.D. (TTUHSC)	Dr. DeShields reported that Texas Tech also continues to have difficulty recruiting in those remote areas where there are not many qualified physicians, nurses, or psychiatrists available. She then noted that there is the issue of the nurses having to go through security check before getting on the unit.	Ms. Frazier asked if there was a way to work with security to let the nurses through?	
	She agreed that these nurses are not only overworked, they are underpaid and also lose their dignity working in a prison environment.	Dr. Linthicum responded that this was due to the contraband being smuggled into the units causing security issues.	
	Dr. DeShields concluded by noting again that TTUHSC continues to enhance on their advertisement and recruitment methods through newly contracted agencies.		

Agenda Topic / Presenter	Presentation	Discussion	Action
- Critical Vacancy Positions Update (Cont.)	Dr. Griffin thanked Dr. DeShields for the update then called on Dr. Linthicum.		
- Lannette Linthicum, M.D. (TDCJ)	Dr. Linthicum noted that they share the same difficulties in recruiting and retaining health care provider staff as her colleagues and continues to have multiple postings and advertisement in journals and newspapers. Dr. Linthicum further added that her staff worked hard in putting together the staffing study and again emphasized the need to adjust the salaries to better compete with the market in recruiting qualified applicants and retaining those staff.	Dr. DeShields added that the US statistics show that in the last three years, the number of job posting of all health care provider disciplines have gone up more than 45%, particularly for psychiatrist.	
- Recognition: Sonny Wells, DDS	Dr. Griffin thanked Dr. Linthicum then noted that Dr. Sonny Wells joined the meeting earlier and called on Dr. Linthicum to provide the presentation to Dr. Wells on his recent retirement. Dr. Linthicum on behalf of TDCJ, thanked Dr. Sonny Wells for his many contributions and excellent service he provided to the Correctional Health Care Program and to the State of Texas by presenting him with a plaque. She noted that Dr. Wells began his career with TDCJ in 1986 as a unit dentist and acknowledged his distinguished professional career as he retired from his position of UTMB Dental Director then wished him well on his future endeavors. Dr Griffin asked if Dr. Wells would like to make any comments.	Mr. McNutt noted that Mr. Hightower presented a Resolution of Appreciation on behalf of the Committee to Dr. Wells at his retirement party held in Huntsville earlier in December. (Attachment 2) Dr. Wells thanked the Committee and staff for recognizing him and stated that it has been a remarkable journey. He expressed his appreciation for the support, the friendship; and that it was an honor to work with Dr. Linthicum, Dr. Murray, Dr. Raimer and the staff of all three partner agencies.	

Agenda Topic/Presenter	Presentation	Discussion	Action
X. Medical Director's Report **- Lannette Linthicum, M.D. (TDCJ)**	Dr. Griffin next called on Dr. Linthicum to provide the TDCJ Medical Director's Report. Dr. Linthicum noted that her report is provided at Tab F of the agenda packet.		
- Office of Professional Standards	During the first quarter of FY 2009, Dr. Linthicum reported that seven facilities were audited and she highlighted some of the audits listed on pages 130 – 132 of the agenda packet.		
- Grievances and Patient Liaison Correspondences.	She then reported that the Patient Liaison Program and the Step II Grievance Program received a total of 2,744 correspondences. Of the total number of correspondences received, 286 or 10.42% action requests were generated.		
- Quality Improvement (QI) Access to Care	Quality Improvement / Quality Monitoring staff performed 114 access to care audits for this quarter. A total of 1,026 indicators were reviewed and 41 indicators fell below the 80% threshold.		
- Capital Assets Monitoring	The Capital Assets Contract Monitoring Office audited seven facilities for this quarter and these audits are conducted to determine compliance with the Health Services Policy and State Property Accounting policy inventory procedures.		
- Office of Preventive Medicine	Dr. Linthicum again noted that the Office of Preventive Medicine monitors the incidence of infectious diseases for TDCJ. For the first quarter of FY 2009, there were 201 reports of suspected syphilis; 327 Methicillin-Resistant Staphylococcus Aureus (MRSA) cases were reported compared to 918 during the same quarter of FY 2008. There was an average of 23 Tuberculosis (TB) cases under management per month during this quarter, compared to an average of 19 per month during the first quarter of the FY 2008. Dr. Linthicum stated that the Office of Preventive Medicine's Sexual Assault Nurse Examiner (SANE) Coordinator provided 19 training session during the first quarter of FY 2009 attended by 12 facilities with 147 medical staff trained.		

Agenda Topic / Presenter	Presentation	Discussion	Action
- Office of Preventive Medicine (Cont.)	She further noted that currently, the Peer Education Programs are on all the Institutional Division Facilities that TDCJ operates. The Office of Preventive Medicine is currently expanding this program into the Private Prison Facilities.		
- Mortality and Morbidity	The Mortality and Morbidity Committee reviewed 106 deaths. Of those 106 deaths, 16 were referred to peer review committees and those breakdowns are found on page 133 of the agenda packet.		
- Mental Health Services Monitoring	The Mental Health Services Monitoring and Liaison with County Jails identified 14 offenders with immediate mental health needs prior to TDCJ intake. Dr. Linthicum added that the MHMR history was reviewed for 19,527 offenders brought into TDCJ-ID/SJ through the intake process. She further noted that 350 offenders with high risk factors (very young or old or have long sentences) transferred into TDCJ-ID were interviewed which resulted in 19 referrals. The master's level psychiatrist made 19 Administrative Segregation visits this quarter and observed 4,312 offenders, interviewed 2,451 offenders and referred 10 for further evaluations.		
- Health Services Liaison Utilization Review	During the first quarter of FY 2009, a total of 105 hospital discharges and 47 inpatient facility discharge audits were conducted. She noted that the summary of the audits are found on page 134 of the agenda packet.		
- Accreditation	Dr. Linthicum next reported that the American Correctional Association Panel of Commissioners did not meet in the fist quarter of FY 2009 and these accreditations were presented in January 2009 therefore will be provided in the second quarter report.		
- Biomedical Research Projects	Dr. Linthicum concluded by stating that the summary and pending research projects as provided by the TDCJ Executive Services are provided in the consent items on pages 52-59 of the agenda packet.		

Agenda Topic / Presenter	Presentation	Discussion	Action
- Medical Director's Report Denise DeShields, M.D. (TTUHSC)	Dr. Griffin thanked Dr. Linthicum for the report and called next on Dr. DeShields to provide the TTUHSC Medical Director's Report Dr. DeShields reported that the population for the first quarter of FY 2009 averaged at 30,643 and that there were no significant changes on encounters for this quarter compared to the last quarter of FY 2008. Dr. DeShields recalled that couple meetings ago she reported that after nearly a 3-year search, the Medical Director for the PAMIO position had finally been filled. Unfortunately, this did not work out and the person hired for that position decided to leave and now Tech is back to recruiting for that position again. She further reported that the Highland Facility that provided ancillary and non-emergent care when Montford was overloaded has been taken over by a new group and will keep the Committee updated on the status. Dr. DeShields concluded by stating that Texas Tech continues to look at various incentive methods and enhanced advertisement methods in order to recruit and retain staff in West Texas.		
- Owen Murray, M.D. (UTMB)	Dr.Griffin thanked Dr. Deshields for the update then called on Dr. Murray to provide the UTMB Medical Director's Report. Dr. Murray reported that there has been some staff changes he wanted to convey to the Committee. John Allen who was the Executive Director of Operations left UTMB-CMC after being hired as President of MDI in Florida. He then sadly reported that Julie Lawson, PA was killed in an accident while she was on vacation with her family out of state. Dr. Murray further stated that they are in the process of working out a new organizational chart which should be available sometime in June and will keep the Committee updated on this.		

Agenda Topic / Presenter	Presentation	Discussion	Action
UTMB Medical Director's Report (Cont.)	Dr. Murray next reported that using agency staff as discussed earlier continues to drive costs up. Most of the staff that used to work there found other jobs while UTMB was still in the recovery phase. He did note however that offsite numbers are coming down. Dr. Murray then stated that though UTMB sustained damage from Hurricane Ike, the storm also exposed some areas that needed to be looked into. He further stated that Bryan Schneider, Director of Support Services is assessing what clinical needs can better be served. UTMB-CMC continues to host the weekly conference and thanked Dr. Linthicum, Mr. Quarterman for their continued support. Dr. Murray concluded by saying that he spoke with Representative Terri Hodge who has always been an advocate for offenders and their families at the Capitol and that she wanted him to relay to the Committee the positive remarks she made about the offender health care.		
XIII – TCOOMMI Update - Dee Wilson	Dr. Griffin thanked Dr. Murray for the report then called on Ms. Wilson to provide the TCOOMMI update. Ms. Wilson stated that the TCOOMMI's Biennial Report was provided to the Committee and staff under separate cover. She further reported that for this biennium, continued progress was made toward establishing a comprehensive continuity of care system that emphasized its primary goals of public safety and treatment interventions which eliminated or reduced duplication, improved coordination and minimized overall costs to local and state governments. Ms. Wilson next reported that due to changes in state policy and internal procedures, the number of offenders identified as eligible for the Medically Recommended Intensive Supervision (MRIS)		

Agenda Topic / Presenter	Presentation	Discussion	Action
- TCOOMMI Report (Cont.)	consideration increased during this reporting period. While the number of eligible offenders presented to the Parole Board increased, Ms. Wilson noted that the overall approval rate declined. The FY 2008 approval rate being 24% compared to 35% in FY07. A contributing factor to the decline she noted could be due to the increase in offender deaths during the MRIS process and Ms. Wilson stated that TCOOMMI has instituted an internal review process to examine the referral time. Ms. Wilson concluded by stating that TCOOMMI continues to work with the managed care providers and the Board of Pardons and Parole to examine options for those elderly offenders who could be safely released to the community.		
XII. Financial Reports - Lynn Webb	Dr. Griffin thanked Ms. Wilson for the update then called on Mr. Webb to provide the financial updates. Mr. Webb noted that the financial summary will cover data for the first quarter of FY 2009 ending November 30, 2008 and that the report is provided at Tab H of the agenda packet. The average daily offender population remained stable at 150,760 for the first quarter FY 2009 compared to 151,638 for the same quarter in FY 2008; a decrease of 878 or 0.58%. Consistent with trends over the last several years, Mr. Webb noted that the number of offenders aged 55 and older has continued to rise at a faster than the overall offender population to 10,724 this quarter compared to 10,120 for the same quarter a year ago which is an increase of 604 or 6.0%. The overall HIV+ population has remained stable throughout the last two years at 2,492 through this quarter or about 1.65% of the population served. The average number of psychiatric inpatients within the system was 1,950 and this inpatient caseload he		

Agenda Topic / Presenter	Presentation	Discussion	Action
- Financial Report **(Cont.)**	noted again is limited by the number of available inpatient beds in the system. The mental health outpatient visits was 18,964 representing 12.6% of the service population. Overall healthcare costs as noted earlier by Mr. McNutt through the first quarter of FY 2009 totaled $117.1M. On a combined basis, Mr. Webb noted that this amount is below overall revenues earned by the university providers by approximately $1.6M or 1.4%. He further reported that UTMB's total revenue through the quarter was $94.1M; expenditures totaled $92.5M resulting in a net gain of $1.5M. Texas Tech's total revenue was $24.7M; expenditures totaled $24.6M resulting in a net gain of $53,793. Mr. Webb then noted that of the $117.1M in expenses reported through the first quarter of FY 2009, onsite services comprised $58.0M or about 49.5% of expenses; pharmacy services totaled $12.2M or about 10.5% of total expenses; offsite services accounted for $32.0M or 27.3% of total expenses; mental health services totaled $11.3M or 9.6% of the total costs; and indirect support expenses accounted for $3.6M or about 3.1% of the total costs. He further reported that Table 5 on page 179 of the agenda packet shows that the total cost per offender per day for all health care services statewide through the first quarter FY 2009 was $8.54 compared to $8.06 through the first quarter of FY 2008. The average cost per offender per day for the last four fiscal years was $7.86. He again noted that the older offenders continues to access the health care delivery system at a much higher acuity and frequency than younger offenders. Hospital costs received to date for older offenders averaged $670 per offender vs. $106 for younger offenders. Chart 15 on page 181 shows that the older offenders were utilizing health care resources at a rate more than six times higher than the younger offenders. While comprising only about 7.1% of the overall service population, older offenders account for 32.5% of the hospitalization costs received to date.		

Agenda Topic / Presenter	Presentation	Discussion	Action
- Financial Report (Cont.)	Mr. Webb further reported that older offenders represented over four times more often in the dialysis population than younger offenders and dialysis costs continue to be significant averaging about $20.4K per patient per year. He added that providing dialysis treatment for an average of 181 patients through this quarter cost $923,405. Table 9 on page 183 of the agenda packet shows that total drug costs through the first quarter of FY 2009 totaled $9.3M. Of this $5.3M or just over $1.7M per month, was for HIV medication costs which was about 57.1% of the total drug cost. Psychiatric drug costs were approximately $0.4M or about 3.1% of overall drug costs and Hepatitis C drugs costs were $0.3M and represented about 3.7% of the drug cost. Mr. Webb again noted that it is a legislative requirement that both UTMB and Texas Tech report if they hold any monies in reserve for correctional managed health care. UTMB stated that they hold no such reserves and report a total operating gain of $1,569,739 through the end of this quarter. UTMB stated that with previous trends, UTMB was expected to have a $22.7M shortfall for FY 2009 which was used in forecasting budget number in the submitted Legislative Appropriations Request (LAR). Texas Tech reports that they hold no such reserves and report a total operating gain of $53,793 through this quarter. Texas Tech however forecasted a $1.6M operating shortfall for FY2009 which was used in the submitted and forecasted budgeted LAR numbers. A summary analysis of the ending balances revenue and payments through November 30, FY 2009 is provided at Table 10 on page 184. The summary indicates that the net unencumbered balance on all CMHCC accounts on November 30, 2008 was negative $7,119.95 due to the net effect of the second quarter FY 2009 advanced payments. Mr. Webb concluded by stating that detailed transaction level data from both providers is being tested on a monthly basis to verify reasonableness, accuracy, and compliance with policies and procedures.		

Agenda Topic / Presenter	Presentation	Discussion	Action
	Dr. Griffin thanked Mr. Webb for the update.		
- XIII. Public Comments James Griffin, M.D.	Dr. Griffin then stated that the next agenda item is where the Committee at each regular meeting provides an opportunity to receive public comments. Dr. Griffin noted that there were no such request at this time.		
- XIV. Date / Location of Next Meeting James Griffin, M.D.	Dr. Griffin next noted that the next CMHC meeting is scheduled for 9:00 a.m. on June 9, 2009 to be held at the Dallas Love Field Main Terminal Conference Room.		
	Dr. asked if there were any other comments or discussions?	Mr. Nelson thanked the Committee and staff for a job well done and stated that he is now becoming more aware of the challenges faced by the Committee in providing health care to the offender population.	
- XV. Adjournment	Hearing no further comments, Dr. Griffin thanked Mr. Nelson and Ms. Lord for attending; then adjourned the meeting.		

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

_____

Date:

ATTACHMENT 1

03/26/2009

Status of Exception Item Request

	Requested	Senate	House
Article V	$ 181,135,518.00	$ 86,833,390.00	$ 5,737,966.00
Article XI	$ -	$ 25,657,270.00	$ 111,175,374.00
Total	$ 181,135,518.00	$ 112,490,660.00	$ 116,913,340.00

Legislative Update as of March 26, 2009

Article V

	Requested	Senate	House
1. Adjustment to Base to Reflect Current Cost	$ 56,833,390.00	$ 56,833,390.00	$ -
2. Market Adjustment to Retain & Hire Staff	$ 46,252,810.00	$ 20,000,000.00	$ -
3. Increase Hospital / Specialty Care Costs	$ 29,438,905.00	$ 10,000,000.00	$ -
4. Critical Capital Equipment Replacement	$ 5,737,966.00	$ -	$ 5,737,966.00
5. Hepatitis Biopsy	$ 4,422,680.00	$ -	$ -
6. Phased in Implementation of Staffing Study	$ 35,209,207.00	$ -	
7. New Initiatives	$ 3,240,560.00		
Total	$ 181,135,518.00	$ 86,833,390.00	$ 5,737,966.00

Article XI

	Requested	Senate	House
1. Adjustment to Base to Reflect Current Cost	$ 56,833,390.00		$ 56,833,390.00
2. Market Adjustment to Retain & Hire Staff	$ 46,252,810.00	$ 10,860,740.00	$ 30,860,740.00
3. Increase Hospital / Specialty Care Costs	$ 29,438,905.00	$ 9,058,564.00	$ 19,058,564.00
4. Critical Capital Equipment Replacement	$ 5,737,966.00	$ 5,737,966.00	$ -
5. Hepatitis Biopsy	$ 4,422,680.00	$ -	$ 4,422,680.00
6. Phased in Implementation of Staffing Study	$ 35,209,207.00	$ -	$ -
7. New Initiatives	$ 3,240,560.00		
Total	$ 181,135,518.00	$ 25,657,270.00	$ 111,175,374.00

ATTACHMENT 2

Resolution of Appreciation

Albert D. “Sonny” Wells, D.D.S.

WHEREAS, Albert D. “Sonny” Wells, began his career with the Texas Department of Criminal Justice in 1986 as the Unit Dentist at the Coffield Unit, then was promoted to serve as the Northern Regional Dental Director; and

WHEREAS, Dr. Wells was recruited for and accepted a position with the newly formed Correctional Managed Care Program with The University of Texas Medical Branch as the Dental Director. In that capacity he was responsible for the UTMB dental services contracts with the Texas Department of Criminal Justice, Texas Youth Commission and the Federal Bureau of Prisons; and

WHEREAS, Dr. Wells excelled academically having attained a Doctor of Dental Surgery from Baylor College of Dentistry in Dallas and is a Certified Correctional Health Professional; and

WHEREAS, Dr. Wells has more than 33 years of professional dentistry experience, having worked in a variety of progressively more responsible clinical, administrative and leadership roles in the correctional healthcare program; and

WHEREAS, Dr. Wells has served on a variety of workgroups and standing committees including Chairing the Joint Dental Work Group Committee, and served as a member on the Policy and Procedures Committee, Pharmacy and Therapeutics Committee, and the System Leadership Committee; to name a few; and

WHEREAS, the Texas Correctional Health Care Program has greatly benefited from his demonstrated leadership, clinical expertise, and dedication both on a professional and personal basis; and

WHEREAS, the Correctional Managed Health Care Committee, its staff and its partner agencies wish to gratefully acknowledge the many contributions and distinguished professional career of Albert D. “Sonny” Wells 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 his outstanding service 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.

Presented this 17th day of December in the Year 2008, by the Correctional Managed Health Care Committee

James D. Griffin, M.D.
Chairman, CMHCC

Allen R. Hightower
Executive Director, CMHC

Consent Item 2

TDCJ Health Services Monitoring Reports

ATTACHMENT 1

Rate of 100% Compliance with Standards by Operational Categories
Second Quarter, Fiscal Year 2009
December 2008, January and February 2009

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*
Beto Facility	98%	52	53	22%	5	23	81%	25	31	65%	13	20	64%	7	11	100%	11	11
Cleveland Facility	100%	52	52	65%	13	20	91%	28	31	90%	18	20	80%	4	5	100%	11	11
Diboll Facility	98%	44	45	57%	12	21	73%	16	22	95%	19	20	80%	4	5	100%	11	11
Duncan Facility	96%	45	47	66%	14	21	90%	26	29	100%	19	19	100%	5	5	100%	11	11
Hobby Facility	100%	52	52	59%	16	27	67%	20	30	85%	17	20	82%	9	11	100%	11	11
Marlin Facility	96%	44	46	38%	5	18	73%	22	30	89%	17	19	83%	5	6	100%	11	11
Ney Facility	100%	53	53	76%	16	21	81%	25	31	80%	16	20	80%	4	5	100%	11	11
San Saba Facility	100%	51	51	78%	14	18	94%	16	17	70%	14	20	66%	4	6	100%	11	11
Torres Facility	98%	53	54	53%	10	19	81%	26	32	95%	19	20	20%	1	5	100%	11	11
Young Facility	98%	52	53	42%	13	33	90%	32	36	95%	18	19	88%	7	8	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 = $\frac{\text{number of audited items in each category that were 100\% compliance with the Standard}}{\textit{number of items audited.}}$

ATTACHMENT 2

Percent Compliance Rate on Selected Items Requiring Medical Records Review
Second Quarter, Fiscal Year 2009
December 2008, January and February 2009

Unit	Operations/ Administration			General Medical/Nursing			CID/TB			Dental			Mental Health		
		Items in Compliance	*n*		Items in Compliance	*n*			*n*		Items in Compliance	*n*		Items in Compliance	*n*
Beto Facility	100%	20	20	85%	363	426	98%	59	60	92%	103	112	83%	125	150
Cleveland Facility	100%	12	12	92%	341	372	100%	39	39	90%	95	106	100%	49	49
Diboll Facility	100%	10	10	87%	317	364	100%	46	46	92%	89	97	100%	46	46
Duncan Facility	100%	7	7	91%	342	376	100%	73	73	100%	88	88	100%	49	49
Hobby Facility	100%	1	1	94%	387	412	94%	50	53	82%	83	101	97%	85	88
Marlin Facility	56%	5	9	80%	195	244	84%	59	70	99%	97	98	98%	48	49
Ney Facility	100%	28	28	97%	287	296	96%	55	57	88%	88	100	97%	32	33
San Saba Facility	100%	8	8	99%	254	256	96%	24	25	84%	87	104	88%	43	49
Torres Facility	79%	19	24	94%	292	312	100%	75	75	87%	65	75	91%	40	44
Young Facility	100%	10	10	79%	294	372	91%	31	34	98%	87	89	98%	83	85

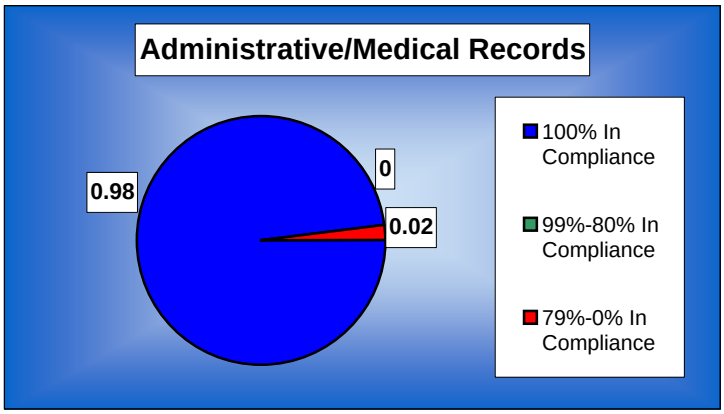
n **= number of records audited for each question.**

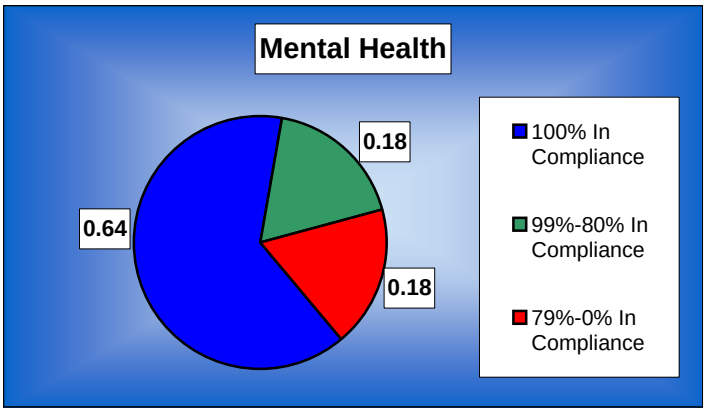
Note: Selected items requiring medical record review are reflected in this table.
The items were chosen to avoid having interdependent items counted more than once.

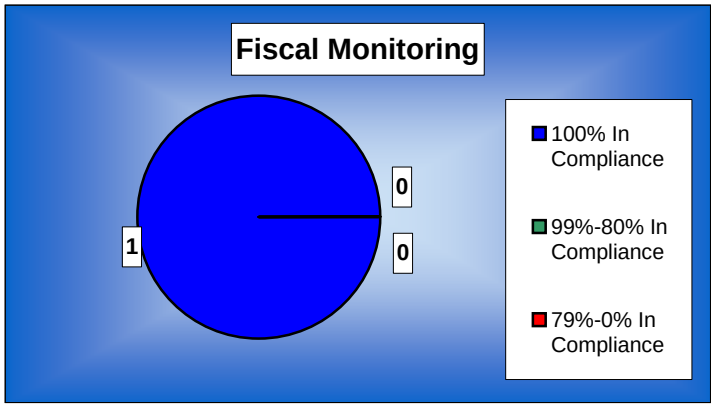
Average Percent Compliance Rate = Sum of medical records audited that were in compliance X 100
Number of records audited

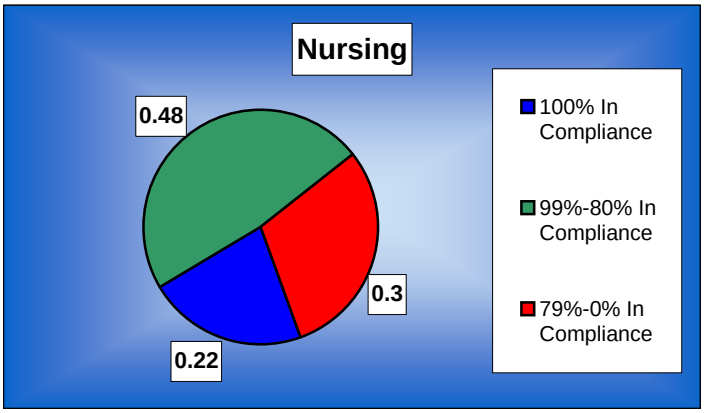
***The medical record review section of the Operations/Administration portion of the Operational Review Audit consists of only three questions, frequently with low numbers of applicable records.**

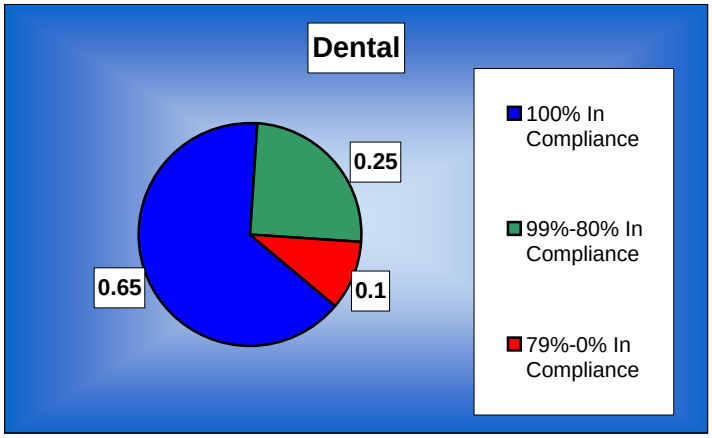
Quarterly Reports for
Compliance Rate By Operational Categories
Beto Facility
January 7, 2009

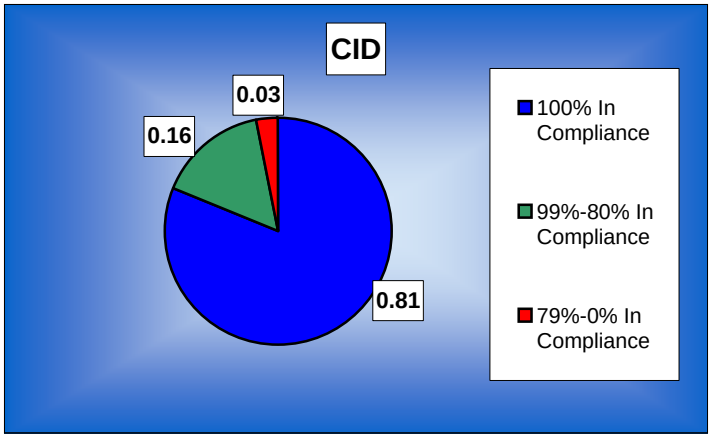




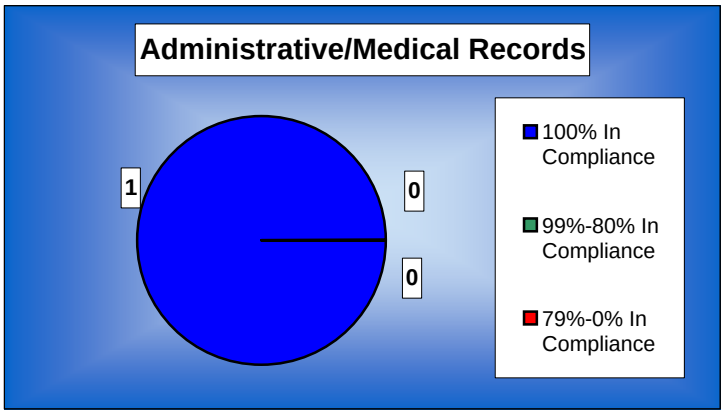


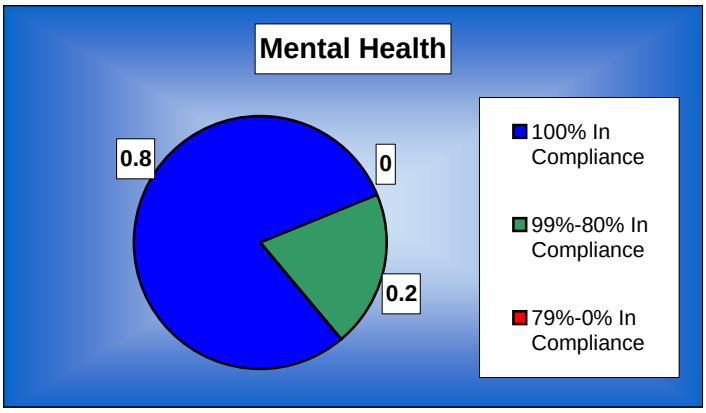


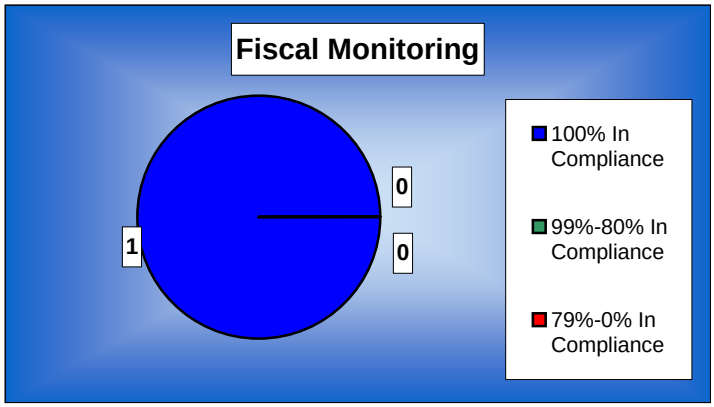


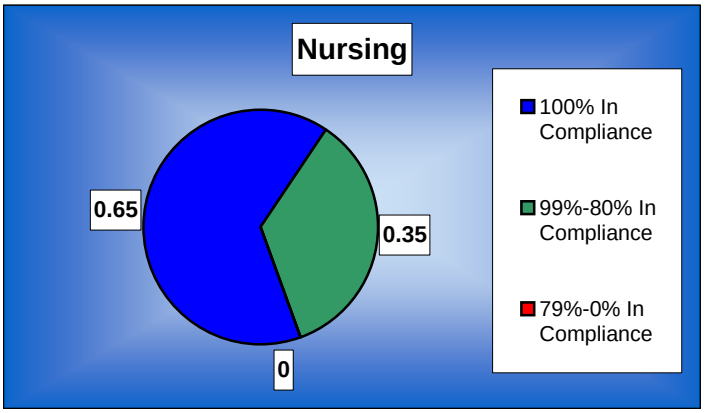


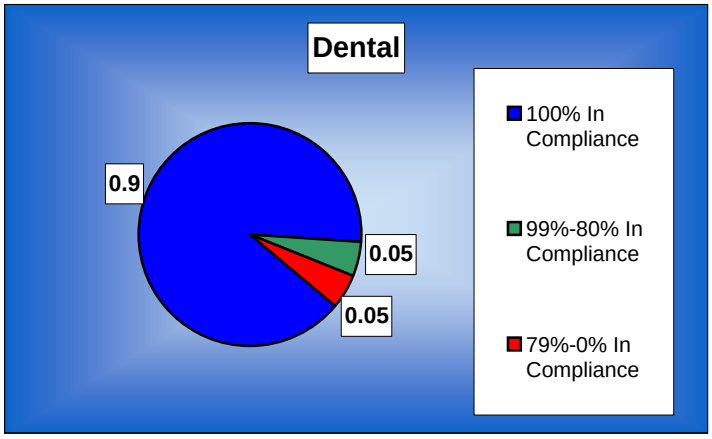
Quarterly Reports for
Compliance Rate By Operational Categories
Cleveland Facility
February 4, 2009

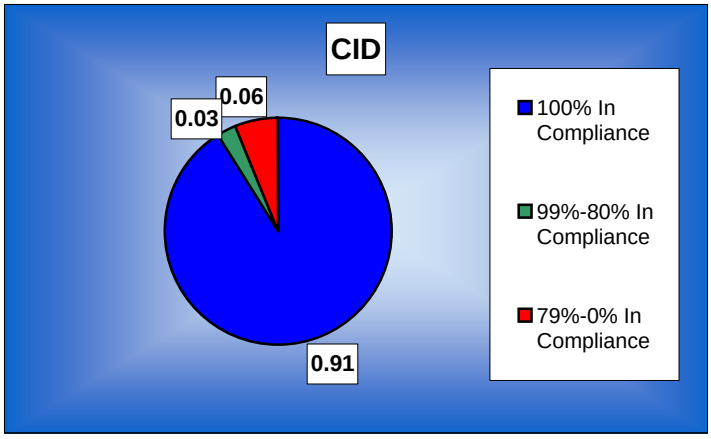




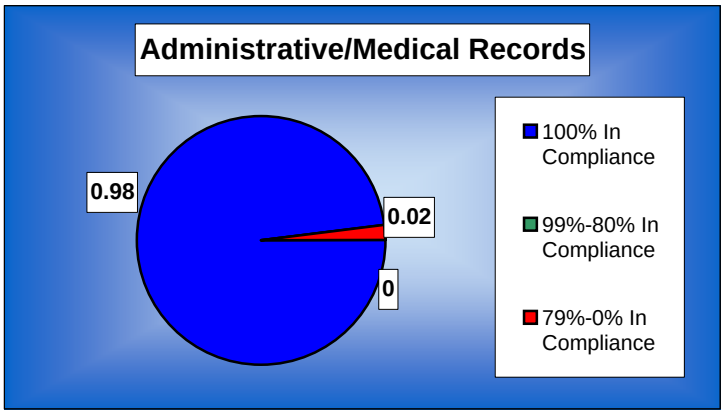


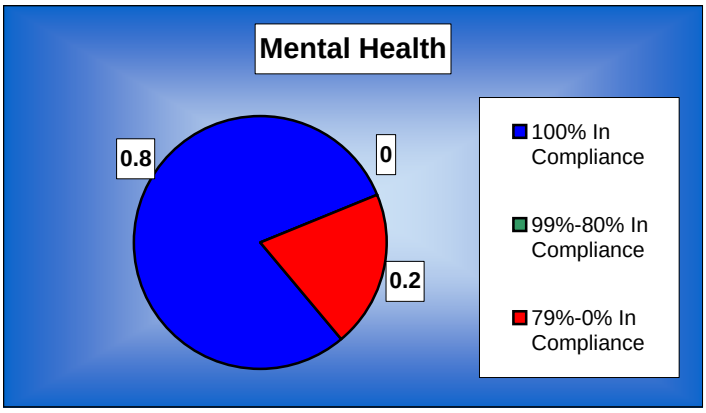


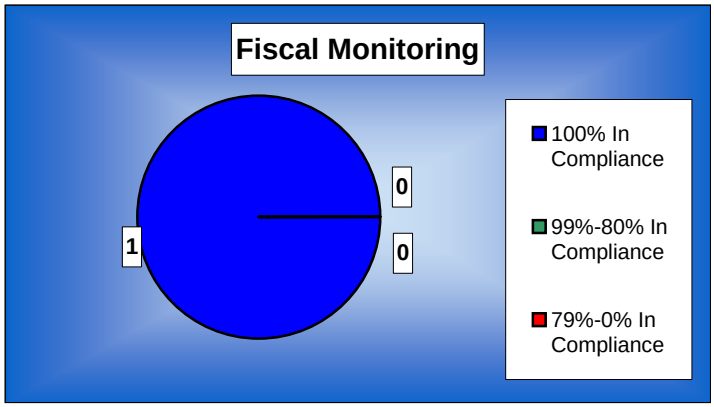


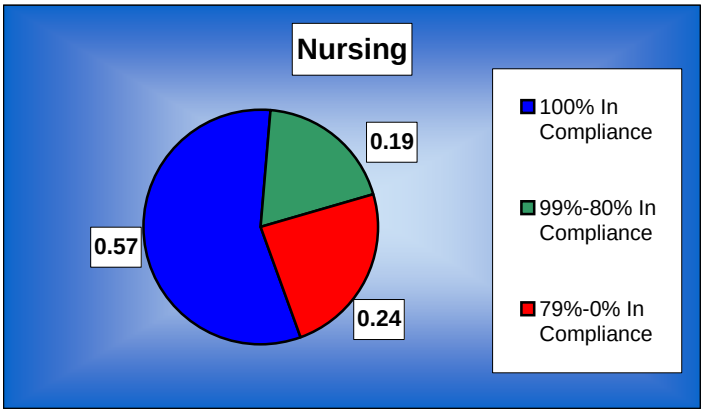


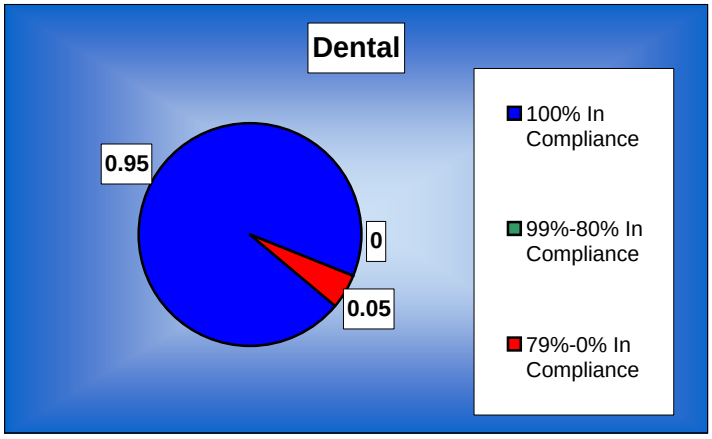
Quarterly Reports for
Compliance Rate By Operational Categories
Diboll Facility
February 6, 2009

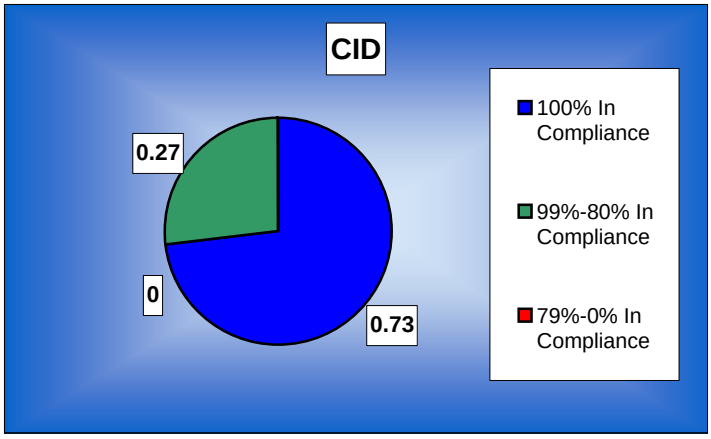












Quarterly Reports for
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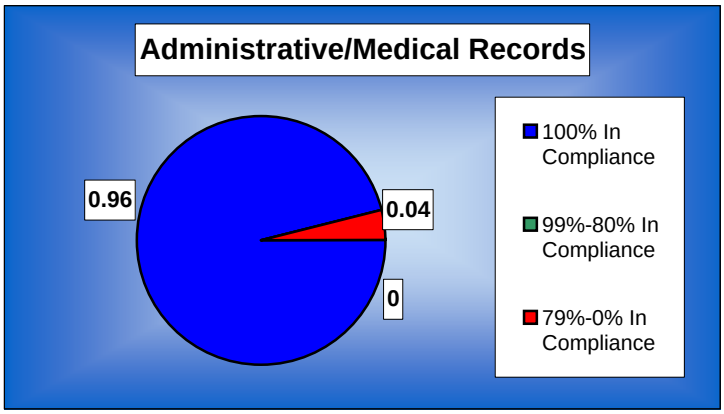
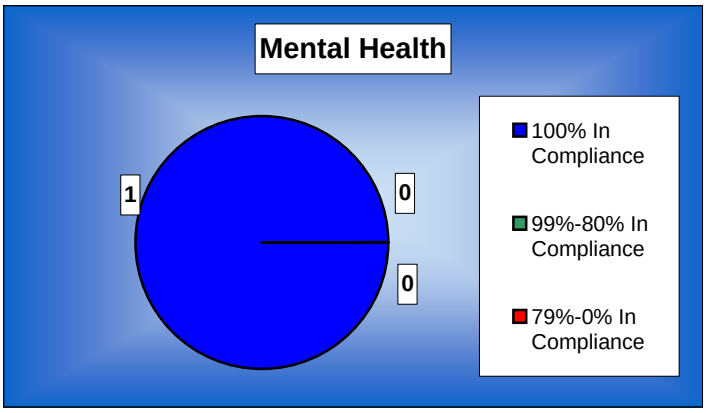
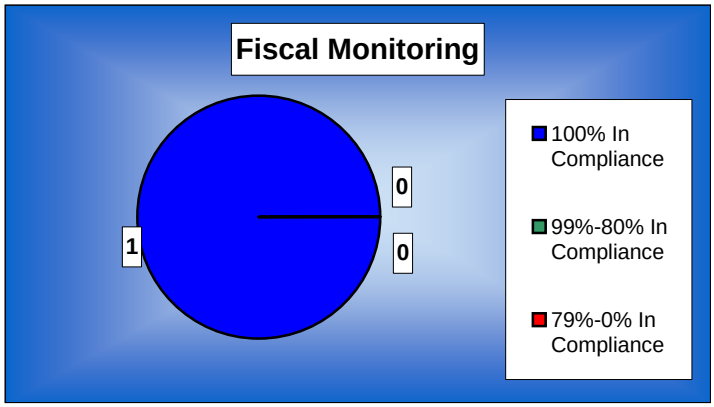
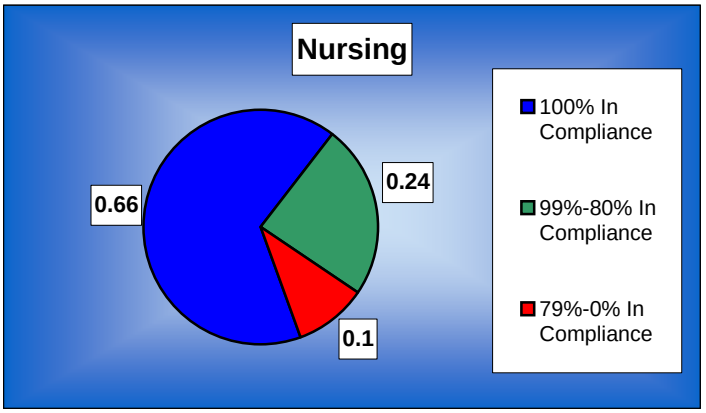
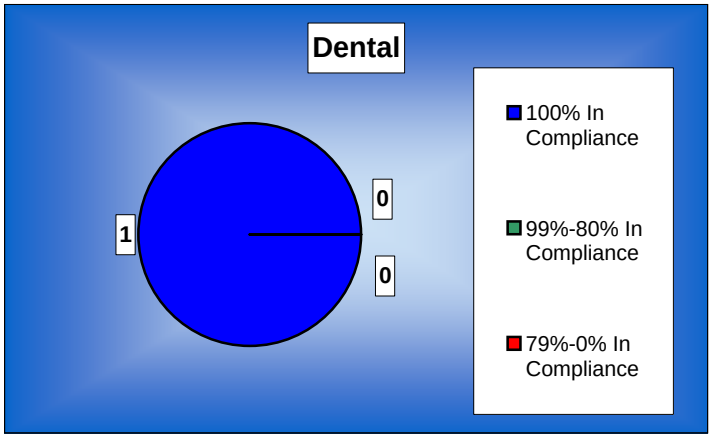
Duncan Facility
February 5, 2009

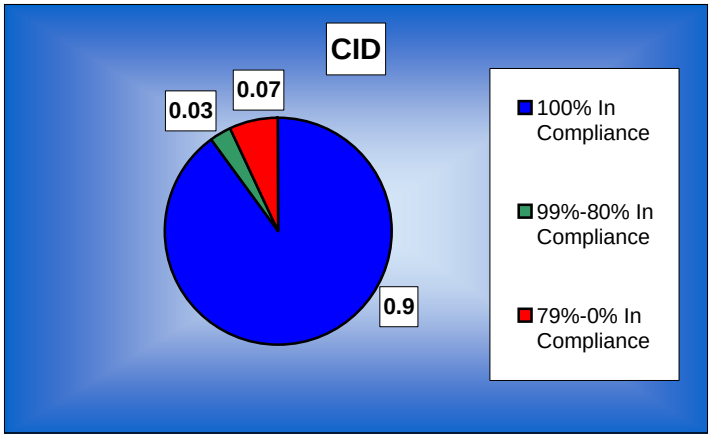




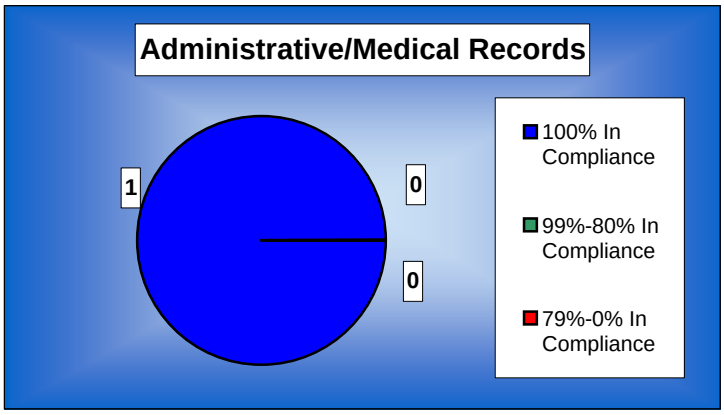


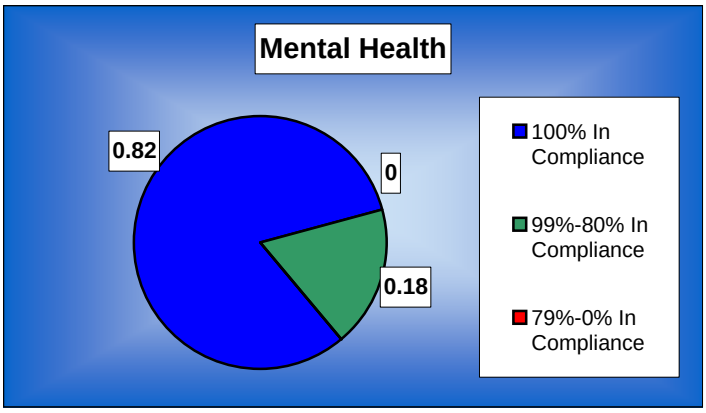


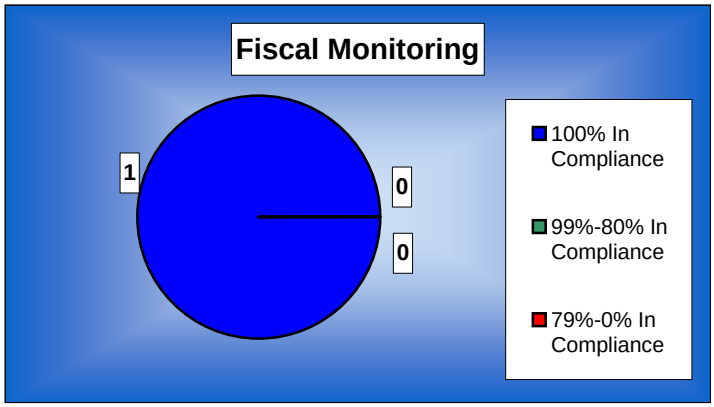


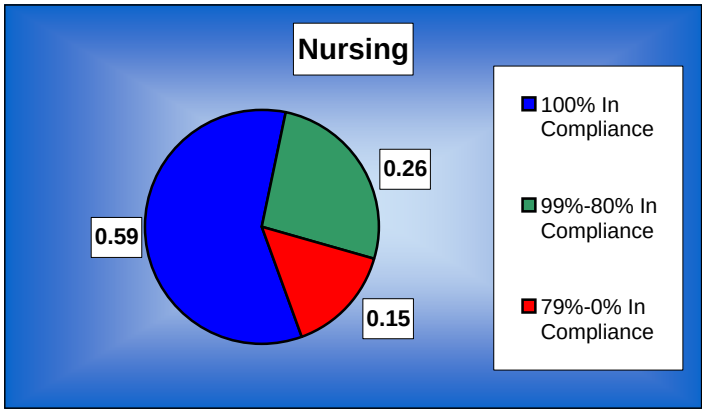


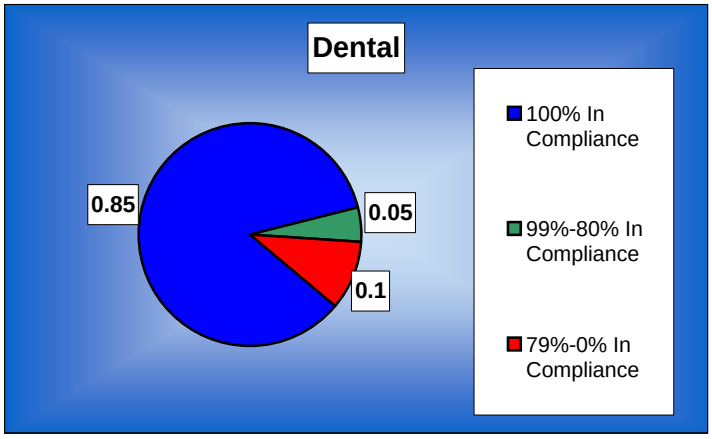
Quarterly Reports for
Compliance Rate By Operational Categories
Hobby Facility
December 1, 2008

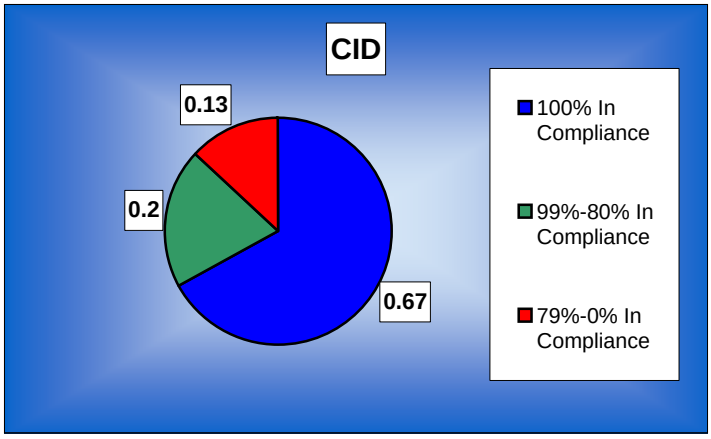




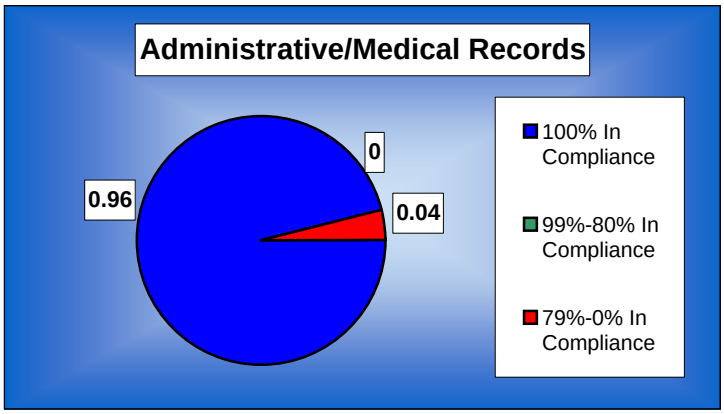


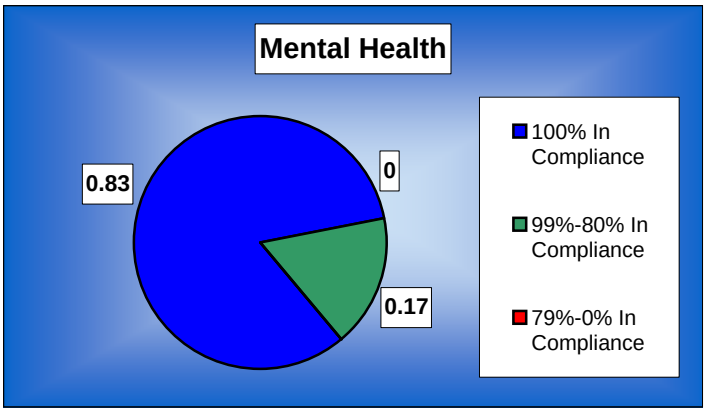


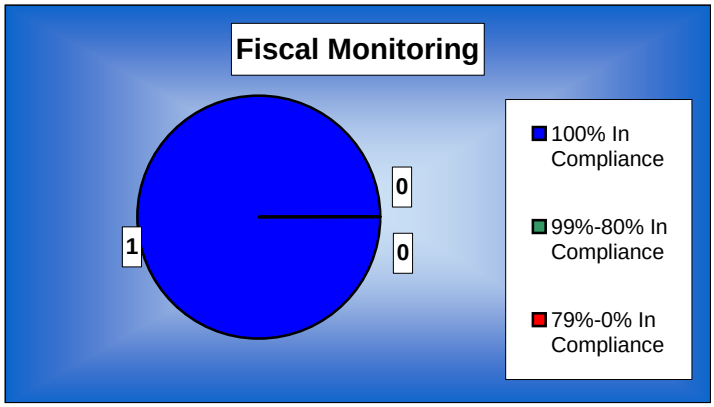


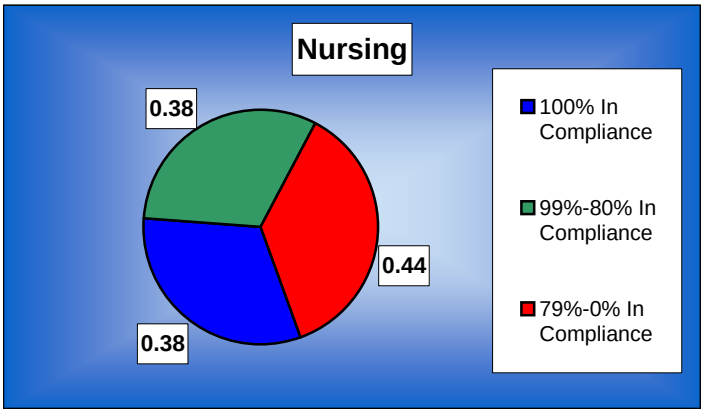


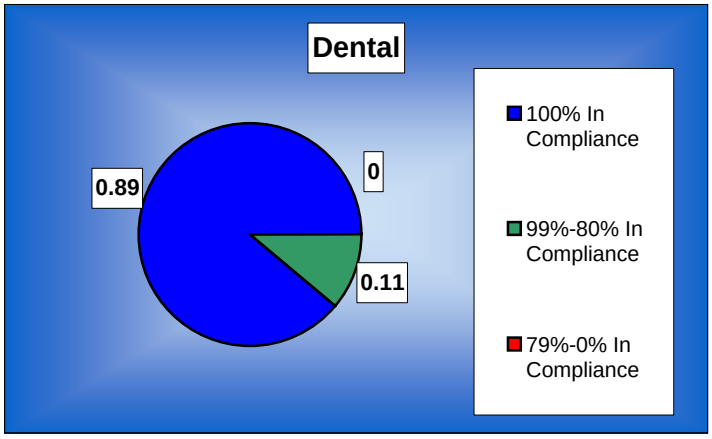
Quarterly Reports for
Compliance Rate By Operational Categories
Marlin Facility
January 20, 2009

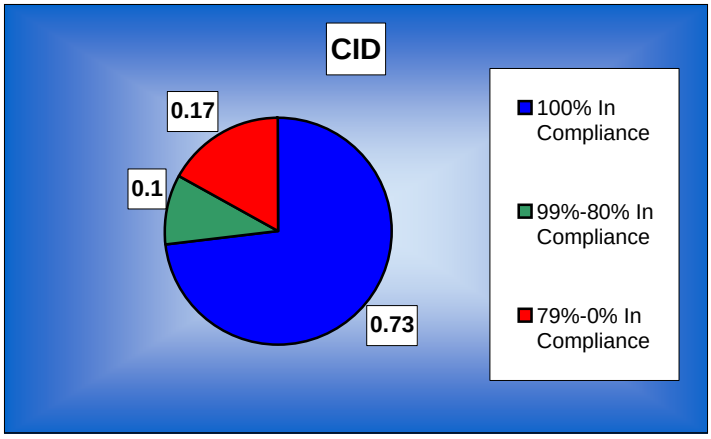




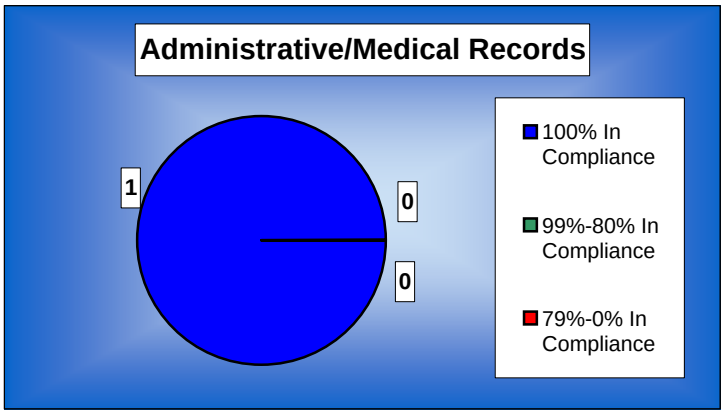


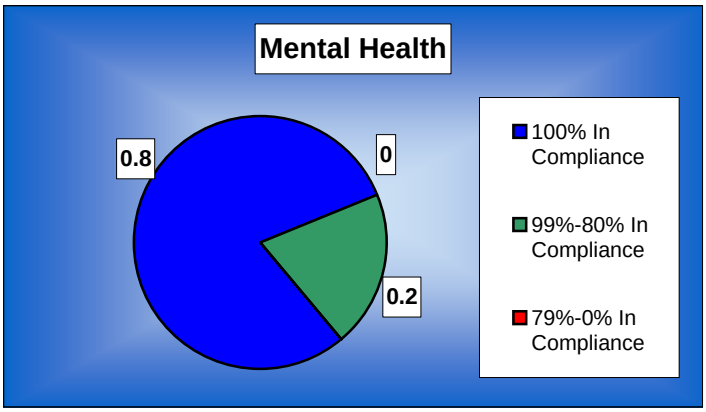


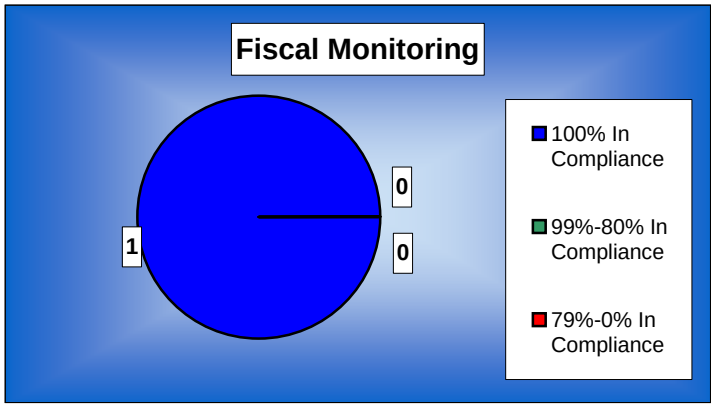


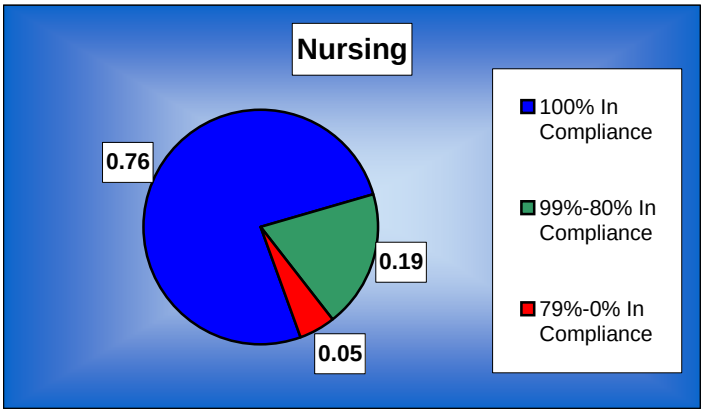


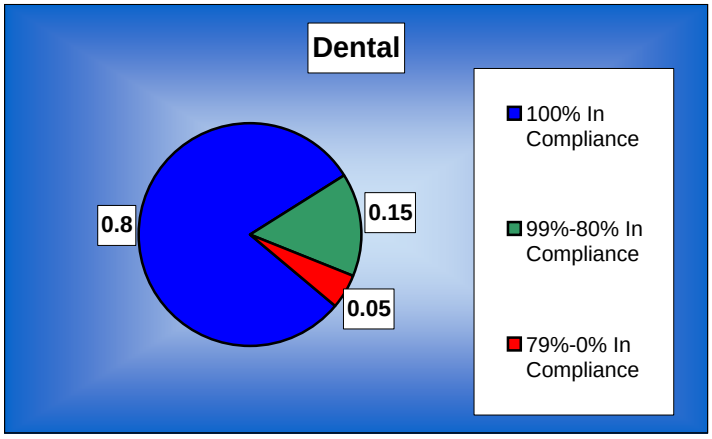
Quarterly Reports for
Compliance Rate By Operational Categories
Ney Facility
December 2, 2008

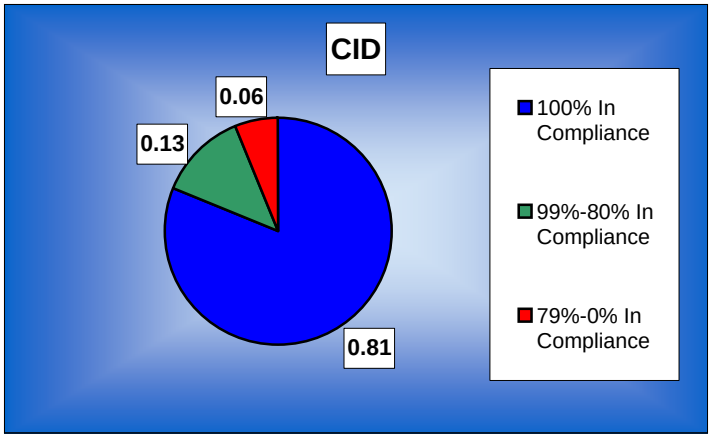




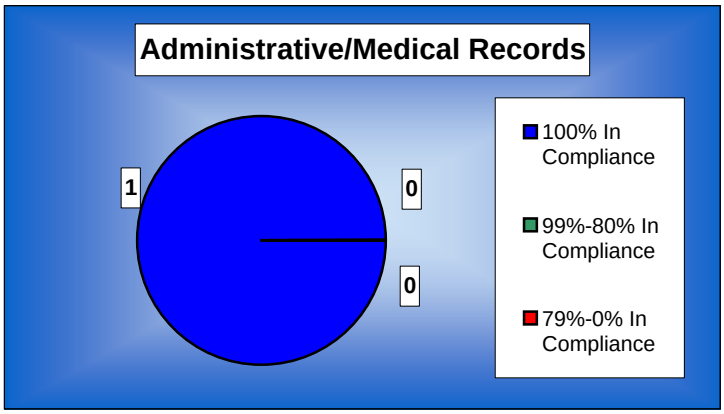


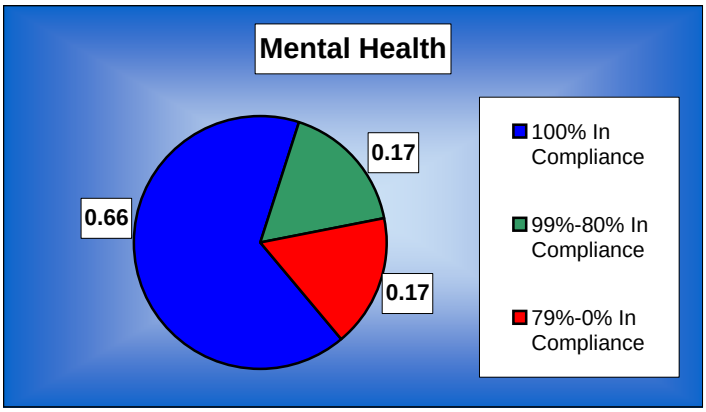


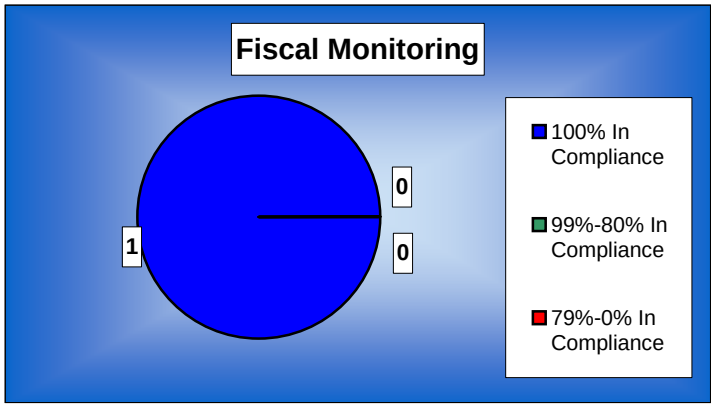


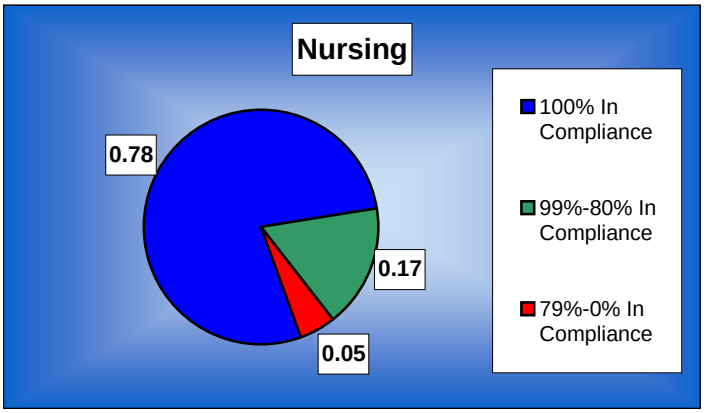


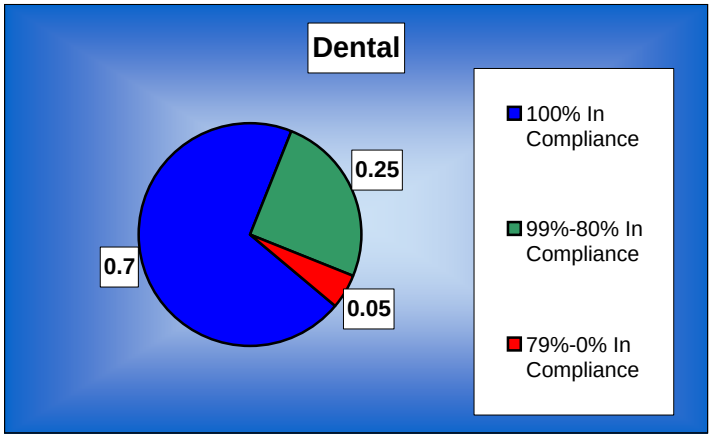
Quarterly Reports for
Compliance Rate By Operational Categories
San Saba Facility
January 21, 2009

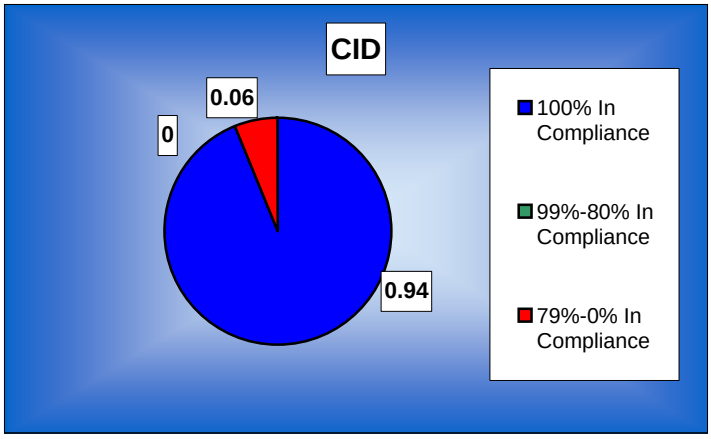




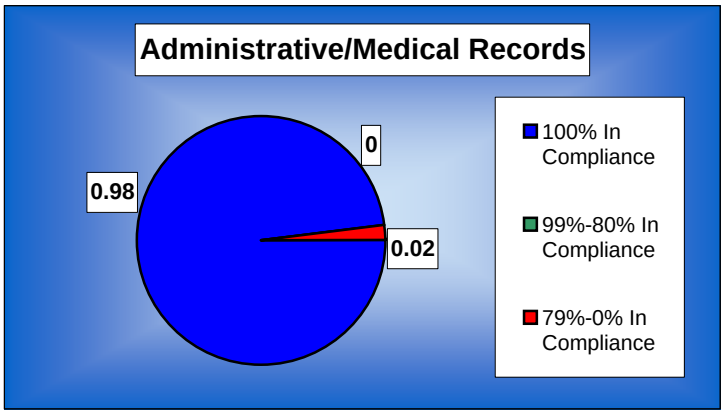


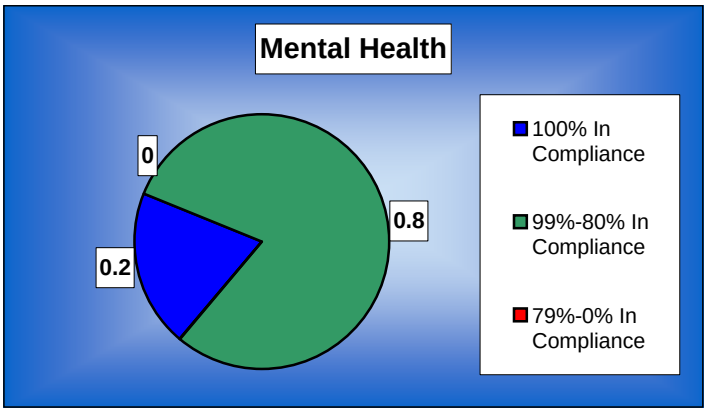


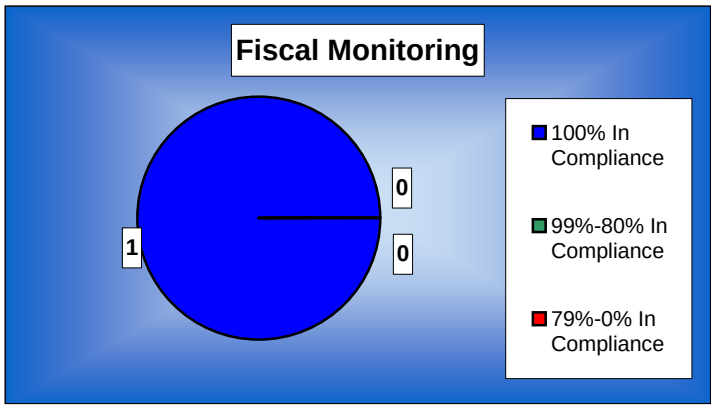


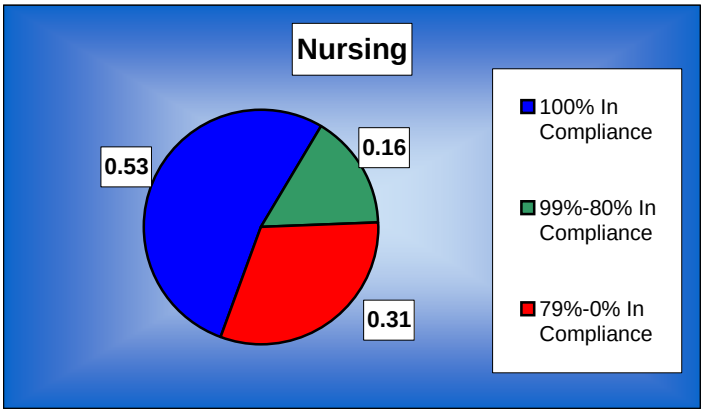


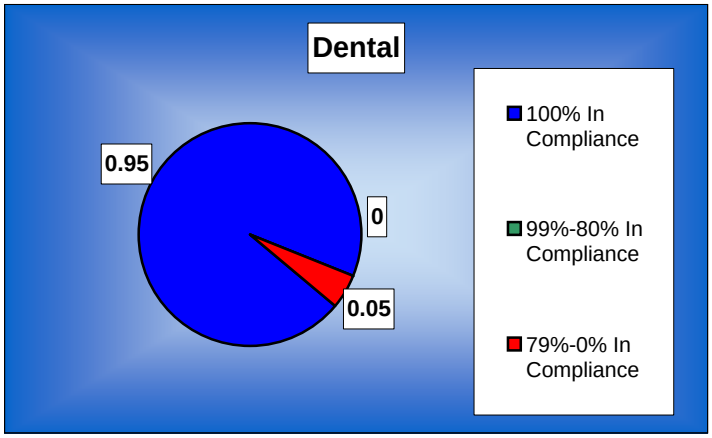
Quarterly Reports for
Compliance Rate By Operational Categories
Torres Facility
December 3, 2008

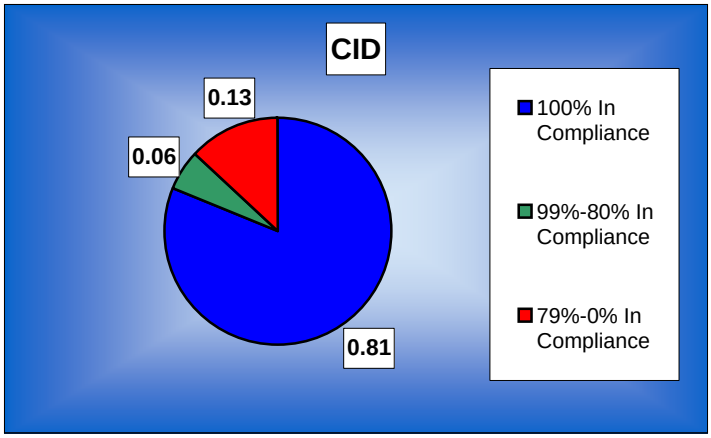




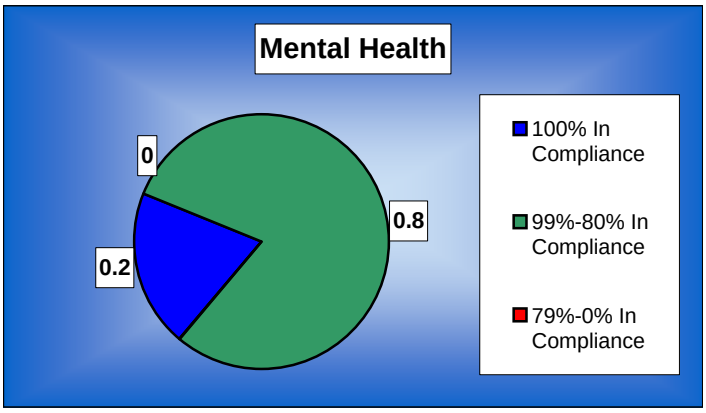




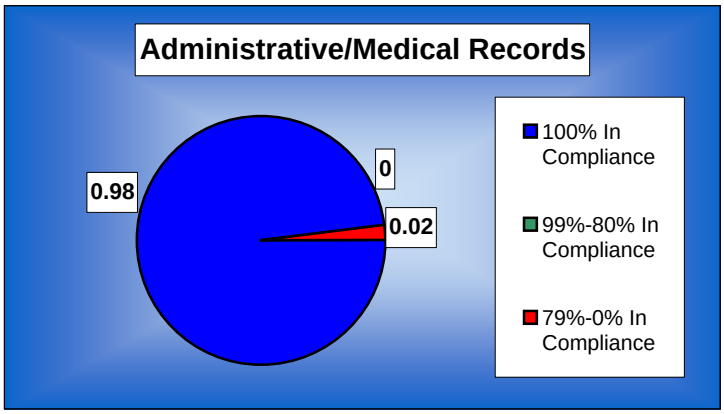


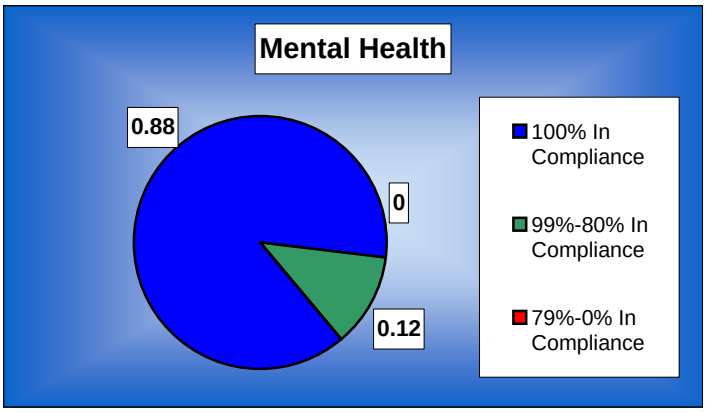


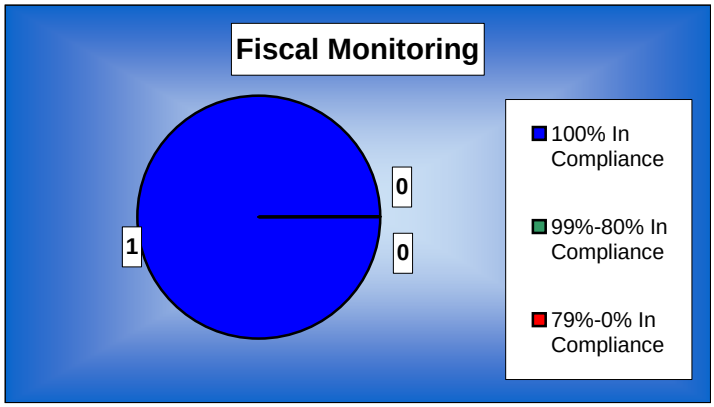
Quarterly Reports for
Compliance Rate By Operational Categories
Torres Facility
December 3, 2008

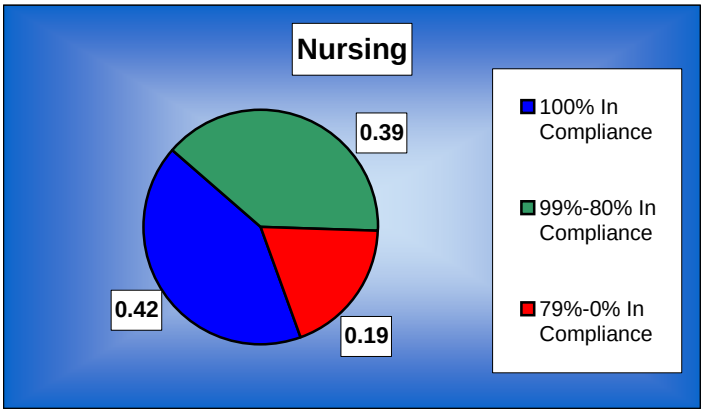


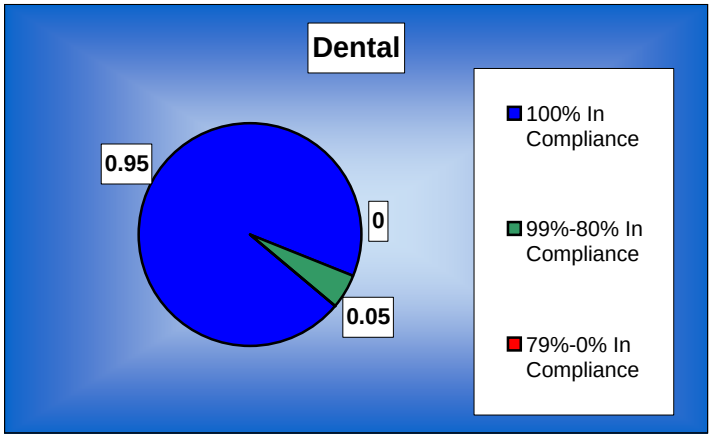
Quarterly Reports for
Compliance Rate By Operational Categories
Young Facility
January 6, 2009

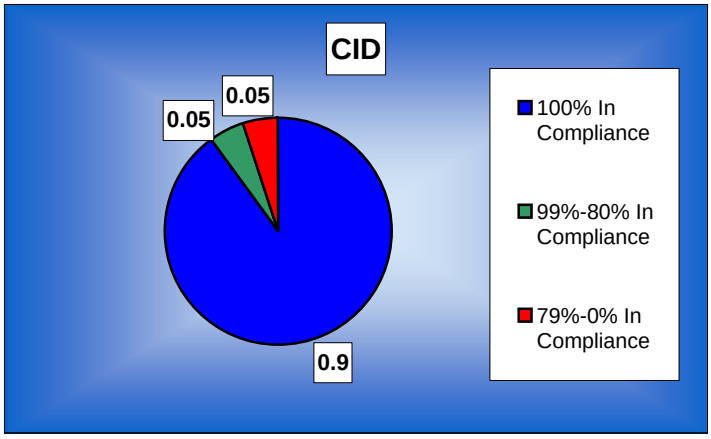












Texas Department of Criminal Justice
Office of Preventive Medicine
Monthly Activity Report

Month: December 2008

Reports Received	This Month	Same Month Last Year	Year to Date	Last Year to Date
Chlamydia	7	0	39	54
Gonorrhea	2	2	26	35
Syphilis	65	41	769	648
Hepatitis A	0	0	0	0
Hepatitis B (acute cases)	0	0	8	15
Hepatitis C	217	209	3614	4220
HIV Screens (non-pre-release)	7400	8269	79095	73759
HIV Screens (pre-release)	3876	2587	40905	37928
HIV + pre-release tests	1	9	53	53
HIV Infections (total new)	51	52	631	567
AIDS	1	12	211	209
Methicillin-Resistant *Staph Aureus*	207	298	3928	5267
Methicillin-Sensitive *Staph Aureus*	98	99	1701	1788
Occupational Exposures (TDCJ Staff)	9	9	163	298
Occupational Exposures (Medical Staff)	7	5	79	55
HIV CPX Initiation	6	3	55	60
Tuberculosis skin tests – intake (#positive)	116	259	3246	3498
Tuberculosis skin tests – annual (#positive)	16	35	576	705
Tuberculosis cases				
(1) Diagnosed during intake and attributed to county of origin	0	0	7	4
(2) Entered TDCJ on TB medications	3	0	14	19
(3) Diagnosed during incarceration in TDCJ	2	2	26	16
TB cases under management	24	18		
Peer Education Programs	0	0	108	75
Peer Education Educators	0	0	1106	716
Peer Education Participants	3396	2282	46527	40971
Sexual Assault In-Service (sessions/units)	2/1	0	33/26	45/39
Sexual Assault In-Service Participants	13	0	253	270
Alleged Assaults & Chart Reviews	47	43	614	591
BBE Labs (Offenders)	1	N/A	38	N/A

NOTES: Year to date data may not equal sum of monthly data because of late reporting. Hepatitis C cases in parenthesis are acute cases and are also included in the total number reported. Only acute cases are reportable to the Department of State Health Services.

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

Month: January 2009

Reportable Condition	Reports Received		Cases Confirmed	
	This Month	Same Month Last Year	Year to Date	Last Year to Date
Chlamydia	5	6	5	6
Gonorrhea	2	1	2	1
Syphilis	84	57	84	57
Hepatitis A	0	0	0	0
Hepatitis B (acute cases)	0	0	0	0
Hepatitis C	286	403	286 (1)	403
HIV Screens (non-pre-release)	6166	5450	6166	5450
HIV Screens (pre-release)	3669	2963	3669	2963
HIV + pre-release tests	0	12	0	12
HIV Infections (total new)	52	70	52	70
AIDS	0	110	0	110
Methicillin-Resistant *Staph Aureus*	414	327	414	284
Methicillin-Sensitive *Staph Aureus*	251	127	254	106
Occupational Exposures (TDCJ Staff)	5	9	5	9
Occupational Exposures (Medical Staff)	5	9	5	9
HIV CPX Initiation	4	4	4	4
Tuberculosis skin tests – intake (#positive)	182	144	182	144
Tuberculosis skin tests – annual (#positive)	44	27	44	27
Tuberculosis cases				
(1) Diagnosed during intake and attributed to county of origin	0	0	0	0
(2) Entered TDCJ on TB medications	0	0	0	0
(3) Diagnosed during incarceration in TDCJ	2	2	2	2
TB cases under management	21	15		
Peer Education Programs	108	95	108	95
Peer Education Educators	15	0	1121	716
Peer Education Participants	7008	3138	7008	3138
Sexual Assault In-Service (sessions/units)	0	0	0	0
Sexual Assault In-Service Participants	0	0	0	0
Alleged Assaults & Chart Reviews	41	36	41	36
BBE Labs (Offenders)	2	N/A	2	N/A

NOTES: Year to date data may not equal sum of monthly data because of late reporting. Hepatitis C cases in parenthesis are acute cases and are also included in the total number reported. Only acute cases are reportable to the Department of State Health Services.

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

Month: February 2009

Reportable Condition	Reports Received		Cases Confirmed	
	This Month	Same Month Last Year	Year to Date	Last Year to Date
Chlamydia	8	3	13	9
Gonorrhea	2	2	4	3
Syphilis	68	59	152	117
Hepatitis A	0	0	0	0
Hepatitis B (acute cases)	2	1	2	1
Hepatitis C Chronic Cases (Acute)	325	333	608 (1)	736 (2)
HIV Screens (non-pre-release)	6138	6097	12304	11547
HIV Screens (pre-release)	3011	2762	6680	5713
HIV + pre-release tests	3	15	3	27
HIV Infections (total new)	28	71	80	141
AIDS	3	1	3	7
Methicillin-Resistant *Staph Aureus*	221	290	376	703
Methicillin-Sensitive *Staph Aureus*	125	104	635	284
Occupational Exposures (TDCJ Staff)	6	19	11	22
Occupational Exposures (Medical Staff)	5	5	10	13
HIV CPX Initiation	3	5	7	9
Tuberculosis skin tests – intake (#positive)	210	286	487	641
Tuberculosis skin tests – annual (#positive)	50	33	110	74
Tuberculosis cases				
(1) Diagnosed during intake and attributed to county of origin	0	1	0	1
(2) Entered TDCJ on TB medications	1	0	1	0
(3) Diagnosed during incarceration in TDCJ	3	7	5	9
TB cases under management	23	22		
Peer Education Programs	0	2	108	97
Peer Education Educators	77	26	1198	742
Peer Education Participants	4667	3907	11675	7045
Sexual Assault In-Service (sessions/units)	1/1	3/2	1/1	3/2
Sexual Assault In-Service Participants	10	17	10	17
Alleged Assaults & Chart Reviews	57	51	98	87
BBE Labs (Offenders)	7	5	9	5

NOTES: Year to date data may not equal sum of monthly data because of late reporting. Hepatitis C cases in parenthesis are acute cases and are also included in the total number reported. Only acute cases are reportable to the Department of State Health Services.

Office of Health Services Liaison Utilization Review Audit
Hospital and Inpatient Facilities Audited with Deficiencies Noted
Second Quarter FY-2009 (December 2008, January, and February 2009)

Hospital	University	Audits Performed*	Deficiencies Noted	Comments (See Key)
Angleton/Danbury	UTMB	4	4	A=3; E=3
Bayshore	UTMB	1	1	A=1
Ben Taub	UTMB	2	2	A=1; E=1
Brackenridge	UTMB	1	1	B=1
Christus Spohn	UTMB	5	5	A=2; E=5
Conroe Regional	UTMB	17	15	A=8; C=3; E=14
Coryell Memorial	UTMB	4	4	E=4
ETMC/Trinity	UTMB	2	2	A=1; E=1
ETMC/Tyler	UTMB	1		
Falls County/Marlin	UTMB	1	1	A=1; E=1
Hendrick Memorial	TTUHSC	5	5	A=4; E=3
Hospital Galveston❖	UTMB	11	8	A=8; C=4; E=3
Huntsville Memorial	UTMB	6	6	A=4; C=3; E=6
John Peter Smith	UTMB	2	1	A=1; C=1; E=1
Mainland Memorial	UTMB	6	6	A=3; E=6
McAllen Medical Center	UTMB	1	1	E=1
Medical Center/College Sta.	UTMB	4	3	A=2; C=1; E=2
Memorial Hermann/Beaumont	UTMB	3	3	A=2; C=1; E=3
Memorial Hermann/Houston	UTMB	1	1	A=1; E=1
Methodist/Houston	UTMB	1	1	A=1; E=1
Northwest Texas	TTUHSC	3	3	A=3; E=3
Oak Bend	UTMB	1	1	A=1; E=1
Palestine Regional	UTMB	2	1	A=1; C=1
Pampa	TTUHSC	2	1	A=1; C=1
Parkland Hospital	UTMB	1	1	A=1; E=1
Scott & White/Dallas	UTMB	2	2	B=1; E=1
Thomason	TTUHSC	2	2	A=2; E=2
Trinity Mother Frances	UTMB	1	1	A=1; C=1
United Regional/11th St.	TTUHSC	2	2	A=1; B=1; C=1; E=1
University Medical Center	TTUHSC	5	5	A=5; C=2; E=5
UT Tyler	UTMB	12	9	A=7; C=2; E=9
Wadley Regional	UTMB	1		
Inpatient Facility				
Beto	UTMB	1	1	A=1; C=1; E=1
Clements	TTUHSC	6	6	A=4; E=4
Estelle	UTMB	3		
Hughes	UTMB	4	2	A=2
Luther	UTMB	1	1	A=1
Montford	TTUHSC	24	21	A=7; C=5; E=17
Polunsky	UTMB	2	1	A=1
Robertson	TTUHSC	2	2	A=2; C=1
Telford	UTMB	2	2	A=1; E=1
UT Tyler	UTMB	9	9	A=5; C=1; D=1; E=7
Carole Young	UTMB	7	2	A=2; E=1

spitals and inpatient facilities with no data listed were not selected during this quarter's random audit.
spital Galveston re-opened January 4, 2009. Discharges were reported to HSL beginning February 1, 2009.

A	On the day of discharge, were vital signs within normal limits for the patient's condition?
B	Was the level of medical services available at the receiving facility sufficient to meet the offender's current needs?
C	Was the medical record reviewed by qualified health care staff and referred to an appropriate medical provider (if applicable) on the day of arrival at the unit?
D	Did the patient require unscheduled medical care related to the admitting diagnosis within the first seven days after discharge?
E	Was the discharge summary available in the offender's electronic medical record (including results of diagnostic tests, discharge planning, medication recommendations and/or treatments, etc.) within 24 hours of arriving at the unit?

FIXED ASSETS CONTRACT MONITORING AUDIT
BY UNIT
SECOND QUARTER, FISCAL YEAR 2009

December-2008	Numbered Property On Inventory Report	Total Number of Deletions	Total Number of Transfers	Total Number of New Equipment
Hobby	36	0	1	0
Ney	20	0	0	0
Torres	33	0	0	0

January-2009	Numbered Property On Inventory Report	Total Number of Deletions	Total Number of Transfers	Total Number of New Equipment
Young	89	0	17	0
Beto	116	0	0	8
Marlin	14	0	0	0
San Saba	14	0	0	0

February-2009	Numbered Property On Inventory Report	Total Number of Deletions	Total Number of Transfers	Total Number of New Equipment
Cleveland	12	0	0	2
Duncan	16	0	1	2
Diboll	14	0	0	2

CAPITAL ASSETS AUDIT
SECOND QUARTER, FISCAL YEAR 2009
December 2008, January, and February 2009

Audit Tools	December	January	February	Total
Total number of units audited	3	4	3	10
Total numbered property	89	233	42	364
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
Second Quarter FY-2009

University of Texas Medical Branch

Unit	Audit Date	% Compliance	
		Mandatory	Non-Mandatory
Telford	December 2008	100 %	99%
Terrell	December 2008	100%	98.4%
Coffield	January 2009	100 %	97.7%
Connally	January 2009	100%	98%
Ferguson	February 2009	100 %	97.9%
Darrington	February 2009	100%	97.9%

Texas Tech University Health Science Center

Unit	Audit Date	% Compliance	
		Mandatory	Non-Mandatory
Sayle	January 2009	100 %	98.5%

Executive Services
Active Monthly Research Projects – Medical
Health Services Division

FY 09 / 2nd Quarterly Report : December 2008 - February 2009

Project Number: 408-RM03

Researcher: Ned Snyder

IRB Number: 02-377

IRB Expires: June 30, 2009

Research Began: June 3, 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: ***Manuscript has been published; Recommend closing the project, Preparing letter for Dr. Snyder***

Progress Report Due: **January 17, 2009**

Projected Completion Date: July 31, 2008

Units: Hospital Galveston

Project Number: 433-RM04

Researcher: Ned Snyder

IRB Number: 03-357

IRB Expires: June 30, 2009

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: ***Manuscript has been published; Recommend closing the project, Preparing letter for Dr. Snyder***

Progress Report Due: **February 12, 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: ***1/27/09 Email from researcher stating that he will be sending the final draft of his manuscript for review***

Progress Report Due: **January 23, 2009**

Projected Completion Date: September 1, 2007

Units: Lychner, Stringfellow

Project Number: 475-RM05

Researcher: Robert Morgan

IRB Number: L05-077

IRB Expires: February 27, 2009

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: September 18, 2008

Projected Completion Date: January 1, 2008

Units: Gatesville, Montford

Project Number: 490-RM06

Researcher: Sharon Melville

IRB Number: Exempt

IRB Expires: IRB Exempt

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: April 22, 2008

Projected Completion Date: April 30, 2010

Units: System-wide

Project Number: 503-RM06

Researcher: William O'Brien

Transferred to Dr. White

IRB Number: 06-189

IRB Expires: April 30, 2008 *(see Project Status)*

Research Began: August 2, 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: Data Collection

04/21/08: E-mail to Dr. O'Brien and Dr. White requesting Final Report as required by Research Agreement.

04/21/08: E-mail from Dr. White, no subjects were enrolled at our site and the trial still has patients on it at other sites so no results are available.

07/08/08: E-mail to Dr. White requesting new IRB and updated Progress Report.

Recommend closing project

Progress Report Due: July 16, 2007

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

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

01/08/08: As of this date, I have not received an updated Progress Report.

03/05/08: E-mail to Dr. O'Brien, has this project been transferred to Dr. White.

(see Project Status)

Projected Completion Date: To be determined by trial sponsor

Units: UTMB

Project Number: 513-MR07

Researcher:	IRB Number:	IRB Expires:	Research Began:
H. Morgan Scott	Exempt	IRB Exempt	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	**February 7, 2009**	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	June 30, 2009	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:
Article has been published Executive Services has received Email copy.	June 6, 2009	December 31, 2009

Units: Data Collection

Project Number: 527-MR07

Researcher:	IRB Number:	IRB Expires:	Research Began:
Ned Snyder	05-277	June 30, 2008 ***07/08/08: E-mail to Dedra Hicks requesting new IRB.***	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:
Analyzing Data	**January 17, 2009**	July 31, 2009

Units: UTMB

Project Number: 542-MR07

Researcher: Dr. Jacques Baillargeon

IRB Number: 07-277

IRB Expires: August 31, 2008

Research Began: April 13, 2007

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

Data Collection Began: April 13, 2007

Proponent: University of Texas Medical Branch

Data Collection End: To be determined

Project Status: Articles published
Manuscript Reviewed 9/29/08
Feb'09 Articles Published

Progress Report Due: N/A

Projected Completion Date: October 2, 2008

Units: Data Collection

Project Number: 544-MR07

Researcher: Dr. Roger Soloway

IRB Number: 07-171

IRB Expires: June 30, 2008

Research Began: March 19, 2008

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

Data Collection Begin: August 20, 2008

Proponent: University of Texas Medical Branch at Galveston

Data Collection End: To Be Determined

Project Status: Data Collection

Progress Report Due: January 17, 2009

Projected Completion Date: April 30, 2010

Units: UTMB

Project Number: 564-RM08

Researcher: Dr. Amy Harzke

IRB Number: UTMB/Exempt
DHSH

IRB Expires: N/A
August 13, 2009

Research Begin: July 30, 2008

Title of Research: Causes of Death Among Texas Prisoners, 1983-2003

Data Collection Begin: December 5, 2008

Proponent: UTMB

Data Collection End: To be determined

Project Status: Data Collection

Progress Report Due: May 15, 2009

Projected Completion Date: March 1, 2010

Units: Data Collection

Project Number: 568-RM08

Researcher:
Julito Uy

IRB Number:
24-Nov-08

IRB Expires:
August 26, 2009

Research Began:
September 9, 2008

Title of Research:
A prevalence Study on Obesity and Associated Morbidity among male Offenders in a Texas State Correctional Facility

Data Collection Began:
February 5, 2009

Proponent:
Texas Tech University

Data Collection End:
To be determined

Project Status:
Data Collection

Progress Report Due:
May 19, 2009

Projected Completion Date:
August 26, 2009

Units: Clements

Executive Services
Pending Research Projects – Medical
Health Services Division

FY 09 / 2nd Quarterly Report: December 2008 – February 2009

Project Number: 549-RML07

Researcher:	IRB Number:	IRB Expires:	Research Begin:
Dr. Jacques Baillargeon	**07-318**	**September 30, 2008**	January 31, 2008

Title of Research:

Psychiatric Barriers to Outpatient Care in Released HIV-monoinfected and HIV/HCV coinfected Offenders

Data Collection Begin:

Pending Panel Review

Proponent:

University of Texas Medical Branch, Galveston

Data Collection End:

To be determined

Project Status:	Progress Report Due:	Projected Completion Date:
Pending Peer Review stipulations RE: HIPPAA ***Article was published from prior study (#542), Journal of the American Medical Association.***	N/A	To be determined

Units: Data Collection

Project Number: 570-RM08

Researcher:	IRB Number:	IRB Expires:	Research Begin:
Fredericus Van Kujik	**08-045**	December 31, 2009	January 21, 2009

Title of Research:

Analysis of Amyloid Products in the Vitreous of Patients with Diabetic Retinopahthy and Age-Related Macular Degeneration

Data Collection Begin:

Pending Approval

Proponent:

UTMB

Data Collection End:

To be determined

Project Status:	Progress Report Due:	Projected Completion Date:
Pending OGC Approval	N/A	December 31, 2009

Units: UTMB Department of Opthalmology

TDCJ HEALTH SERVICES
LARGE FACILITY ADMINISTRATIVE SEGREGATION MENTAL HEALTH AUDITS
SECOND QUARTER FY 2009
(December 2008, January, and February 2009)

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
MICHAEL	12/3&4/08	100%	100%	4	8	471	120/175	4/6
DARRINGTON	12/9/08	100%	100%	0	4	215	37/97	4/6
RAMSEY 1	12/11/08	100%	100%	0	2	52	20/32	2/6
ESTELLE (ECB)	12/29&30/08`	100%	100%	2	10	556	80/227	1/6
TELFORD	1/6&7/2009	100%	N/A	0	10	467	58/201	4/6
STILES	1/14,15,16/2009	92%	100%	2	12	480	94/150	4/6
EASTHAM	1/21/2009	100%	100%	2	6	342	34/138	3/6
SMITH (ECB)	1/27&28/2009	100%	100%	1	8	461	135/137	3/6
ALLRED (ECB)	2/10&11/2009	100%	100%	2	8	444	85/146	3/6
ALLRED (12 Bldg)	2/11&12/2009	92%	87.5%	1	10	485	152/142	4/6
ELLIS	2/23/2009	100%	100%	0	3	97	10/56	2/4
ROBERTSON	2/25&26/2009	92%	100%	1	5	443	70/171	3/6
TOTAL		1,176	1,087.5	15	86	4,513	895/1,672	37/70
AVERAGE		98.0%	98.86%	1.25	7.17	376.1	74.58/139.3	3.1/5.8

Consent Item 3(a)

UTMB Medical Director’s Report

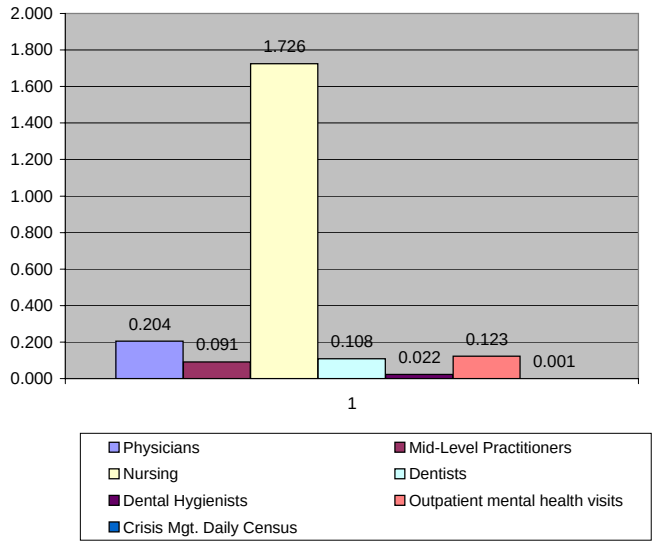
Correctional Health Care
MEDICAL DIRECTOR'S REPORT

SECOND QUARTER
FY 2009

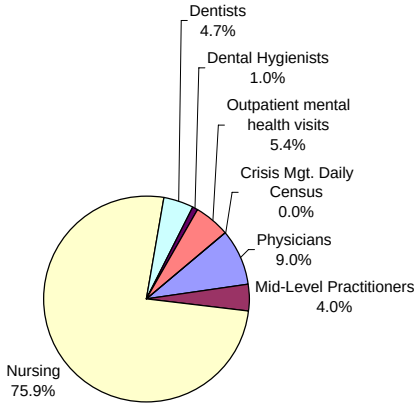
Medical Director's Report:

	December		January		February		Qtly Average	
Average Population	**120,405**		**119,824**		**119,839**		**120,023**	
	Number	**Rate Per Offender**	**Number**	**Rate Per Offender**	**Number**	**Rate Per Offender**	**Number**	**Rate Per Offender**
Medical encounters								
Physicians	23,810	0.198	24,720	0.206	25,079	0.209	**24,536**	**0.204**
Mid-Level Practitioners	11,694	0.097	10,853	0.091	10,346	0.086	**10,964**	**0.091**
Nursing	205,315	1.705	212,994	1.778	203,014	1.694	**207,108**	**1.726**
Sub-total	**240,819**	**2.000**	**248,567**	**2.074**	**238,439**	**1.990**	**242,608**	**2.021**
Dental encounters								
Dentists	12,535	0.104	13,588	0.113	12,707	0.106	**12,943**	**0.108**
Dental Hygienists	2,615	0.022	2,713	0.023	2,584	0.022	**2,637**	**0.022**
Sub-total	**15,150**	**0.126**	**16,301**	**0.136**	**15,291**	**0.128**	**15,581**	**0.130**
Mental health encounters								
Outpatient mental health visits	14,657	0.122	15,100	0.126	14,521	0.121	**14,759**	**0.123**
Crisis Mgt. Daily Census	53	0.000	64	0.001	67	0.001	**61**	**0.001**
Sub-total	**14,710**	**0.122**	**15,164**	**0.127**	**14,588**	**0.122**	**14,821**	**0.123**
Total encounters	**270,679**	**2.248**	**280,032**	**2.337**	**268,318**	**2.239**	**273,010**	**2.275**

Encounters as Rate Per Offender Per Month



Encounters by Type

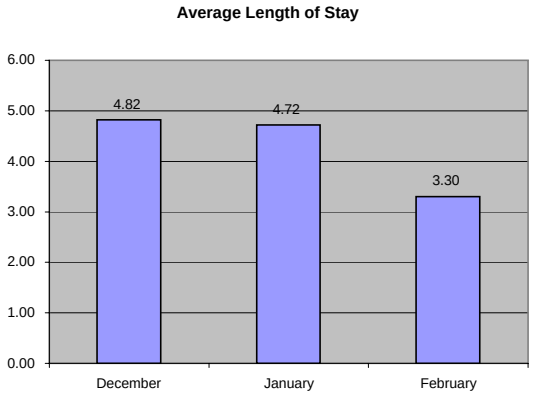


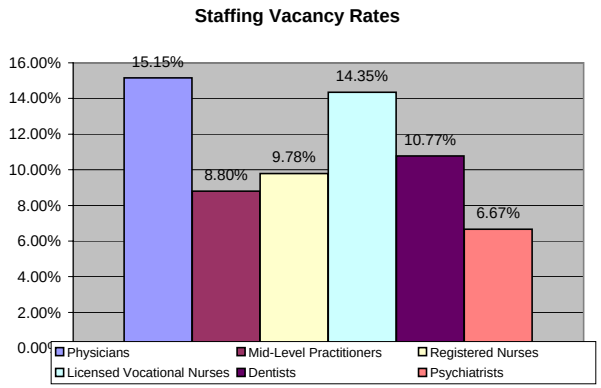
Medical Director's Report (Page 2):

	December	January	February	Qtly Average
Medical Inpatient Facilities				
Average Daily Census	1.00	33.00	55.00	**29.67**
Number of Admissions	11.00	195.00	218.00	**141.33**
Average Length of Stay	4.82	4.72	3.30	**4.28**
Number of Clinic Visits	*	*	*	**#VALUE!**
Mental Health Inpatient Facilities				
Average Daily Census	1,022.87	1,033.55	1,016.43	**1,024.28**
PAMIO/MROP Census	704.75	679.93	684.32	**689.67**
Specialty Referrals Completed	*	*	*	**#VALUE!**
Telemedicine Consults	*	*	*	**#VALUE!**

* Information Not Available Due to Hurricane Ike

	Average This Quarter			Percent
Health Care Staffing	**Filled**	**Vacant**	**Total**	**Vacant**
Physicians	56.00	10.00	66.00	15.15%
Mid-Level Practitioners	114.00	11.00	125.00	8.80%
Registered Nurses	461.00	50.00	511.00	9.78%
Licensed Vocational Nurses	543.00	91.00	634.00	14.35%
Dentists	58.00	7.00	65.00	10.77%
Psychiatrists	14.00	1.00	15.00	6.67%





Consent Item 3(b)

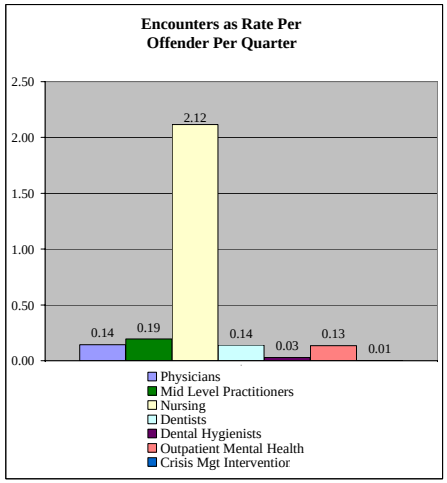
TTUHSC Medical Director’s Report

Correctional Managed Health Care
MEDICAL DIRECTOR'S REPORT

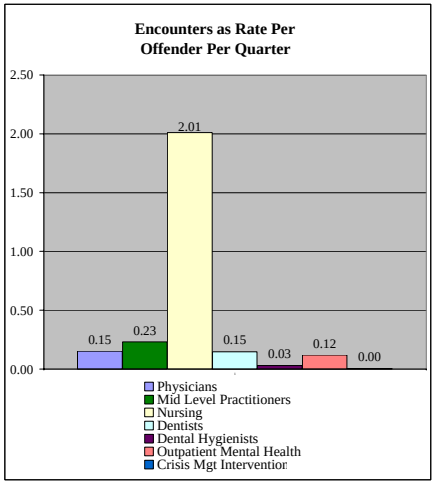
SECOND QUARTER
FY 2009

Medical Director's Report:

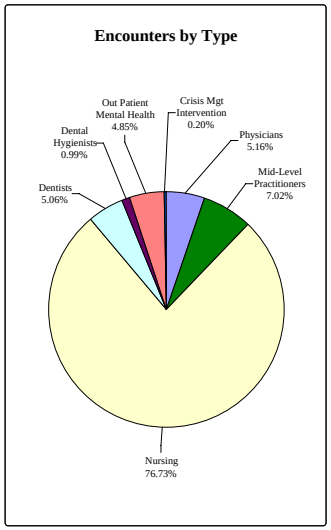
	December		January		February		Quarterly Average	
Average Population	30,637.58		30,582.65		30,386.28		30,535.50	
Medical Encounters	Number	Rate Per Offender	Number	Rate Per Offender	Number	Rate Per Offender	Number	Rate Per Offender
Physicians	4,706	0.154	4,366	0.143	4,784	0.157	4,619	0.151
Mid-Level Practitioners	7,074	0.231	6,775	0.222	7,339	0.242	7,063	0.231
Nursing	60,466	1.974	62,895	2.057	60,881	2.004	61,414	2.011
Sub-Total	**72,246**	**2.358**	**74,036**	**2.421**	**73,004**	**2.403**	**73,095**	**2.394**
Dental Encounters								
Dentists	4,558	0.149	4,436	0.145	4,486	0.148	4,493	0.147
Dental Hygienists	957	0.031	914	0.030	914	0.030	928	0.030
Sub-Total	**5,515**	**0.180**	**5,350**	**0.175**	**5,400**	**0.178**	**5,422**	**0.178**
Mental Health Encounters								
Outpatient mental health visits	3,926	0.128	3,313	0.108	3,775	0.124	3,671	0.120
Crisis Mgt. Interventions	159	0.005	136	0.004	147	0.005	147	0.005
Sub-Total	**4,085**	**0.133**	**3,449**	**0.113**	**3,922**	**0.129**	**3,819**	**0.125**
Total Encounters	**81,846**	**2.671**	**82,835**	**2.709**	**82,326**	**2.709**	**82,336**	**2.696**



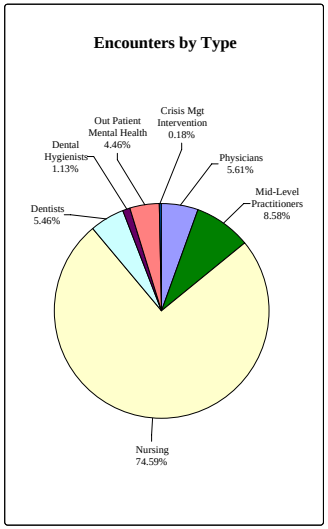
1st Quarter 2009



2nd Quarter 2009



1st Quarter 2009

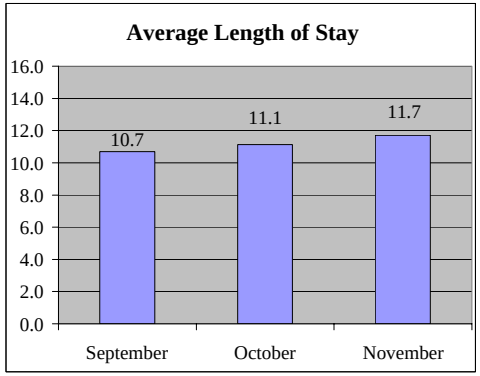


2nd Quarter 2009

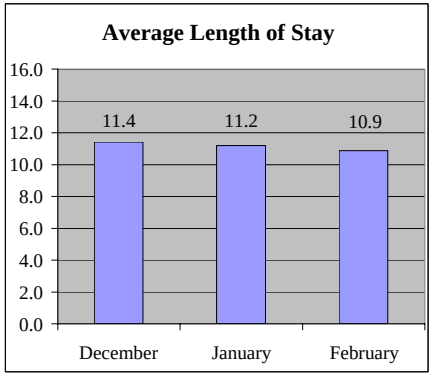
Medical Director's Report (page 2):

	December	January	February	Quarterly Average
Medical Inpatient Facilities				
Average Daily Census	110.12	114.74	119.32	**114.73**
Number of Admissions	206	264	221	**230.33**
Average Length of Stay	11.42	11.19	10.87	**11.16**
Number of Clinic Visits	598	647	559	**601.33**
Mental Health Inpatient Facilities				
Average Daily Census	497	492	478	**489.00**
PAMIO/MROP Census	393	399	414	**402.00**
Specialty Referrals Completed	665	748	751	**721.33**
Telemedicine Consults	337	352	331	**340.00**

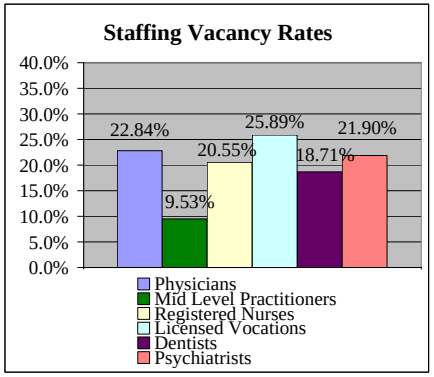
	Average This Quarter			Percent
Health Care Staffing	Filled	Vacant	Total	Vacant
Physicians	20.2	4.8	25	19.20%
Mid-Level Practitioners	27.48	3.38	30.86	10.95%
Registered Nurses	128.7	30	158.7	18.90%
Licensed Vocational Nurses	267.58	82.21	349.79	23.50%
Dentists	16.08	3.96	20.04	19.76%
Psychiatrists	6.64	4	10.64	37.59%



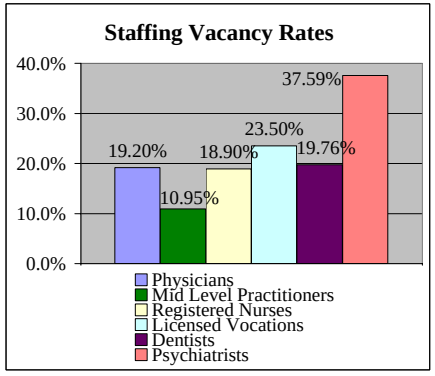
1st Quarter 2009



2nd Quarter 2009



1st Quarter 2009



2nd Quarter 2009

Consent Item 4

Summary of CMHCC Joint Committee / Work Group Activities

Correctional Managed Health Care
Joint Committee/Work Group Activity Summary
for June 2009 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. Lannette Linthicum

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: May 14, 2009
Key Activities:

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

- Infection Control
- Mental Health PULHES
- Monitoring CD4 Viral Load Analysis

(2) Heard reports on Access to Care – Dental Services / Medical Staff / Mental Health Services / Nursing Services / OPS Data

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

(4) Reviewed Monthly Grievance Exception Reports.

(5) Discussed issues related to SAFE Prisons Program

(6) Heard an update on Nursing Work Group

(7) Subcommittee for New SLC Indicators

(8) Discussed Hospital and Inpatient Discharge Audits

Joint Policy and Procedure Committee

Co-Chair: Dr. Mike Kelley, TDCJ Health Services Division / David McNutt, Assistant Director, CMHCC

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

Meeting Date: April 9, 2009

Key Activities:

(1) Updated revisions to policy E-34.2 Periodic Physical Examinations
(2) Approved revisions to policy E-36.1 Dental Treatment Priorities
(3) Approved revisions to policy A-08.9 Referral to the Personality Disorder / Aggressive Behavior Unit
(4) Approved revisions to policy A-08.9 Attachment A, Referral to the Personality Disorder / Aggressive Behavior Unit
(5) Reviewed revisions to policy A-08.10 Referral to the Program for Aggressive Mentally Ill Offender (PAMIO)
(6) Approved revisions to policy A-08.10 Attachment A, Referral to the Program for PAMIO
(7) Approved revisions to policy A-12.1 Grievance Mechanism & Attachment
(8) Approved revisions to policy A-12.2 Patient Liaison Program
(9) Reviewed revisions to policy D-28.4 First Aid Kits
(10) Approved revisions to policy E-32.1 Receiving, Transfer and Continuity of Care Screening
(11) Reviewed revisions to policy F-49.1 Personal Hygiene
(12) Reviewed revisions to policy E-37.1 Daily Triaging of Health Complaints
(13) Approved revisions to policy E-42.3 Transportation of Infirmary and Assisted Living Patients
(14) Reviewed revisions to policy E-47.1 Therapeutic Diets
(15) Approved revisions to policy E-38.1 Sick Call
(16) Approved Minutes from January 8, 2009 Policy and Procedures Committee Meeting

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: May 14, 2009

A. Key Activities

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

- Benzodiazepine Withdrawal
- CAD
- HIV
- Medication Errors
- Pain
- Psychiatry
- Respiratory

(2) Reviewed and discussed monthly reports as follows:

- Adverse Drug Reaction Reports
- Pharmacy Clinical Activity Reports
- Non-Formulary Deferral Reports
- Drug Recalls – (March, 2009)
- Utilization related reports on:
    - HIV Utilization
    - Hepatitis C Utilization
    - Hepatitis B Utilization

(3) Discussion related to Gastrointestinal Issues

(4) Discussion on Topical Agents

(5) Discussion on Respiratory Agents

(6) Discussion on Formulary Addition Request
- Divalproex Sodium (Depakote®) and Risperidon (Risperdal®)
- Docusate Sodium 100 mg Capsultes

(7) Discussion on Disease Management Guideline / Evaulation

- HTN DMG Revision
- Warfarin MUE Report
- Warfarin Clinic Proposal

(8) Discussion on Renal Impairment Dose Adjustment Chart

(9) Action Request (Old Business)

- Revise the Bipolar Depression Disease Management Guidelines
- Conscious Sedation Protocol for Interventional Radiologist Use at Estelle
- Follow-up CGI Form Availability on EMR
- Anemia Management in Pre-Dialysis Patients
- Benzodiazepine Discontinuation Pathway
- Lubriderm Prior Authorization Criteria
- Hepatitis A Vaccine

Action Requests (New Business)

- Commissary Medication Review
  - Medicidin-D Multi Symptom Relief
  - Hydrogen Peroxide
  - Vitamin D
  - Cough Syrup

- Clarification of Policy Related to Patient Education Materials

- Therapeutic Substitution for Vosol-HC
- Medication Administration During Computer Breakdown (Down-time)

(10) Reviewed Policy and Procedures Revisions:

- P&P 05-10
- P&P 30-05
- P&P 55-10
- P&P 55-15
- P&P 55-20
- P&P 60-05
- P&P 60-10
- P&P 65-05

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: April 9, 2009

Key Activities:

(1) Preventive Medicine Update on Norovirus

(2) Discussion on VRE Results in EMR

(3) Discussion on Shingles Manifest

(4) Discussion on HIV Testing and Reporting

(5) Discussion on MyClens

(6) CID – CAT and CID Training

(7) Reviewed the following policies:
- Policy B-14.01 through B-14.02
- Policy B-14.03 Employee TB Testing
- Policy B-14.04 through B-14.10

Joint Dental Work Group

Chair: Dr. Brian Tucker

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

Meeting Date: March 25, 2009

Key Activities:

(1) Report from the Dental Utilization Quality Review Committee
(2) Report from the TDCJ Health Services Director / Western Sector Dental Director / Eastern Sector Director
(3) Report from the Dental Hygiene Manager
(4) Report from the Formulary Committee

Review and discussions on the following:

- Peridontics
- Endodontics
- Prosthodontics

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: December , 2008 (review of 27 cases), January 2009 (review of 28 cases) and February , 2009 (review of 21 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: March 11, 2009 (Meeting in May 2009 Postponed)

Key Activities:

(1) Heard Safety Committee Report
(2) Reviewed Infirmary Policy
(3) Heard Report on Inpatient Psych
(4) Reviewed revisions on the New Code Form
(5) Discussion and review of Pharmacy Audit – Nursing Policy
(6) Discussion and review of Pharmacy Quality Improvement Audit for Nursing

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: May 27, 2009

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:

81st Legislative Session:

Due to the Legislative Session not ending until June 1st and posting of the Correctional Managed Health Care Committee agenda on May 29th, information on legislative tracking will be provided at the September meeting.

Appropriation Bills:

1. FY 2008 – 2009 Emergency Funding (HB 4586):
   - $48,144,918 to reimburse projected shortfalls.
2. FY 2010 – 2011 Funding (SB 1)
   - $92,571,356
3. Total Program Operations Funding:
   - $466,370,463 in FY 2010
   - $468,303,484 in FY 2011

FY 2010-2011 CMHCC Contracts:

Now that the session has ended, we must begin to work diligently with the three partners to sign a contract for FY2010-2011.

All partners have submitted their list of proposed changes and we will work through this in the next few weeks. The contracts need to be signed prior to the first quarter payment in September.

The CMHCC would like to thank all who assisted in providing information, support and resource testimony during the Legislative Session.

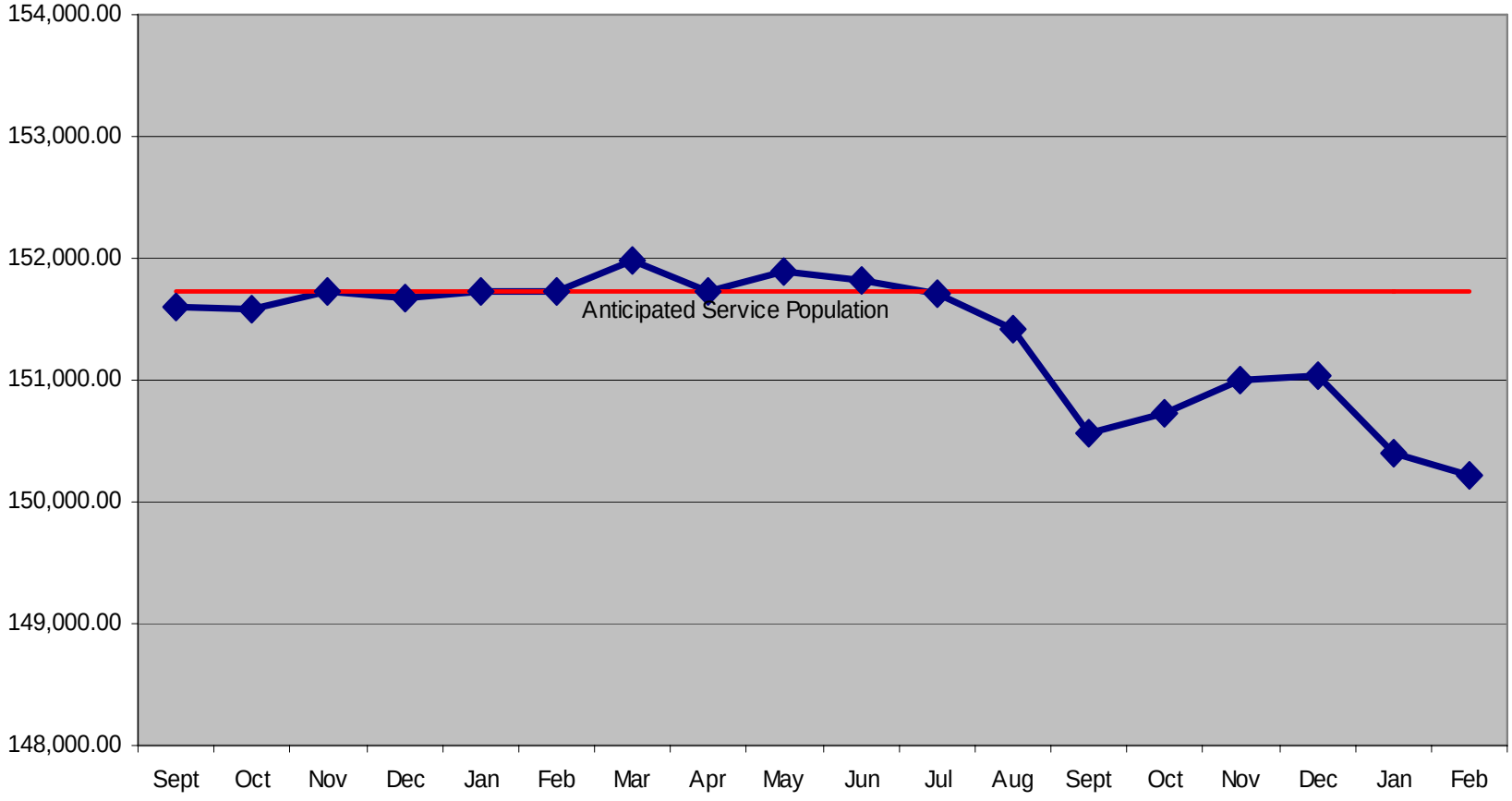
ARH:tb

Correctional Managed Health Care Committee

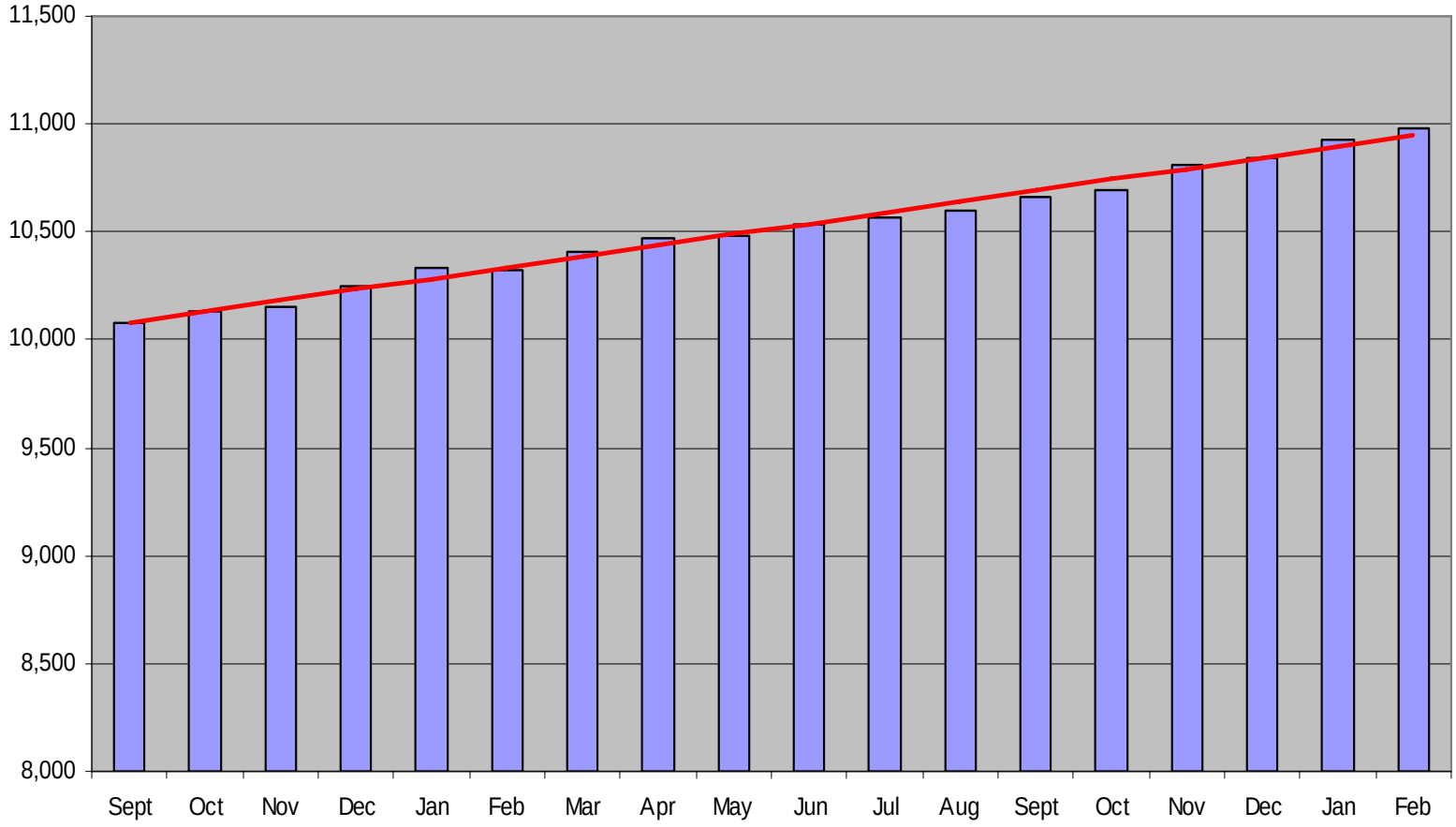
Key Statistics Dashboard

June 2009

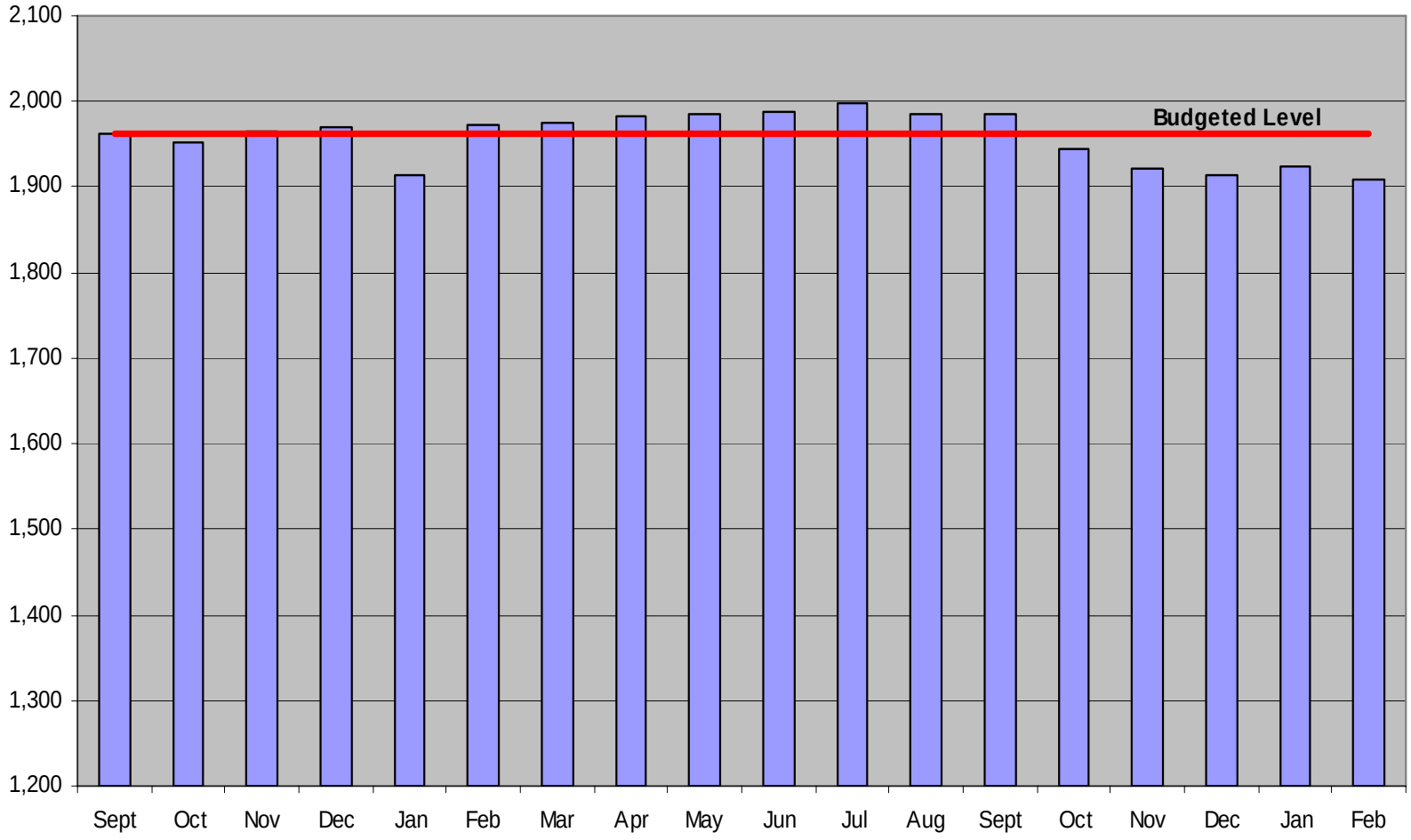
CMHC Service Population
FY 2008-2009 to Date



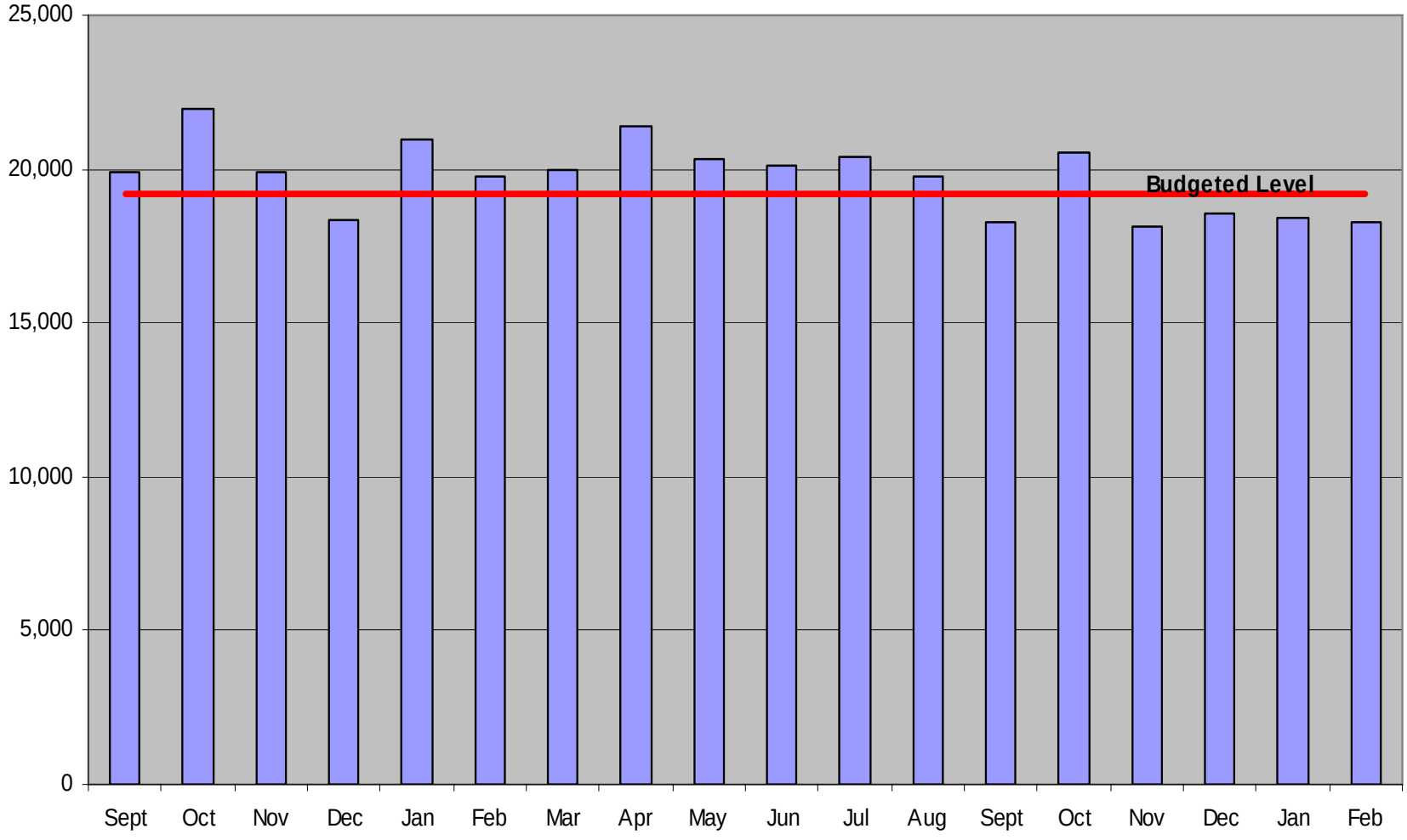
Offenders Age 55+
FY 2008-2009 to Date



Psychiatric Inpatient Census



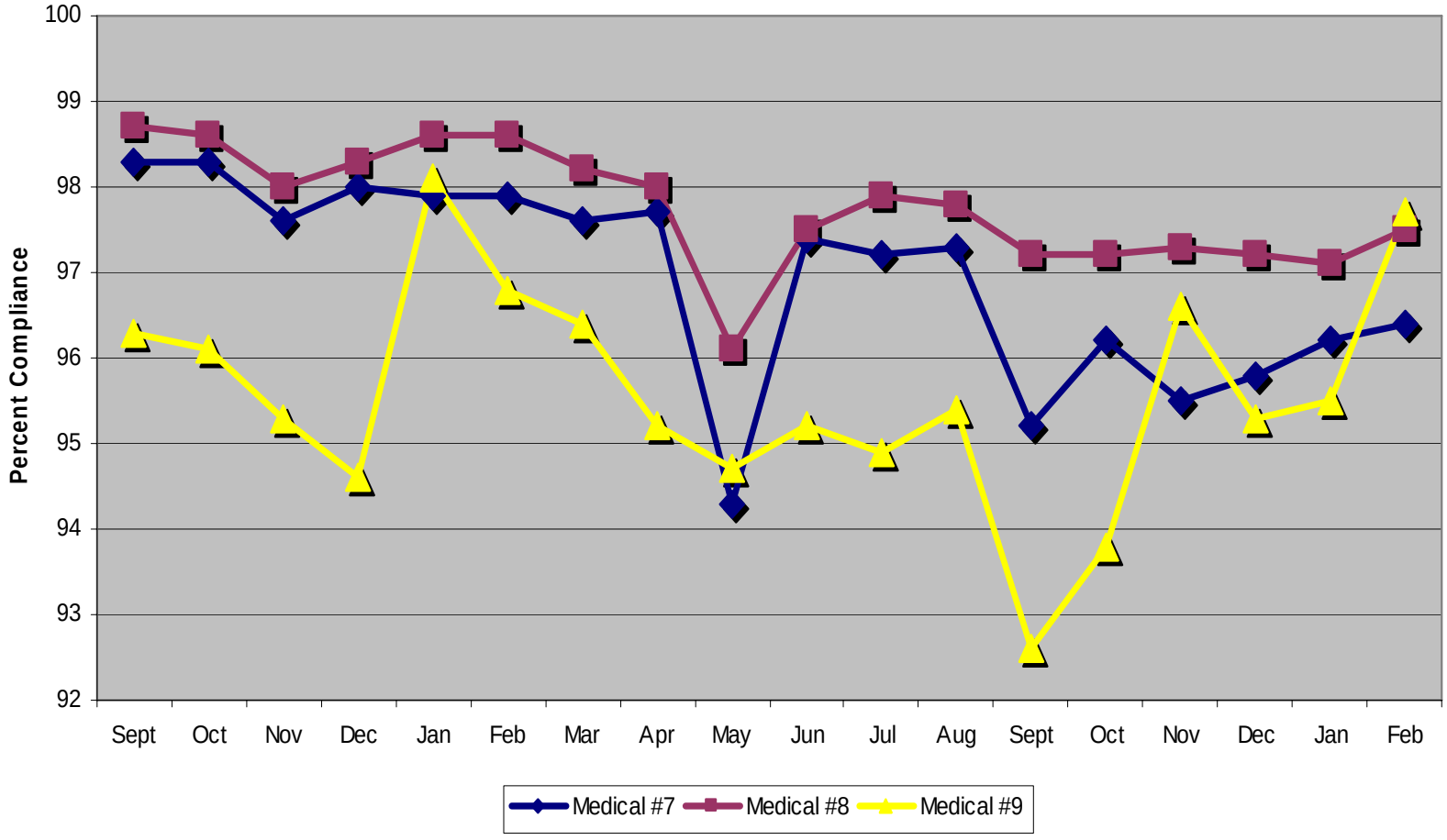
Psychiatric Outpatient Census



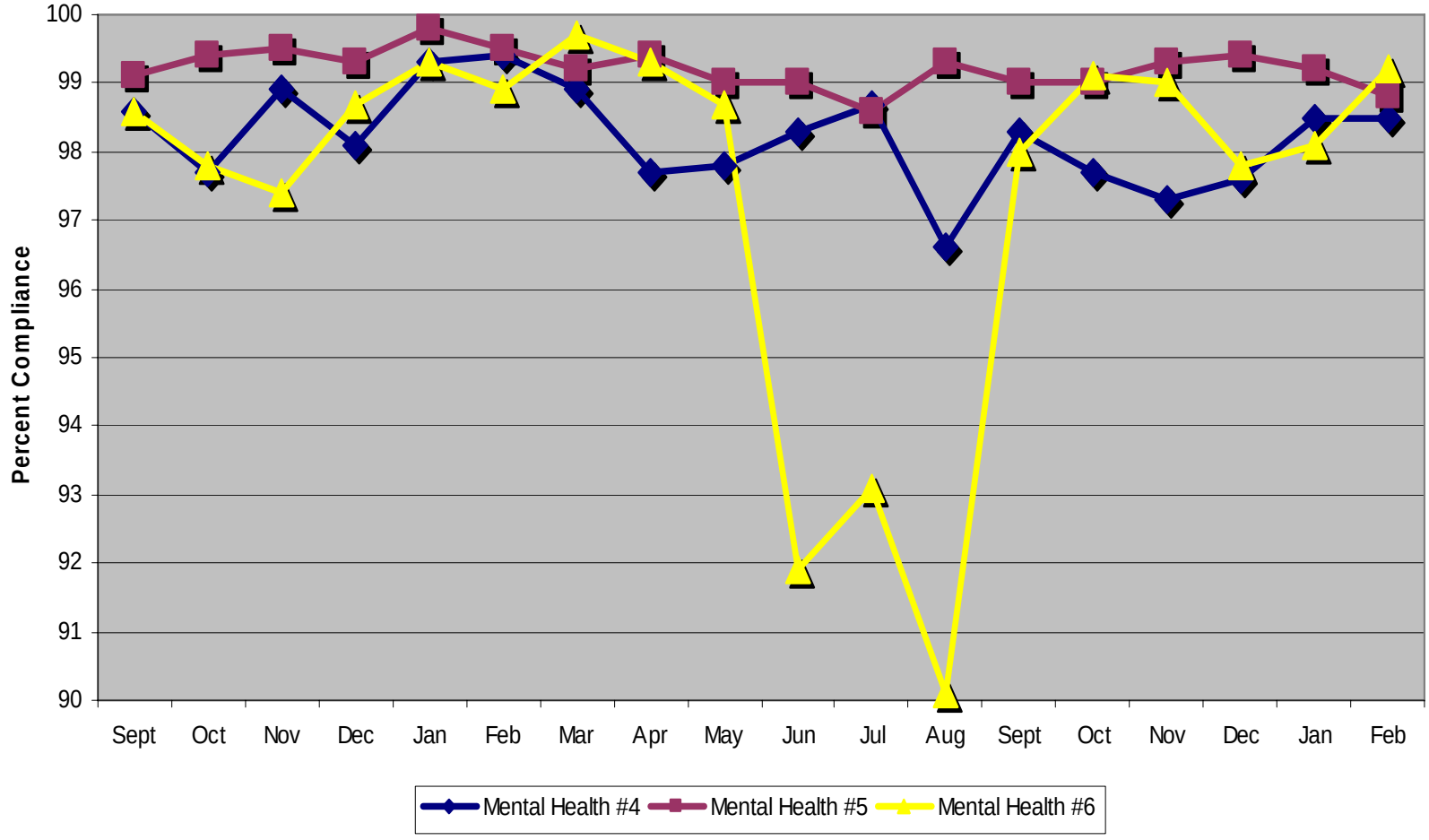
Access to Care Indicators

#1. Sick Call Request (SCR) physically triaged within 48 hrs (72 hrs Fri & Sat)
#2. Dental Chief Complaint Documented in Medical Record (MR) at Time of Triage
#3. Referral to Dentist (Nursing/Dental Triage) seen within 7 days of SCR Receipt
#4 SCR/Referrals (Mental Health) Physically Triaged with 48 hrs (72 hrs Fri & Sat)
#5 Mental Health (MH) Chief Complaint Documented in the MR at Time of Triage
#6 Referred Outpatient MH Status Offenders seen within 14 days of Referral/Triage
#7 SCR for Medical Services Physically Triaged within 48 hrs (72 hrs Fri & Sat)
#8 Medical Chief Complaint Documented in MR at time of triage
#9 Referrals to MD, NP or PA seen within 7 days of receipt of SCR

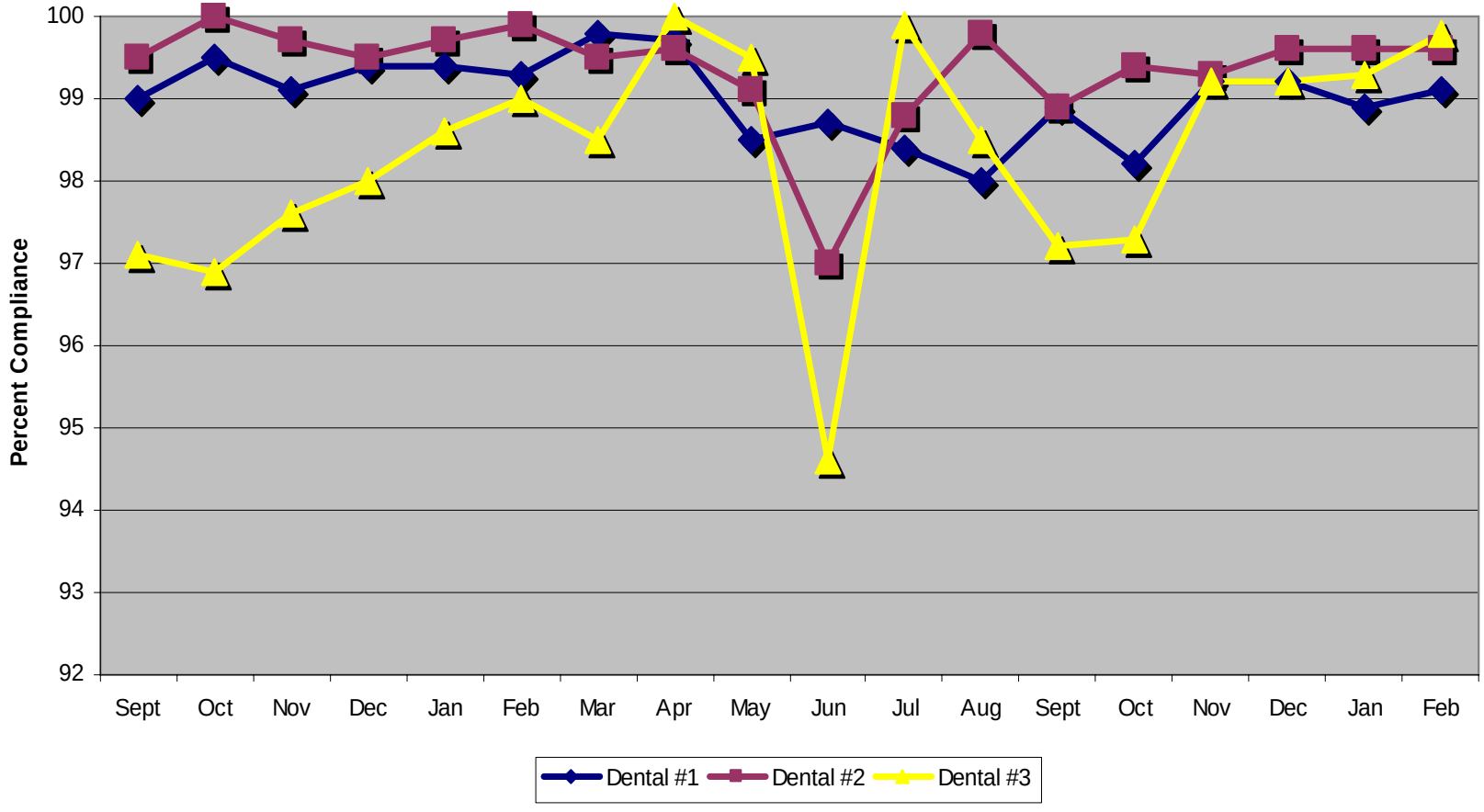
Medical Access to Care
Indicators FY 2008-2009 to Date



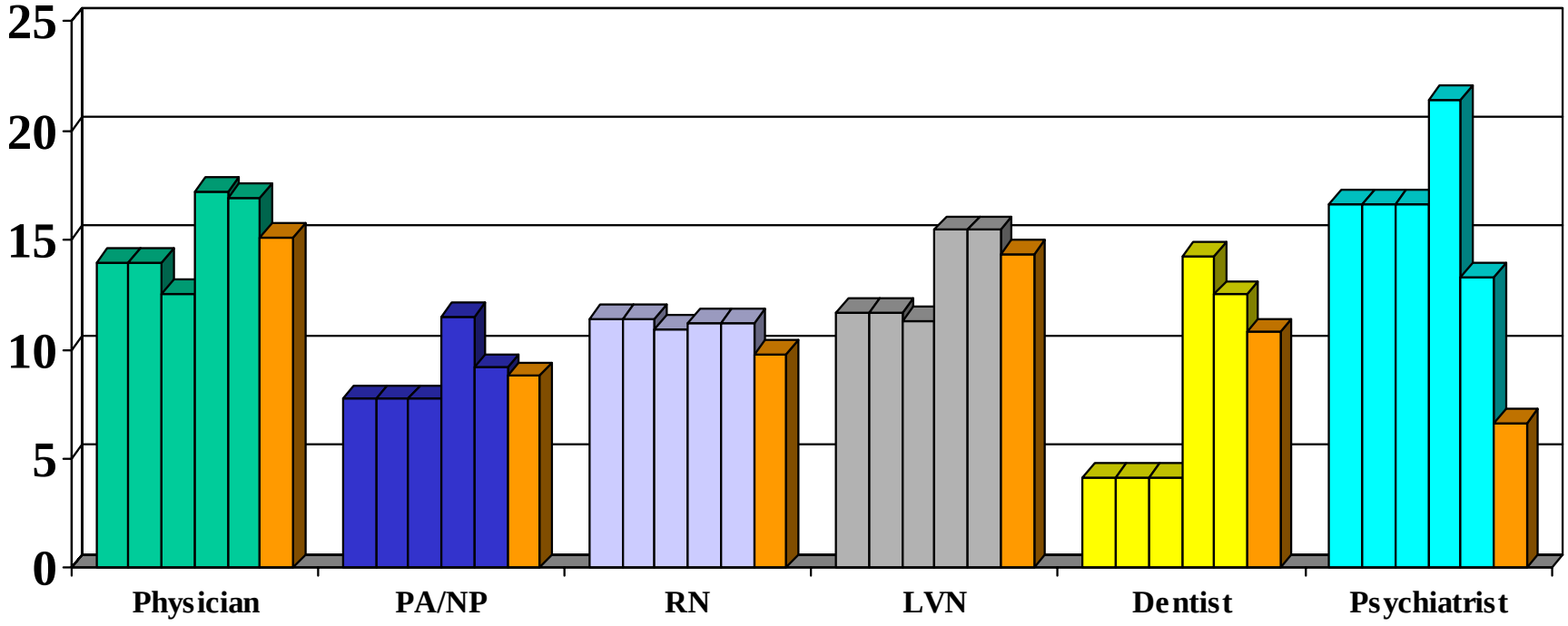
Mental Health Access to Care
Indicators FY 2008-2009 to Date



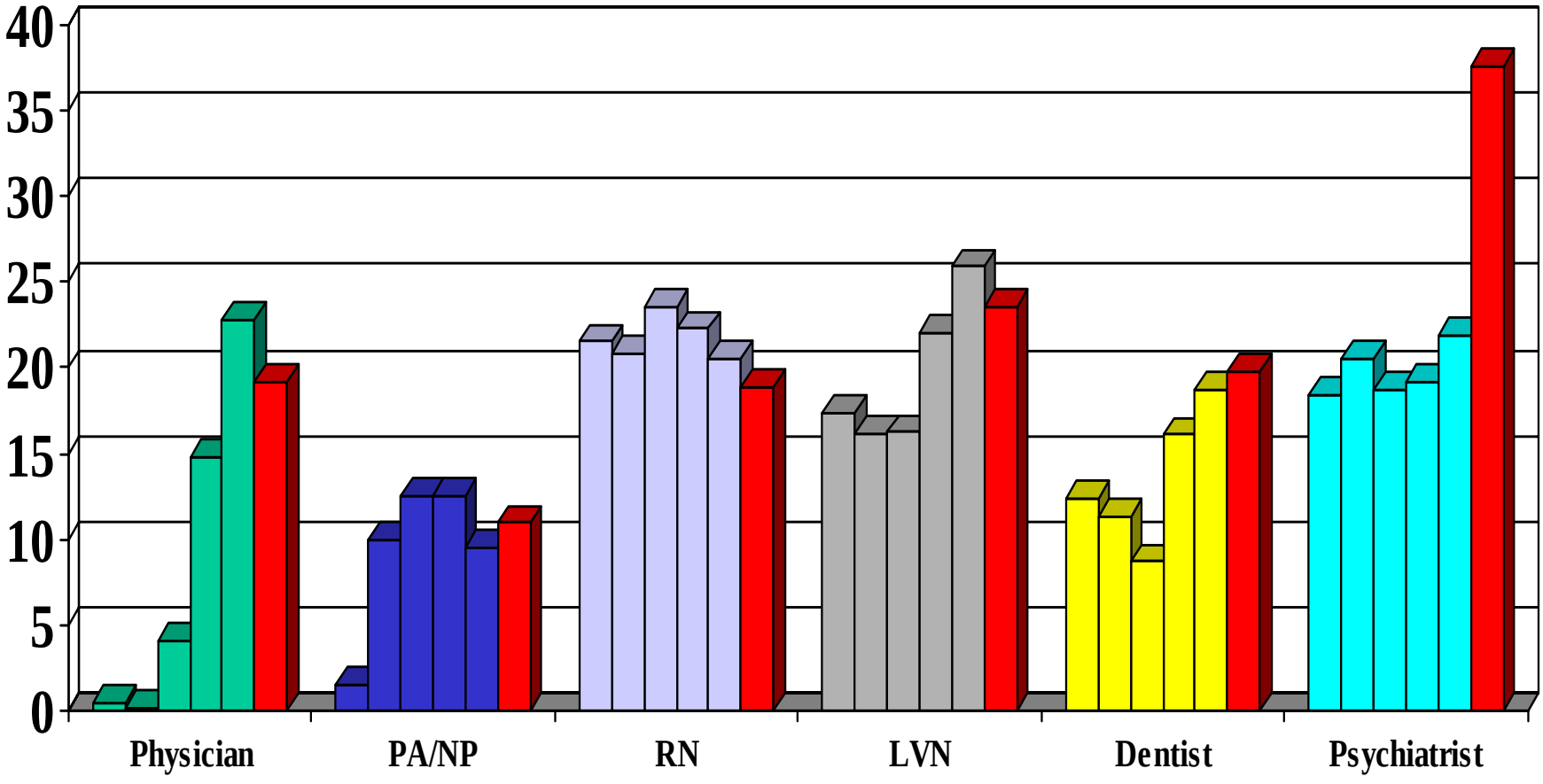
Dental Access to Care
Indicators FY 2008-2009 to Date



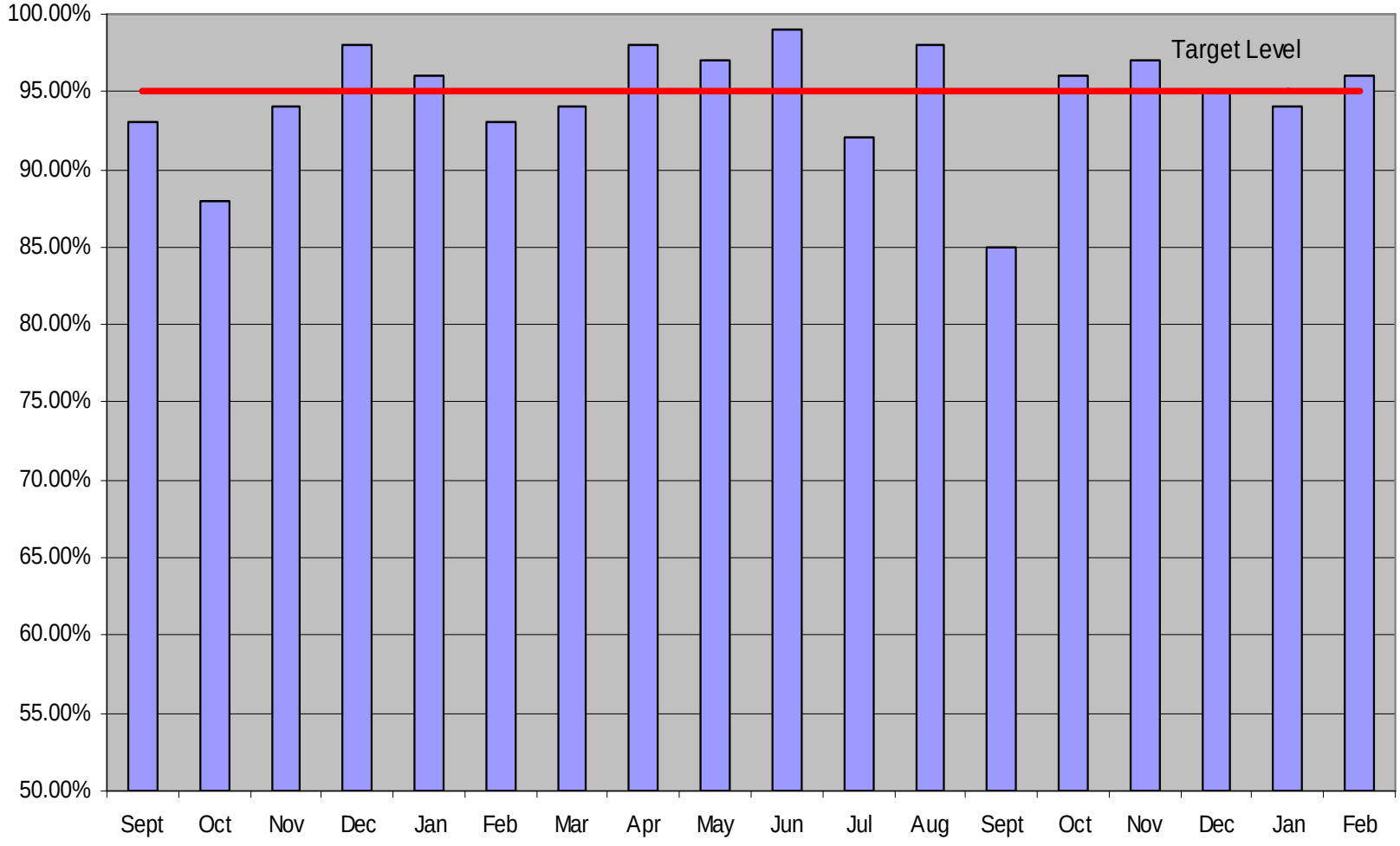
UTMB Vacancy Rates (%)
by Quarter FY 2008 - FY 2009



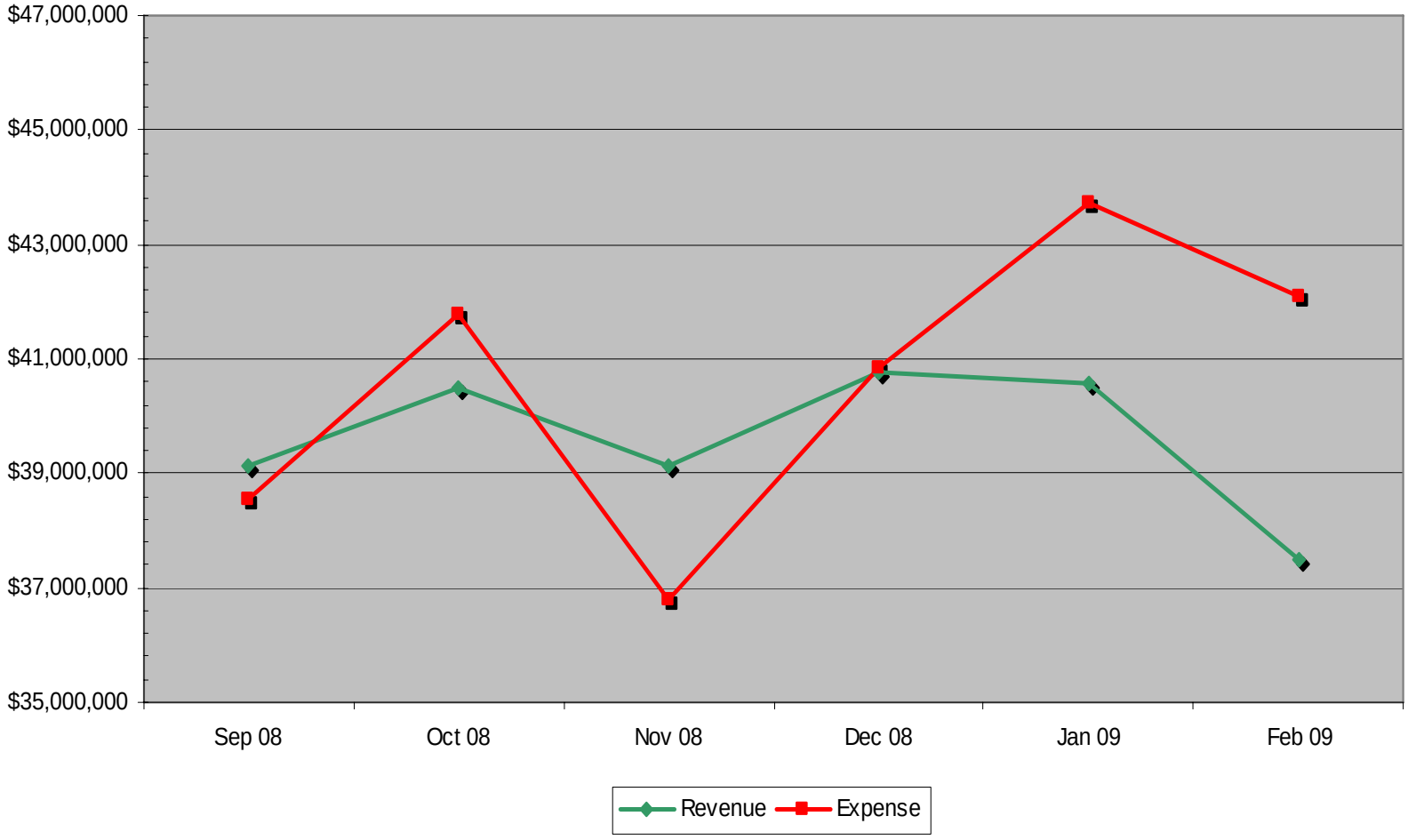
TTUHSC Vacancy Rates (%) by Quarter FY 2008 - FY 2009



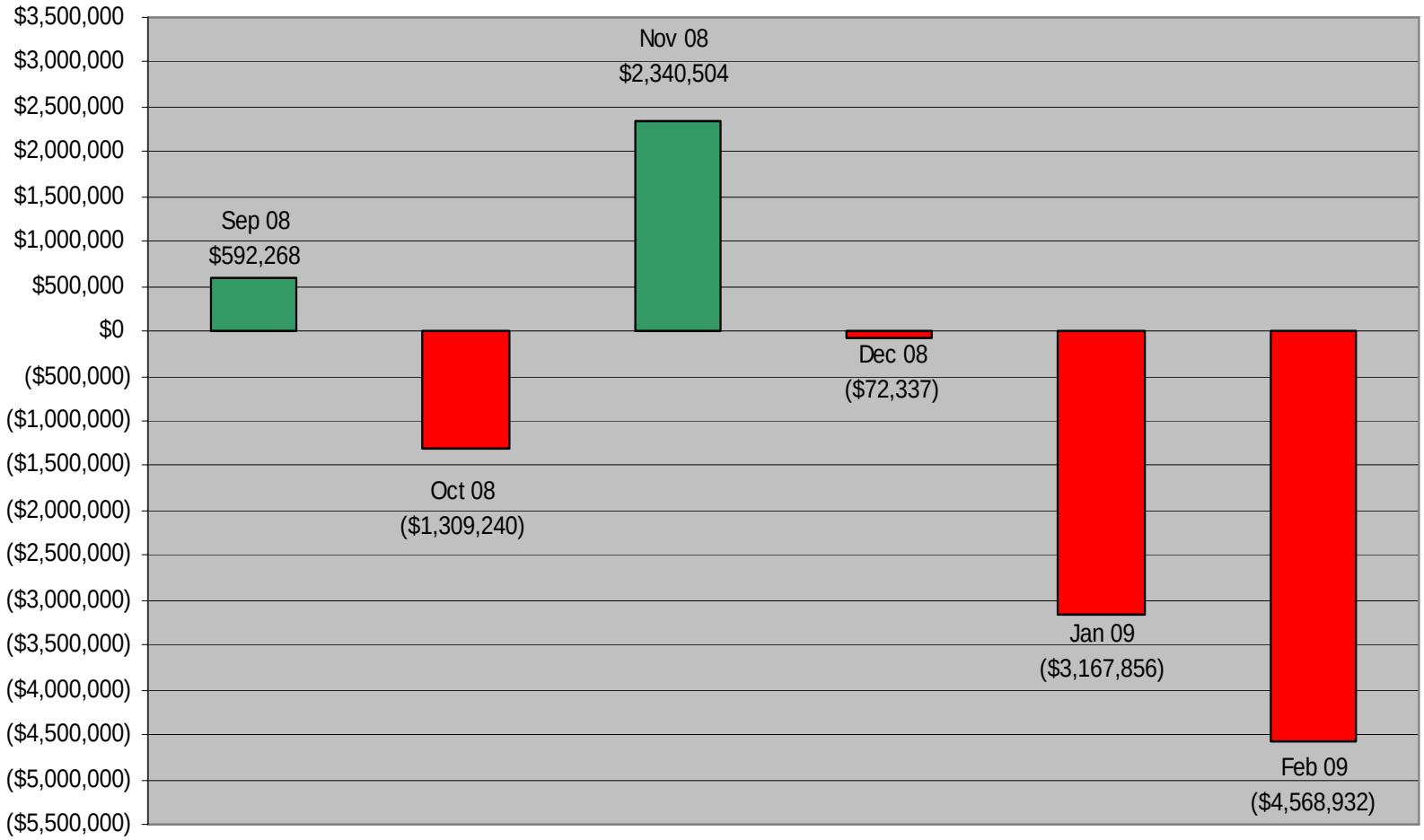
Percent of Timely MRIS Summaries FY 2008-2009



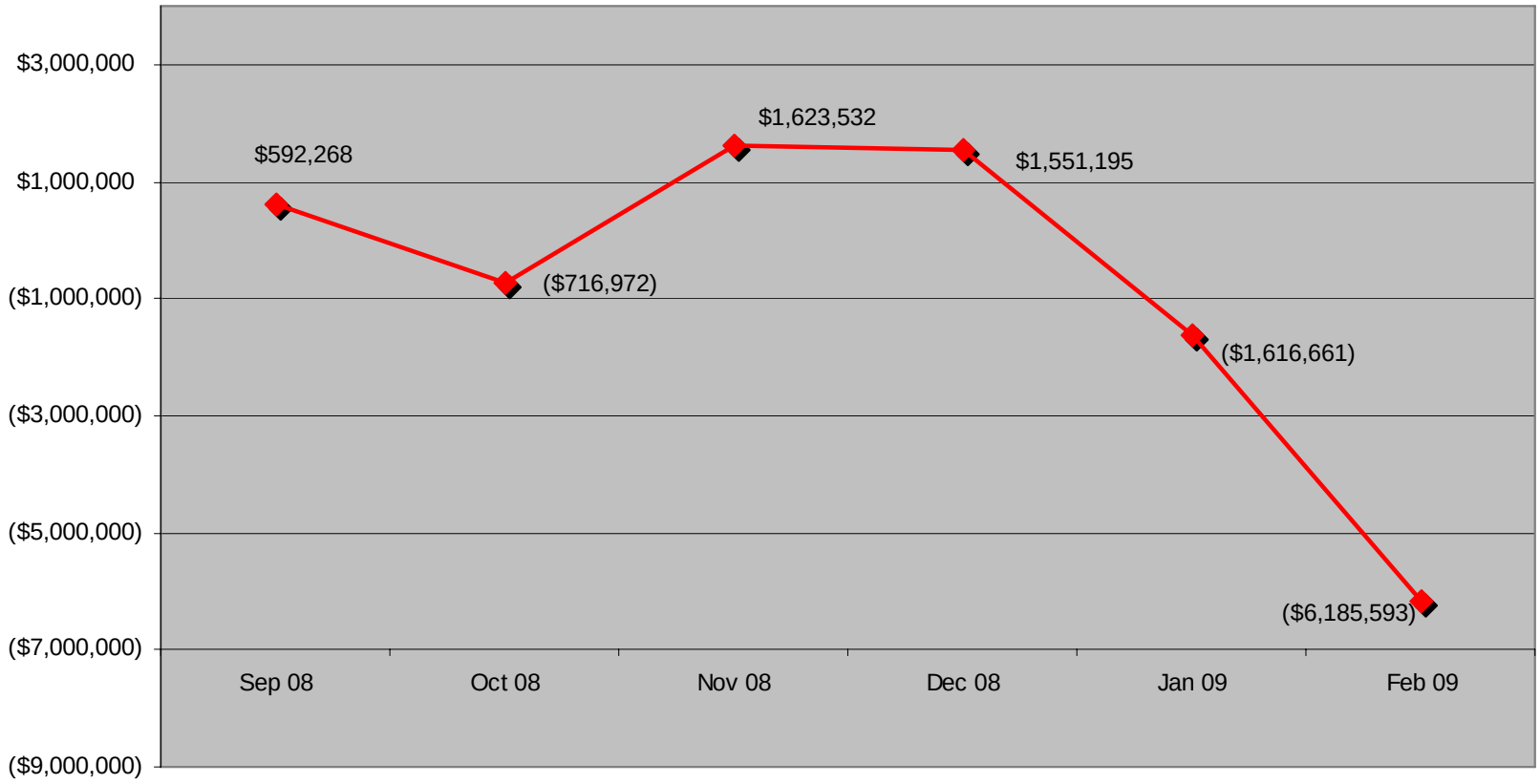
Statewide Revenue v. Expenses by Month
FY 2009



Statewide Loss/Gain by Month
FY 2009



Statewide Cumulative Loss/Gain
FY 2009



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

As of May 2009

Title of Position	CMHCC Partner Agency	Vacant Since (mm/yyyy)	Actions Taken to Fill Position
Physician II	TDCJ	09/01/2007	1 Part-time Position Remaining
Nurse II	TDCJ	03/05/2009	Posted 3/5/09; Re-posted: 5/15/09 due to no qualified applicants.
Nurse II	TDCJ	06/05/2009	Posted 5/20/09; Employee found other employment.
LVN III	TDCJ	05/15/2009	Posted 5/20/2009; Employee found other employment
Correctional Physician	TTUHSC	'08/2007	Enhanced Advertisement and Recruitment through newly contracted Agencies.
PAMIO Medical Director	TTUHSC	02/2009	Enhanced Advertisement and Recruitment through Newly Contracted Agencies.

Summary of Critical Correctional Health Care Personnel Vacancies
Prepared for the Correctional Managed Health Care Committee
Page 2

As of May 2009

Title of Position	CMHCC Partner Agency	Vacant Since (mm/yyyy)	Actions Taken to Fill Position
Psychiatrists	UTMB CMC	4/1/2009	Local and National Advertising, Conference, Contract with Timeline National Recruiting and other Agency Staffing
Dentists	UTMB CMC	3/23/2007	Local and National Advertising, Affiliation with Agency Recruiters
Physician I-III	UTMB CMC	9/1/2006	Local and National Advertising, Conferences, Timeline National Recruiting and other agency
Mid Level Practitioners (PA and FNP)	UTMB CMC	9/1/2006	Local and National Advertising, Career Fairs, Conferences, Intern programs with numerous PA schools
Physical Therapists	UTMB CMC	11/1/2008	Local Advertising, Direct Mails to Texas Licensed Therapists, Agency Contracts

TEXAS DEPARTMENT OF CRIMINAL JUSTICE
HEALTH SERVICES DIVISION

TO: Correctional Managed Health Care Committee

FROM: Mike Kelley M.D., M.P.H.
Director of Preventive Medicine

DATE: May 13, 2009

SUBJECT: Proposed Changes to Infection Control Manual Policies

The changes requested for Infection Control Manual Policy B-14.11, Human Immunodeficiency Virus (HIV) Infection, are indicated by underline and strikeout text on the copy in the meeting package. The changes were reviewed and recommended by the Infection Control Committee.

The changes in the policy statement and in Procedure II are intended to clarify to medical staff that pre-test counseling is no longer required. Post-test counseling is required for positive results; this is unchanged from the current version of the policy. These changes are in accordance with recommendations from the CDC and the Department of State Health Services to eliminate pre-test counseling to reduce barriers to testing.

The changes in Procedures I.A and I.B are proposed in order to separate medical staff from the unit disciplinary process, as discipline should not be part of the provider-patient relationship. This separation is recommended in a guideline from the US Department of Justice.

The changes requested for Infection Control Manual Policy B-14.13, Hepatitis, are also indicated by underline and strikeout text on the copy in the meeting package. The changes were reviewed and recommended by the Infection Control Committee and the Pharmacy and Therapeutics Committee. These changes are proposed to update the policy to the most current national guidelines on the management of hepatitis B that are published by the American Association for the Study of Liver Disease and the 2008 NIH Consensus Statement on Management of Chronic Hepatitis B. The major effect of the changes are to reduce the ALT threshold for considering treatment from twice the upper limit of normal to simply an elevated level. This also simplifies the disease management pathway. Corresponding changes are also made in the Technical Reference document.

Infection Control Policy B-14.11

Human Immunodefeciency Virus (HIV) Infection

HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION

INTRODUCTION

The Department of Health and Human Services (HHS) and the Henry J. Kaiser Foundation sponsored the panel on clinical procedures for the treatment of HIV infection. Similarly, the office of AIDS Research of the National Institute of Health (NIH) sponsored the NIH panel to define principles of therapy of HIV infection. This panel was asked to delineate the scientific principles, based on our understanding of the biology and pathogenesis of HIV infection and disease, that should be used to guide the most effective use of antiretroviral therapy and viral load testing in clinical practice. Two documents were published, The Report of the NIH Panel to Define Principles of Therapy for HIV Infection developed by the NIH panel and the Guidelines for the Use of Antiretroviral Agents in HIV Infected Adults developed by the HHS panel. Together, these reports summarize new data and provide both the scientific basis and specific guidelines for the treatment of HIV infected persons. These recommendations have been incorporated in Health Services policy B-14.11 Human Immunodeficiency Virus (HIV) Infection. The goal of this policy is to assist the facility clinicians and offenders in making informed decisions about treatment **options** so that:

1. Effective antiretroviral therapy is introduced, before extensive immune system damage has occurred.
2. Viral load monitoring is used as an essential tool to determine an HIV infected individuals risk of disease progression and response to antiretroviral therapy.
3. Combinations of antiretroviral drugs are used to suppress HIV replication to below the limits of detection of sensitive viral load assays.
4. Patient adherence to the complicated regimen combination antiretroviral therapy currently required to achieve durable suppression of HIV replication is encouraged by patient-provider relationships that provide education and support concerning the goals, strategies and requirements of antiretroviral therapy.

The treatment recommendations in this policy are meant to serve as **guidelines**. The guidelines are **not** intended to substitute for the judgement of a physician with expertise in the care of HIV infected individuals. The treatment of all HIV infected offenders, where possible, should be directed by a physician with experience in the care of these patients. When this is not possible, the offender should be scheduled for consultation with an infectious disease specialist. This may be accomplished via telemedicine where available. If the offender refuses, contact the Infectious Disease clinic to obtain a **verbal** ITP or contact an experienced HIV treatment practitioner for ITP recommendations which may include pharmacotherapy consultation from clinical pharmacists.

POLICY: Screening and evaluation of inmates at risk for HIV will be standardized. HIV counseling will be conducted by a licensed health care provider or an employee who has completed a TDCJ Health Services-approved training course in HIV counseling. All offenders with a positive HIV test must receive post test counseling and HIV negative offenders should receive information about the meaning of the negative test and risk reduction. Any required counseling must be documented in the medical record The following basic management protocol for inmates with AIDS or HIV infection should be followed.

PROCEDURES

I. HIV ANTIBODY TESTING

A. ROUTINE ANTIBODY TESTING. HIV antibody testing will be available to all inmates upon request. Requests for voluntary tests need not be honored any more frequently than every six months. Because TDCJ wishes to encourage HIV screening, HIV tests should be considered to be TDCJ-directed testing and not subject to co-pay. HIV testing shall be done on all offenders entering TDCJ unless the offender specifically refuses testing. (~~I.e., they should be informed they will be tested unless they refuse~~ see Section I.B for instructions on managing refusals of mandatory tests) or if they are documented to be already infected. Routine testing should also be offered to individuals in the following categories whenever they are identified during their incarceration, if they have not previously been tested:

- Unprotected sexual activity with multiple sex partners.
- Injection drug users (specifically, sharing of unsterilized drug injection equipment) and their sexual partners.
- Inmates who are on dialysis.
- Hemophiliacs.
- Psychiatric inpatients who are acutely psychotic and display clinical symptoms consistent with AIDS-related dementia complex (at the discretion of the treating psychiatrist).
- Inmates who report a previous positive HIV test that has not been confirmed in TDCJ.
- Inmates who sexually assault other inmates during incarceration.
- As required by the Texas Department of Health if determined to be in the best interest of the public health.
- Inmates with a confirmed history of TB disease or a PPD $\geq$ 5 mm., syphilis, or any other sexually transmitted disease. (e.g. Genital herpes, genital warts-human papilloma virus, chlamydia, trichomoniasis, cervical dysplasia/CIN.)

B. MANDATORY TESTING. An offender may refuse routine testing. Special requests for permission to compel testing may be submitted to the Division Director for Health Services for approval in accordance with TDCJ Administrative Directive (A.D.) 6.60, Section V.B.

Mandatory testing of an offender who exposes a staff member to blood or body fluids will be done according to procedures in Correctional Managed Health Care Policy B-14.5. The order for mandatory testing requires approval from the TDCJ Health Services Division. Use of force to obtain blood for this testing is not permitted without a court order. Instead, the offender disciplinary process must be used when an offender does not comply with an order for mandatory testing.

Mandatory testing for HIV must be done prior to the release of an offender from a TDCJ Correctional Institutions Division (TDCJ-CID) facility in accordance with Sections 501.054(i) and 507.023(b) of the Texas Government Code. Processes for this are found in Procedure XII, below.

Every offender who is not already known to be HIV positive must be tested for HIV infection during the intake evaluation, as required by Section 501.054 of the Texas Government Code. Although the test is mandatory under law, consent for testing must still be obtained. If the offender refuses to consent to mandatory testing this must be documented in the medical record and the offender must be informed that the test is required by state law and that they ~~will be referred for~~ may receive a major disciplinary case if they do not cooperate with testing. If the offender still refuses, the unit Practice Manager or equivalent position will inform the Major by providing a written statement that the offender has refused a test required by state law ~~refer the offender to the unit disciplinary officer for action, according to disciplinary processes in place on the unit~~.

Intake units must report the number of tests done, number of refusals and number of diagnostic evaluations done to the Office of Preventive Medicine on a weekly basis as outlined in Procedure XII.

II. CONSENT FOR HIV ANTIBODY TESTING. A *verbal informed consent* **must** be obtained prior to drawing a blood sample to test for the presence of HIV. Documentation of the verbal consent ~~and required counseling (see Section I)~~ will be recorded by the clinician on the clinical note form (HSM-1) in the inmate's medical record.

III. INITIAL EVALUATION OF HIV+ INDIVIDUALS

A. **Medical history**, including sexual history. If offender was known to be HIV positive prior to entering TDCJ, or on a previous TDCJ incarceration, obtain records of

previous treatment.

B. **Physical examination** [including vitals, weight, general exam, neurologic examination and pelvic exam with PAP and GC/Chlamydia cultures]

C. **Baseline diagnostic testing**

1. CBC with differential
2. Chemistry profile to include LFTs, serum creatinine, fasting blood sugar and lipid profile
3. Hepatitis serology: HbsAg, Anti-HBs, anti-HBc total antibody, anti-HCV and anti-HAV total antibody.
4. Syphilis screen, e.g., RPR
5. Urine analysis
6. Calculated estimate of creatinine clearance (see disease management pathway)
7. $CD4^+$ lymphocyte analysis: baseline with confirmation performed 2-3 weeks after baseline
8. HIV RNA viral load determination
9. Varicella-Zoster Immune Status
10. Chest X-ray
11. PPD skin test

D. Newly identified offenders with HIV infection should receive an initial dose of pneumococcal vaccine if not previously vaccinated, or a booster dose if they have not previously had one and more than 5 years have elapsed since their initial dose. They must be offered hepatitis A and/or hepatitis B vaccination if they are susceptible.

Tests performed within 6 months prior to the diagnosis of HIV infection may be considered baseline and do not need to be repeated unless clinically indicated or required by other sections of this policy.

V. CLASSIFICATION OF HIV INFECTION: The classification system for HIV infection among adults categorizes persons on the basis of clinical conditions associated with HIV infection and $CD4^+$ T-lymphocyte counts. The system is based on three ranges of $CD4^+$ T-lymphocyte counts, the percentage of total lymphocyte count represented by the $CD4^+$ count, and three clinical categories. (Table 1 and Attachment A).

All HIV+ individuals will be classified by appropriate Health Services staff according to the 1993 CDC Revised Classification System for HIV Infection and recorded on the Master Problem List and PULHES upon initial evaluation and periodically thereafter as conditions change. Classification categories dependent on the CD4+ count should be based on the patient's **lowest** CD4+ count.

TABLE 1

1993 Revised Classification System for HIV Infection and Expanded AIDS Surveillance Case Definition for Adults*

	CLINICAL CATEGORIES		
$CD4^+$T-CELL CATEGORIES	**(A)** Asymptomatic, acute (primary) HIV, or PGL **	**(B)** Symptomatic, not (A) or (C) conditions	**(C)** AIDS-indicator conditions***
(1) ≥ 500/μl	A1	B1	C1
(2) 200 – 499/μl	A2	B2	C2
(3) <200/μl or < 14%**** AIDS-indicator T-cell count	A3	B3	C3

* Persons with AIDS-indicator conditions (Category C) as well as those with $CD4^+$T-lymphocyte counts less than 200/μl (categories A3 or B3) are reportable as AIDS cases.

** PGL = persistent generalized lymphadenopathy. Clinical Category A includes acute (primary) HIV infection.

*** See Attachment A and Table II

**** $CD4^+$ count as percentage of total lymphocyte count

An appropriate medical alert code must be entered on every offender with HIV infection. The following codes apply:

- 0420 – Asymptomatic HIV infection (CDC Classification A1, A2)
- 0421 – Symptomatic HIV infection (CDC Classification (B1, B2)
- 0422 – AIDS (CDC Classification A3, B3, C1, C2, C3)

VI. INDICATIONS FOR PLASMA HIV RNA TESTING The amount of HIV in a persons blood is the viral load. Plasma HIV RNA levels indicates the magnitude of HIV replication and its associated rate of $CD4^+$positive T cell destruction, while $CD4^+$positive T cell counts indicate the extent of HIV induced immune damage already suffered.

The laboratory parameters of plasma HIV RNA (viral load) and the $CD4^+$ positive T cell count as well as the clinical condition of the patient gives the practitioner important information about the **virologic** and **immunologic** status of the patient and the risk of disease progression to AIDS.

The viral load test is the essential parameter in decisions to **initiate** or **change** antiretroviral therapies. Measurement of the plasma HIV RNA level using quantitative methods may be performed as outlined in Table II.

Table II. Indications for Plasma HIV RNA Testing*

Clinical Indication	Information	Use
Syndrome consistent with acute HIV infection	Establishes diagnosis when HIV antibody test is negative or indeterminate	Diagnosis
Initial evaluation of newly diagnosed HIV infection	Baseline viral load set point	Decision to start or defer therapy
Every 3-4 months In patients not on therapy	Changes in viral load	Decision to start therapy
4 weeks after initiation of antiretroviral therapy	Initial assessment of drug efficacy	Decision to continue or change therapy
3-4 months after start of therapy	Maximal effect of therapy	Decision to continue or change therapy
Every 3-4 months In patients on therapy	Durability of antiretroviral effect	Decision to continue or change therapy
Clinical event or decline in $CD4^+$ T cells	Association with changing or stable viral load	Decision to continue, initiate, or change therapy

* Acute illness (e.g., bacterial pneumonia, tuberculosis, HSV, PCP) and immunizations can cause increases in plasma HIV RNA for 2-4 weeks; viral load testing; should not be performed during this time.

HIV RNA should be measured using the same laboratory and the same assay.

VII. TREATMENT

A. See the HIV Clinical Pathway for guidelines for initiating antiretroviral therapy and for prophylactic therapy of patients with AIDS.

B. A virtual phenotype test will be done before initiating treatment in a treatment naïve patient. Virtual phenotypes may be done at other times as determined by the specialty consultant.

VIII. COMPREHENSIVE FOLLOW-UP FOR HIV+ INDIVIDUALS:

A. **Housing:** HIV+ individuals should be housed *according to their behavior* and the housing guidelines established in A.D. 6.60, Section X (i.e., single cells, dormitory, general population, etc.) and Infection Control Manual Policy B-14.50.

When indicated according to the above-referenced policies, the unit **medical director** should update the inmate's *Health Summary for Classification* (HSM-18) to reflect special housing (house patient with like medical condition). Should inmates with HIV infection, chronic HBV or chronic HCV require special housing they should be housed with another inmate with like condition. HIV+ inmates should *not* be housed with those who have hepatitis B or C unless they are already coinfected with the same organisms.

B. HIV infected individuals should be evaluated in chronic disease clinic at least every six months, unless more frequent clinical monitoring is indicated or they are being seen more frequently in infectious disease clinic. Patients with $CD4^+$ counts <500/μl **will** be referred to a designated physician or infectious disease specialist. Specialist evaluations may be done by telemedicine. Referrals for patients who are candidates for initiating treatment according to the current HIV Clinical Pathway will have an expedited referral.

C. HIV infected individuals with $CD4^+ < 100$ should be referred to opthalmology clinic for a retinal examination to rule out HIV retinopathy and CMV retinitis.

D. For security reasons, the unit health authority may report to the warden, upon request, the names of inmates with a possible blood borne infectious disease (i.e., HBV, HCV, HIV). The physician **must not** disclose the specific infectious disease the inmate has.

E. All AIDS cases must be **reported** to the Office of Preventive Medicine by the CID nurse according to the revised surveillance case definition. In addition, all positive HIV antibody and confirmatory tests, and all $CD4^+$count and/or HIV RNA test results must be reported to the Office of Preventive Medicine. Reporting and confidentiality of HIV antibody results will be governed by the provisions of the Texas Communicable Disease Prevention and Control Act (Art. 81.001 et seq, *Texas Health and Safety Code*). All HIV information shall be sent by U.S. mail, double enveloped, and labeled "**Medically Confidential**".

F. Inmates with confirmed positive HIV test results shall **not** be assigned to **work** in the medical department, in order to protect the inmate from exposure to communicable diseases. There are no other work restrictions, except as dictated by the patient's clinical status.

G. HIV-infected individuals may require **counseling and support systems**, consisting of: physicians, psychiatrists, psychologists, dentists, nurses, chaplains, patient advocates and correctional counselors. These individuals may be involved as deemed necessary on a case-by-case determination.

IX. ADHERENCE TO TREATMENT AND DISCONTINUATION OF THERAPY – PREVENTING DRUG RESISTANCE

A. Antiretroviral medications will be administered by directly administered therapy (DAT). The drugs will not be given KOP.
B. Adherence to therapy will be monitored, and offenders will be counseled about the importance for adherence, and encouraged to improve adherence to therapy.
C. Adherence will be measured after each month of therapy. If adherence to any of the antiretroviral drugs falls below 90%, the patient will be counseled and adherence reassessed in one month. Counseling should be documented in the medical record. If adherence is below 90%, also consider the possibility of drug intolerance and consider changing treatment regimen if necessary.
D. If adherence is below 85% for two consecutive months the patient should be referred to the clinical pharmacist whenever possible for adherence counseling. Repeated referrals to the clinical pharmacist are not required if the patient continues to be non-compliant. See paragraph X.F, below.
E. If compliance remains below 85% for 2 months or more, an expedited referral to a designated physician or infectious disease specialist will be made. This appointment may be at the referral center or by telemedicine or digital medical service (DMS). Patients referred for compliance problems will be reviewed by the specialist every 2-4 weeks to determine the subsequent management of the case and possible discontinuation of antiretroviral treatment. Only the consultant may discontinue antiretroviral medications for low compliance.
F. If antiretroviral medications are stopped for noncompliance, the patient should generally be off treatment for 3 months. During the first 2 months off treatment the patient should receive at least 2 documented counseling sessions for drug compliance. These sessions may be provided by any licensed medical professional. During the third month off medications the patient should demonstrate ability to comply with treatment by presenting to the pill line as if he or she were receiving antiretroviral therapy. This compliance trial should be entered into the PH70 screen as “Compliance Check” x 30 days, non-KOP, with the dosing interval the same as the

previous antiretroviral treatment regimen. Since this is not a medication order, it can be entered on the authority of a nurse.

H. Consideration should also be given to discontinuing antiretroviral drugs when the offender is not benefiting from the treatment. If this is done, it should be done in consultation with an infectious disease specialist.

X. TREATMENT FAILURE

A. If the viral load becomes detectable while on antiretroviral therapy after being non-detectable, or if the viral load increases by a factor of 3 or more, the patient should be evaluated within one month by a designated physician or infectious disease specialist. If an appointment cannot be scheduled within that time frame, telephone consultation should be obtained. Therapy should continue unchanged pending the specialty evaluation.
B. Before determining that consultation is necessary:
   1. Assess compliance and counsel for improvement if necessary.
   2. Determine whether the patient wishes to continue treatment

XI. PRE-RELEASE TESTING

A. Every offender incarcerated in TDCJ-CID must be tested for HIV prior to release unless they are already known to be infected with HIV. Offenders leaving on bench warrant are not included as they are expected to return to TDCJ without being released. Although a test done within the last 6 months of incarceration may be counted as a pre-release test, every effort must be made to test offenders as close to the time of discharge as possible while still allowing time to inform the offender of the result (if positive) and to notify the Texas Department of State Health Services to carry out partner notification prior to release.
B. Offenders who require testing can be identified by running the HIVRL report for your unit. This report is found under the SO00 screen on the mainframe. It is updated daily with offenders scheduled to be released within the next 6 months. It is very important to obtain this list at least weekly because offenders being released under discretionary mandatory supervision will not appear on the list until 7-14 days before their release.
C. It is the responsibility of the unit of assignment prior to release to perform the HIV test. However, an offender who is not tested on his last assigned unit must be tested as soon as he is identified, even if they are in transit or have already arrived at the unit from which they are being released.
D. Highest priority for testing should be those scheduled for release within the next month.
E. Offenders must receive pre-test counseling and give consent for the test, even though

it is mandatory. Verbal consent is acceptable if it is documented in the medical record and the test is done more than 30 days before release. If the test is done less than 30 days before release, a written consent must be obtained using the "Consent for Pre-release HIV Testing" form. Post release locating information must be recorded on this form in case the offender must be contacted after release to receive a positive result.

F. If an offender refuses mandatory pre-release testing, the refusal must be documented in the medical record. The offender must be informed that the test is required by state law and that they will be referred for a major disciplinary case if they do not cooperate with testing. If the offender still refuses, the unit Practice Manager or equivalent position will refer the offender to the unit disciplinary officer for action, according to disciplinary processes in place on the unit.
G. The HIV test must be designated as a pre-release HIV test. A specific "Pre-release HIV Test" is available when ordering the test on the EMR. Otherwise, "pre-release test" must be recorded on the laboratory request slip.
H. The date of the HIV test must be entered by updating the MEDI screen. It is vital to do this promptly, as the information cannot be entered after the offender is released. The information may also be entered through the AD option under the HI00 screen on the mainframe.
I. Offenders with a positive result must receive individual post-test counseling. Because release is imminent, this counseling must be offered promptly when the result is received. During counseling the offender must receive information about services available in their area. In addition, partner elicitation must be carried out and include at a minimum the name and address of a spouse or significant other to whom the offender will be returning after release.
J. Positive pre-release HIV results and partner information must be reported to the Office of Preventive Medicine within one business day.

XII. REPORTING

A. Positive HIV antibody and western blot results must be reported to the Office of Preventive Medicine within 7 days of receipt.
B. CD4+ counts and viral loads must be reported to the Office of Preventive Medicine within 7 days at the following intervals:
    a. Initial results
    b. Results that indicate a change in CDC classification
    c. First occurrence of a CD4 count below 500
    d. First occurrence of a CD4 count below 350
    e. First occurrence of a viral load over 100,000
    f. Initial undetectable viral load result
    g. A detectable viral load after becoming undetectable on treatment
C. Intake units must report the following information to the Office of Preventive Medicine by Tuesday of each week, for the preceding week. Reporting may be by email or fax.

a. Number of intake HIV tests done
b. Number of intake HIV tests refused
c. Number of intake medical diagnostic evaluations done
d. Number of intakes received

XIII. DISCHARGE PLANNING

A. 3-6 months before the projected release date, counseling about preparing for continuity of care after release should be initiated with the offender. Discharge plans are prepared for HIV positive offenders during this time frame by the Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI). Offenders should be encouraged to cooperate with the TCOOMMI Continuity of Care worker, and to consider contacting community based organizations in their community prior to release.
B. Prior to release the offender should be provided copies of his last HIV chronic care note, last infectious disease clinic note, latest viral load and CD4+ results and his medication pass.
C. The medical certification page of the Texas HIV Medication Program application should be filled out and given to the offender along with the medical records listed in XII.B. This form requires the signature of a physician or midlevel staff, but can be filled out by anyone having access to and understanding of the information required.

XIV. EDUCATION AND TRAINING OF STAFF AND INMATES:

Refer to TDCJ Administrative Directive 6.60, Section XI.

Infection Control Policy 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, and HBV-DNA, if the patient is potentially a candidate for treatment.
   4. Vaccinate against hepatitis A if susceptible.
   ~~5. Patient should be referred to be evaluated for treatment if HBV-DNA is ≥ 20,000 and ALT ≥ 2 x ULN.~~
      ~~a. Consider referring for treatment if HBeAg is positive, HBV-DNA is ≥ 20,000, ALT 1-2 x ULN and patient is over 40.~~
      ~~b. 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.~~
   5. Patient should be referred to be evaluated for antiviral treatment if
      a. There is evidence of uncompensated cirrhosis and HBV-DNA is detectable, or
      b. There is evidence of compensated cirrhosis and HBV-DNA is ≥ 2,000 IU/mL, or
      c. HBeAg is negative, ALT is elevated and HBV-DNA is ≥ 2,000 IU/mL, or
      d. HBeAg is positive, ALT is elevated and HBV-DNA is ≥ 20,000 IU/mL
   6. A liver biopsy should be considered to help make a decision about treatment if
      a. HBeAg is negative, ALT is normal and HBV-DNA is ≥ 2,000 IU/mL, or
      b. HBeAg is negative, ALT is elevated and HBV-DNA is < 2,000 IU/mL, or
      c. HBeAg is positive, ALT is normal and HBV-DNA is ≥ 20,000 IU/mL, or
      d. HBeAg is positive, ALT is elevated and HBV-DNA is < 20,000 IU/mL

7. 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.
8. 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 or II.D.6, 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 or biopsy as indicated.
   b. If the patient is not referred to be evaluated for treatment or biopsy, 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 be screened for HCC every 6 to 12 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. If the patient has esophageal varices or ascites consider the use a beta blocker to treat portal hypertension.

C. Consider referring patients with uncompensated cirrhosis to Gastroenterology to be evaluated for possible referral to be considered for liver transplant. The decision to refer a patient must be made on a case by case basis.

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

E. Patients with evidence of compensated or uncompensated cirrhosis must be enrolled in chronic care clinic. They must have bilirubin, creatinine, and INR done every 6 months in addition to any laboratory tests that are clinically indicated. They should be screened for hepatocellular carcinoma every 6 – 12 months.

F. 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 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

G. 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, patients with a MELD score over 22 or with recurrent ascites, recurrent bleeding esophageal varices or recurrent hepatic encephalopathy should be considered for nomination for MRIS.

H. 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

Infection Control Policy 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). HBV-DNA may be reported in copies/mL or in IU/mL. 1 IU/mL is approximately equal to 6 copies/mL. Most labs should be reporting in IU/mL at this time. The level of 2~~0~~,000 IU/ml that is currently used as a diagnostic criterion for chronic hepatitis B is an arbitrary value ~~set at~~ recommended by the American Association for the Study of Liver Disease ~~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.~~ 2,000 in HBeAg negative individuals or over 20,000 in HBeAg positive individuals is an indication for treatment if their ALT level is abnormal. 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,~~ If the ALT is persistently normal, but the HBV-DNA is over 2,000 (20,000 if HBeAg positive) or if the HBV-DNA is below the threshold but the ALT is persistently elevated, treatment may be considered, but 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 DEPARTMENT OF CRIMINAL JUSTICE

HEALTH SERVICES DIVISION MEDICAL DIRECTOR'S REPORT

Second Quarter FY-2009

Lannette Linthicum, MD, CCHP-A, FACP

TDCJ Medical Director's Report

Office of Health Services Monitoring (OHSM)

Operational Review Audit (ORA)

- During the second quarter of FY-2009 (December 2008, January, and February 2009), 10 Operational Review Audits were conducted at the following facilities: Beto, Cleveland, Diboll, Duncan, Hobby, Marlin, Ney, San Saba, Torres, and Young. The nine items most frequently out of compliance follow:

1. Item 5.04(3) requires that the facility's self-reported Access to Care audit be performed accurately. Eight of the 10 facilities were not in compliance with this requirement. The eight facilities out of compliance were: Beto, Cleveland, Diboll, Duncan, Hobby, Marlin, San Saba, and Young. Corrective actions were requested from the eight facilities. Beto, Cleveland, Duncan, Hobby, San Saba, and Young have submitted corrective action plans which have been accepted and the audit process for these units are closed. Two of the eight facility audits remain open at this time. The action plans of the following facilities have been submitted with TDCJ Health Services Division's approval pending as of the date of this report: Diboll and Marlin.

2. Item 5.14 requires that a dated and signed Certification and Record of Segregation visit form have an attached current housing roster. Eight of the 10 facilities were not in compliance with this requirement. The eight facilities out of compliance were: Beto, Cleveland, Diboll, Duncan, Marlin, Ney, Torres, and Young. Corrective actions were requested from the eight facilities. The corrective action plans for the Beto, Cleveland, Duncan, Ney, Torres, and Young Units have been accepted and the audit process for these units is closed. Two of the eight facility audits remain open at this time. The action plans of the following facilities have been submitted with TDCJ Health Services Division's approval pending as of the date of this report: Diboll and Marlin.

3. Item 5.10 requires 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 including the diet type and duration. Seven of the 10 facilities were not in compliance with this requirement. The seven facilities out of compliance were: Beto, Diboll, Duncan, Hobby, Marlin, Ney, and Young. Corrective actions were requested from the seven facilities. The corrective action plans for the Beto, Duncan, Ney, Torres, and Young Units have been accepted and the audit process for these units is closed. Two of the seven facility audits remain open at this time. The action plans of the following facilities have been submitted with TDCJ Health Services Division's approval pending as of the date of this report: Diboll and Marlin.

4. 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 10 facilities were not in compliance with this requirement. The eight facilities out of compliance were: Beto, Diboll, Duncan, Hobby, Ney, San Saba, Torres, and Young. Corrective actions were requested from the eight facilities. The corrective action plans for the Beto, Duncan, Hobby, Ney, San Saba, Torres and Young Units have been accepted and the audit process for these units is closed. One of the eight facility audit remains open at this time. The action plans of the following facilities have been submitted with TDCJ Health Services Division's approval pending as of the date of this report: Diboll.

5. Item 4.02 requires offenders identified as having potential mental health needs, have a mental health evaluation completed by a Qualified Mental Health Professional within fourteen days of identification or referral. Six of the 10 facilities were not in compliance with this requirement. The six facilities out of compliance were: Beto, Hobby, Marlin, Ney, San Saba and Torres.

Operational Review Audit (ORA) Cont'd.

Corrective actions were requested from the six facilities. The corrective action plans for the Beto, Hobby, Ney, San Saba, Torres, and Young Units have been accepted and the audit process for these units is closed.

6. Item 5.19 requires the medical provider document on the HSM-4 physical exams annually, on male offenders 60 years of age or older, to include digital rectal exam and fecal occult blood testing. Six of the 10 facilities were not in compliance with this requirement. The six facilities out of compliance were: Beto, Diboll, Duncan, Marlin, Ney, and Torres. Corrective actions were requested from the six facilities. The corrective action plans for the Beto, Duncan, Ney, and Torres Units have been accepted and the audit process for these units is closed. Two of the six facility audits remain open at this time. The action plans of the following facilities have been submitted with TDCJ Health Services Division's approval pending as of the date of this report: Diboll and Marlin.

7. Item 6.34 (2) requires all Hepatitis C Virus (HCV) infected patients with an Aspartate Aminotranferase (AST) Platelet Ratio Index (APRI) score greater than 0.42 or Abnormal liver function (Prothrombin Time (PT), Total Bilirulin (Tbili), or Albumin (alb) be referred to the designated physician, clinic, or appropriately treated according to Correctional Managed Health Care (CMHC) Hepatitis C evaluation and treatment pathway. Six of the 10 facilities were not in compliance with this requirement. The six facilities out of compliance were: Cleveland, Diboll, Duncan, Marlin, Ney, and Torres. Corrective actions were requested from the six facilities. The corrective action plans for the Cleveland, Duncan, Ney, and Torres Units have been accepted and the audit process for these units is closed. Two of the six facility audits remain open at this time. The action plans of the following facilities have been submitted with TDCJ Health Services Division's approval pending as of the date of this report: Diboll and Marlin.

8. Item 3.08 requires that dental staff review the incoming health records for priority one conditions. Five of the 10 facilities were not in compliance with this requirement. The five facilities out of compliance were: Cleveland, Hobby, Ney, San Saba, and Torres. Corrective actions were requested from the five facilities. The corrective action plans for the Cleveland, Hobby, Ney, San Saba, and Torres Units have been accepted and the audit process for these units is closed.

9. Item 6.33 (1) requires that platelet counts and AST values are obtained to calculate the APRI score at least annually for all patients chronically infected or newly diagnosed with HCV. Five of the 10 facilities were not in compliance with this requirement. The five facilities out of compliance were: Cleveland, Diboll, Marlin, Torres, and Young. Corrective actions were requested from the five facilities. The corrective action plan for the Cleveland, Torres, and Young Units has been accepted and the audit process for these units is closed. Two of the five facility audits remain open at this time. The action plans of the following facilities have been submitted with TDCJ Health Services Division's approval pending as of the date of this report: Diboll and Marlin.

Grievances and Patient Liaison Correspondence

During the second quarter of FY-2009 (December 2008, January, and February 2009), the Patient Liaison Program and the Step II Grievance Program received 2,651 correspondences. The Patient Liaison Program had 1,302 and Step II Grievance had 1,349. Of the total number of correspondence received, 331 (12.49 percent) Action Requests were generated by the Patient Liaison Program and the Step II Grievance Program. The percentage of sustained offender grievances for Step II medical grievances is 8.3 percent.

Quality Improvement (QI) Access to Care Audits

During the second quarter of FY-2009 (December 2008, January, and February 2009), the Patient Liaison Program nurses and investigators performed 115 Access to Care (ATC) audits. The ATC audits looked at verification of facility information. A random sample of Sick Call Requests was also audited by the Office of Professional Standards (OPS) staff. At each facility, the OPS staff continued education of the medical staff. Of the 112 facilities, representing a total of 1,035 indicators reviewed, 29 of them fell below the 80 percent threshold representing three percent.

Capital Assets Monitoring

The Fixed Assets Contract Monitoring office audited 10 units during the Second Quarter FY-2009. These audits are conducted to determine compliance with the Health Services Policy and State Property Accounting (SPA) policy inventory procedures. Audit findings found 10 of 10 facilities audited were within the compliance range.

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 second quarter of FY-2009:

- 217 cases of suspected syphilis were reported in the Second Quarter FY-2009, compared to 201 in the previous quarter. These figures represent a slight overestimation of actual number of cases, as some of the suspected cases will later be resolved prior infections, rather than new cases.

- 842 Methicillin-Resistant Staphylococcus Aureus (MRSA) cases were reported in this quarter, compared to 915 during the same quarter of FY-2008.

- There was an average of 23 Tuberculosis (TB) cases under management per month during the Second Quarter FY-2009, compared to an average of 18 per month during the Second Quarter of the FY-2008.

- In FY-2006, the Office of Preventive Medicine began reporting the activities of the Sexual Assault Nurse Examiner (SANE) Coordinator. This position collaborates with 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 facility providers in the performance of medical examination, evidence collection and documentation, and use of the sexual assault kits. During the Second Quarter FY-2009, three training sessions have been held, attended by two facilities, with 23 medical staff trained. This position also audits the documentation and services provided by medical personnel for each sexual assault reported. There have been 145 chart reviews performed for the Second Quarter FY-2009. Five deficiencies were found not compliant with policy. Corrective action responses were requested for those deficiencies. Three of the corrective actions are open at this time. 10 baseline labs were drawn on exposed victims.

- In the First Quarter FY-2009, it was reported that all 112 Correctional Institutions Division (CID) facilities had a 100 percent Peer Education Programs in place. Currently, Peer Education Programs are available at 108 of the 112 facilities housing Correctional Institution Division (CID) offenders. During the Second Quarter FY-2009, 15,071 offenders attended classes presented by peer educators. This is a 62 percent increase from the 9,327 attendees in the Second Quarter FY-2008.

Mortality and Morbidity

There were 76 deaths reviewed by the Mortality and Morbidity Committee during the months of December 2008, January, and February 2009. Of those 76 deaths, 11 were referred to peer review committees and one was referred to utilization review.

Peer Review Committee	Number of Cases Referred
Physician & Nursing Peer Review	4
Nursing Peer Review	4
Physician Peer Review	3
Total	**11**

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 second quarter of FY-2009.

- Liaison with County Jails identified the immediate mental health needs of 35 offenders approved for expedited admission to TDCJ due to psychiatric conditions. This information was provided to the appropriate TDCJ facility prior to intake.

- The Mental Health/Mental Retardation (MHMR) history was reviewed for 18,009 offenders brought into TDCJ CID/State Jails. Intake facilities were provided with critical mental health data, not otherwise available, for 2,180 offenders.

- 3,653 Texas Uniform Health Status Update forms were reviewed, which identified 911 deficiencies (primarily incomplete data).

- 366 offenders with high risk factors (very young, old, or long sentences) transferring into the Correctional Institutional Division were interviewed resulting in 20 referrals.

- 35 offenders were screened for TDCJ Boot Camp.

- 21 Administrative Segregation facilities were audited. 4,608 offenders were observed, 2,417 of them were interviewed, and 37 offenders were referred for further evaluation. Access to Care (ATC-4/5) met or exceeded 80 percent compliance for 20 facilities and one facility had no mental health Sick Call Requests. ATC-6 (referral from triage) compliance was 100 percent except for one facility which had a compliance of 87.5 percent and four of the small facilities had no referrals from triage.

Clinical Administration

During the second quarter of FY-2009 ten percent of the combined UTMB and TTUHSC hospital and infirmary discharges were audited. A total of 115 hospital discharges and 65 inpatient facility discharge audits were conducted. The chart below is a summary of the audits showing the number of cases with deficiencies and the percentage.

Texas Tech Hospital Discharges

Month	Unstable Discharges [1] (Cases with deficiencies)	Readmissions [2] (Cases with deficiencies)	Lack Documentation (Cases with deficiencies)
December	6 (14%)	0	7 (17%)
January	6 (15%)	0	5 (13%)
February	4 (12%)	1 (3%)	2 (6%)

UTMB Hospital Discharges

Month	Unstable Discharges [1] (Cases with deficiencies)	Readmissions [2] (Cases with deficiencies)	Lack Documentation (Cases with deficiencies)
December	21 (50%)	5 (12%)	31 (74%)
January	19 (49%)	0	27 (69%)
February	14 (41%)	1 (3%)	12 (35%)

Texas Tech Infirmary Discharges

Month	Unstable Discharges [1] (Cases with deficiencies)	Readmissions [2] (Cases with deficiencies)	Lack Documentation (Cases with deficiencies)
December	1 (4%)	0	6 (26%)
January	10 (43%)	0	5 (22%)
February	12 (52%)	0	1 (4%)

UTMB Infirmary Discharges

Month	Unstable Discharges [1] (Cases with deficiencies)	Readmissions [2] (Cases with deficiencies)	Lack Documentation (Cases with deficiencies)
December	4 (17%)	0	6 (26%)
January	9 (39%)	0	6 (26%)
February	4 (21%)	0	2 (10%)

Footnotes:

[1] Discharged patient offenders were unable to function in a general population setting, or vital signs were not recorded on the day of discharge so patient stability was not able to be determined.

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

Accreditation

The American Correctional Association (ACA) Winter Conference was held in Kissimmee, Florida in January 2009. The ACA Panel of Commissioners awarded initial ACA Accreditation to the Cotulla, Jester I, Vance, and Jester III Facilities. In addition, reaccreditation was awarded to Briscoe, Cole, Choice Moore, Gist, Luther, Polunsky, and Smith Facilities.

Biomedical Research Projects

The following is a summary of current and pending research projects as reported by the Texas Department of Criminal Justice (TDCJ) Executive Services:

- Correctional Institution Division (CID) Active Monthly Medical Research Projects – 45,
- Health Services Division Active Monthly Medical Research Projects – 13, and
- Health Services Division Pending Medical Research Projects – 2.

An Overview of the Joint Infection Control Committee

For the Correctional Managed Health Care Committee

June 9, 2009

Joint Infection Control Committee Functions

- Monitor the incidence of infections
- Review, evaluate and make recommendations regarding factors within TDCJ that may have a bearing on infection control
- Recommend control measures to the TDCJ Director of Health Services
- Develop infection control policies

Joint Infection Control Committee Membership

- TDCJ Director of Preventive Medicine (Chair)
- Preventive Medicine staff
- University medical directors and directors of nursing
- University dental directors
- Director of Pharmacy Services
- TDCJ Representatives
  - Laundry and Food Service
  - Transportation
  - Risk Management

Infection Control Manual

- System wide resource
- Policies reviewed annually
- Sections
  - Employee health
  - Management and control of specific diseases
  - Disease reporting and infection control practices
  - Miscellaneous
    - Offender occupational and housing issues
    - Foodborne outbreak procedures

Policy development

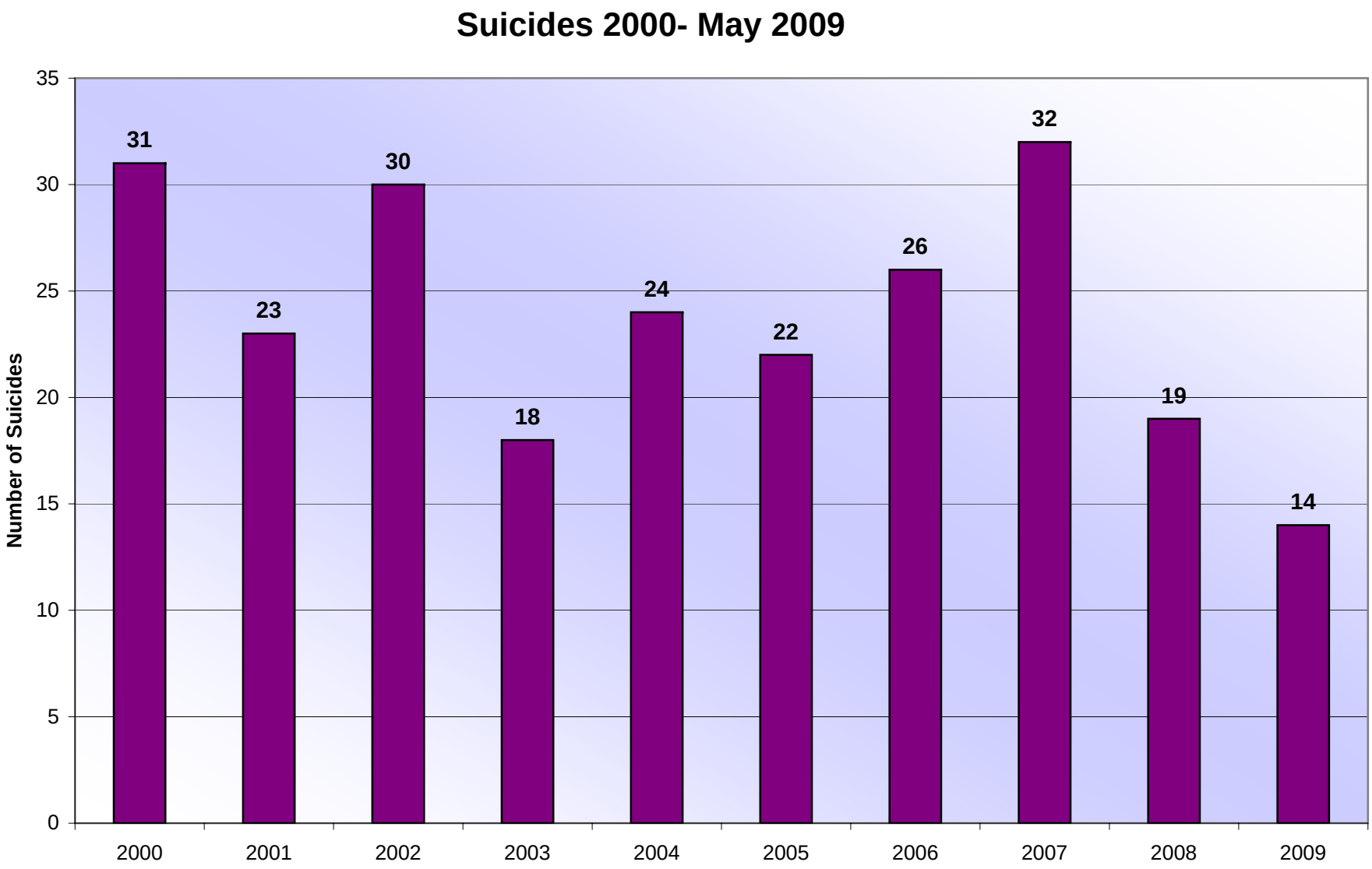
- Literature review
- National and state guidelines
  - CDC, DSHS
  - NCCHC, ACA
- Special policies
  - HIV
  - Hepatitis
  - Joint working committee with medical specialist representation

Diseases of Special Interest 2007-2009

- Norovirus
- Varicella
- Parotitis
- Swine flu

Recent Special Interest Items

- Mandatory HIV testing and seroconversions
- Pandemic influenza preparedness
  - Pandemic flu plan
  - Strategic National Stockpile
  - Tamiflu purchase
- Use of quarantine for infection control
- Testing of respiratory isolation rooms
- Newer vaccine recommendations – HPV, shingles, varicella
- Strategy for Hepatitis B vaccination


Suicides 2000- May 2009
Number of Suicides
35
30
25
20
15
10
5
0
31
23
30
18
24
22
26
32
19
14
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009

MH-G-04 *essential*

SUICIDE PREVENTION PROGRAM

Standard

The facility identifies suicidal inmates and intervenes appropriately.

Compliance Indicators

1. A suicide prevention program includes the following outcomes:
   a. facility staff identify suicidal inmates and immediately initiate precautions,
   b. suicidal inmates are evaluated promptly by the designated clinician who directs the intervention and assures follow-up as needed,
   c. actively suicidal inmates, regardless of housing, are placed on constant observation, and
   d. potentially suicidal inmates, except when placed in isolated housing, are monitored on an irregular schedule with a frequency of no more than 15 minutes between checks. If, however, the potentially suicidal inmate is placed in isolation, constant observation is required.
2. Key components of a suicide prevention program include the following elements:
   a. training,
   b. identification,
   c. referral,
   d. evaluation,
   e. treatment,
   f. housing and monitoring,
   g. communication,
   h. intervention,
   i. notification,
   j. review, and
   k. debriefing.
3. The use of other inmates in any way (e.g., companions, suicide-prevention aides) may be appropriate, but is not a substitute for staff supervision.
4. Treatment plans addressing suicidal ideation and its reoccurrence are developed, and patient follow-up occurs as clinically indicated.
5. The mental health authority approves the facility's suicide prevention plan; training curriculum for staff, including development of intake screening for suicide potential and referral protocols; and training for staff conducting the suicide screening at intake.
6. All aspects of the standard are addressed by written policy and defined procedures.

Discussion

This standard is intended to ensure that suicides are prevented if at all possible. When suicides do occur, appropriate corrective action is identified and implemented to prevent future suicides.

While inmates may become suicidal at any point during their stay, high-risk periods include the time immediately on admission; following new legal problems (e.g., new charges, additional sentences, institutional proceedings, denial of parole); after the receipt of bad news regarding self or family (e.g., serious illness, the loss of a loved one), after suffering humiliation (e.g., sexual assault) or rejection; or pending release after a long period of incarceration. Inmates in specialized single-cell housing are also at increased risk of suicide. In addition, inmates in the early stages of recovery from severe depression may be at risk.

Key components of a successful suicide prevention program include the following:

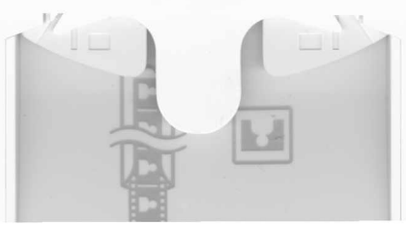
1. Training. All staff members who work with inmates are trained to recognize verbal and behavioral cues that indicate potential suicide and how to respond appropriately. Initial and at least biennial training are provided, although annual training is highly recommended.
2. Identification. The receiving screening form contains observation and interview items related to potential suicide risk. If a staff member identifies someone who is potentially suicidal, the inmate is placed on suicide precautions and is referred immediately to mental health staff.
3. Referral. There are procedures for referring potentially suicidal inmates and those who have attempted suicide to mental health care providers or facilities. The procedures specify a time frame for response to the referral.
4. Evaluation. An evaluation, conducted by a qualified mental health professional, determines the level of suicide risk, level of supervision needed, and need for transfer to an inpatient mental health facility or program, as well as underlying mental illnesses associated with the suicide behavior or ideology (e.g., depression). Patients are reassessed regularly to identify changes in condition that indicate a need for a change in supervision level or required transfer or commitment. The evaluation includes procedures for periodic follow-up assessment after the individual's discharge from suicide precautions.
5. Treatment. Strategies and services to address the underlying reasons (e.g., depression, auditory commands) for the inmate's suicide ideology are to be considered. The strategies include treatment needs when the patient is at heighten risk to suicide as well as follow up treatment interventions and monitoring strategies to reduce the likelihood of relapse.
6. Housing. Unless constant supervision is maintained, a suicidal inmate is not isolated but is housed in the general population, mental health unit, or

medical infirmary, and located in close proximity to staff. All cells or rooms housing suicidal inmates are as suicide-resistant as possible (e.g., without protrusions that would enable hanging.)

7. Monitoring. There are procedures for monitoring an inmate identified as potentially suicidal. Regular, documented supervision is maintained, usually every 15 minutes or more frequently if necessary. Although several protocols exist for monitoring suicidal inmates, when an actively suicidal inmate is housed alone in a room, supervision through continuous monitoring by staff should be maintained. Other supervision aids (e.g., closed circuit television, inmate companions or watchers) can be used as a supplement to, but never as a substitute for, staff monitoring.
8. Communication. Procedures for communication between mental health care, health care, and correctional personnel regarding inmate status are in place to provide clear and current information. These procedures include communication between transferring authorities (e.g., county facility, medical/psychiatric facility) and facility correctional personnel.
9. Intervention. There are procedures addressing how to handle a suicide attempt in progress, including appropriate first-aid measures.
10. Notification. Procedures state when correctional administrators, outside authorities, and family members are notified of potential, attempted, or completed suicides.
11. Reporting. Procedures for documenting the identification and monitoring of potential or attempted suicides are detailed, as are procedures for reporting a completed suicide.
12. Review. There are procedures for mental health, medical, and administrative review if a suicide or a serious suicide attempt (as defined by the suicide plan) occurs. See MH-A-10 Procedure in the Event of an Inmate Death for details.
13. Debriefing. There are procedures for offering timely debriefing to all affected personnel and inmates. Debriefing is a process whereby individuals are given an opportunity to express their thoughts and feelings about an incident (e.g., suicide or attempt), develop an understanding of stress symptoms resulting from the incident, and develop ways to deal with those symptoms. Debriefing can be done by an in-house response team or outside consultants prepared to handle these highly stressful situations. There are different approaches to debriefing, including highly confrontational or "forced interventions" methods. Such methods are not intended under this standard.

Optional Recommendations

Because suicide is a leading cause of death in correctional facilities nationwide, an active approach to the management of suicidal inmates is recommended. In facilities where 24-hour mental health staff coverage is not present, designated health and/or custody staff should be able to initiate suicide precautions until the mental health professional on call can be contacted for further orders. On the



other hand, only designated qualified mental health professionals should be authorized to remove an inmate from suicide precautionary measures.

Where feasible, persons trained in debriefing procedures should be used. Practical guidelines on the debriefing process are available from organizations such as the International Critical Incident Stress Foundation.

Preventing Suicide in Prison: A Collaborative Responsibility of Administrative, Custodial, and Clinical Staff

Anasseril E. Daniel, MD

Suicide is a sentinel event in prison, and preventive efforts reflect the adequacy and comprehensiveness of mental health, psychiatric, custodial, and administrative services in a correctional system. This article reviews the literature on suicide in prison during the past three decades and identifies the pattern and occurrence of risk factors. These risk factors are classified as demographic, institutional, and clinical. Based on this review, the author outlines specific administrative, custodial, and clinical steps and procedures that form the basis of a comprehensive suicide-prevention program that can be implemented in small and large systems. The author recognizes the limitations of staff availability, the budget constraints, and the ineffectiveness of efforts to prevent suicides that occur without any warning. Ultimately, a prevention program is the collective responsibility of administrative, custodial, and clinical staff.

J Am Acad Psychiatry Law 34:165–75, 2006

The study of suicide in prisons has increased dramatically since the 1980s. Factors contributing to this increase include the rising frequency of suicide in prisons; class action lawsuits related to suicide; deinstitutionalization of the mentally ill; and lack of community-based programs for mentally ill criminals.[1–6] Legal reforms, prison diversionary programs, and regional differences in suicide rates[7] have also influenced the research.

Suicide Rate: Problems and Controversies

Suicide is the third leading cause of death in U.S. prisons and the second in jails.[1] The suicide rate in prisons ranged from 18 to 40 per 100,000 during the past three decades.[8–11] Populous urban jails such as those in New York,[12] Atlanta,[13] and Miami[14] have higher suicide rates than do non-urban jails. A study of six Midwestern jails from 1966 to 1971 showed a rate of 58 per 100,000 inmates per year.[15] The jail suicide rate is nine times that of the general population, with a range of 107 to 187.5 per 100,000.[16] The rate of 10 to 17 per 100,000 in federal prisons is slightly lower than the rates in state prisons.[3] The highest rate in a prison is noted among death row inmates with 146.5 per 100,000.[17]

The suicide rate in prison is usually compared with the commonly accepted national general population rate of 12 per 100,000; however, the comparison is inaccurate because of the disparity in the distribution of men and women in prison. When this general population rate of 12 per 100,000 is broken down by gender, the rate for men is 18 and 6 for women. Therefore, a prison rate of 18 to 20 is comparable with the rate in males in the general population.[3]

Underreporting of suicide seems to be a problem. If a suicide victim is found and rushed to the hospital, only to die there, records may not show that the victim committed suicide in prison. Also, if the facility chooses to report some deaths as suicides—but

Dr. Daniel is Director of Psychiatric Services for the Missouri Department of Corrections by contract, Jefferson City, MO, and Clinical Professor of Psychiatry, University of Missouri, Columbia, MO. Address correspondence to: Anasseril E. Daniel, MD, Daniel Correctional Psychiatric Services, 33 E. Broadway, Suite 115, Columbia, MO 65203.

not others, for fear of litigation—suicide rates could be inaccurate.[5] Prison staff are more likely to report white inmate suicide, accounting for possible underrepresentation of suicides of black inmates.[18] Risk factors such as drug abuse, unemployment, interpersonal conflicts, and mental illness are common to both the general public and prison. How different would the prison rate be if these factors were controlled?[17]

The suicide rate is calculated on the basis of average daily population (ADP) in jails and prisons, which does not factor in the admissions, leading to miscalculation of the actual rate.[1] Furthermore, the immediate post-release suicides noted among inmates who serve long sentences for violent crimes (such as homicide) and those who are heavy drug users before incarceration are generally left uncounted.[19,20]

Suicide Attempters Versus Suicide Completers

Although a suicide attempt in prison is generally categorized as a type of non-lethal self-injury similar to self-mutilation, it is fundamentally different.[21] All self-harming acts may be seen on a continuum of severity, not as distinct problems, since the motivation for self-injurious behavior is the same for both attempters and completers, and many attempt suicide before they are successful.[22] Some inmates attempt suicide with no intention of ever completing the act, while others persist, using more lethal methods until they are successful. According to Schaller *et al.*[23] and Green *et al.*,[24] both suicide attempters and completers are generally younger than 25, have previously attempted suicide, have a history of psychiatric treatment, and are likely to be addicted to opiates or other substances.[23,24] Most suicide attempters slash their wrists, as opposed to hanging or overdosing on medication, which are common methods used by completers.[25]

In general, prior suicide attempts increase the risk of suicide. From 45 to 63 percent of inmates who commit suicide have attempted it before.[26–30] Of those with a history of prior attempts who complete suicide, two-thirds used lethal methods (i.e., hanging, burning, swallowing a razor blade, strangulation, throat cutting, and drug overdose) during their prior attempts. Although Durand *et al.*[31] found a much lower rate of previous attempts (33 percent) among those who commit suicide, based on the literature, at least half of the individuals attempt suicide before completing the act.

Risk Factors

Because suicide research is retrospective, a definitive cause-and-effect relationship between risk factors and suicidal death cannot be established. Usually, what appears to be causative is reported as associated factors.

Demographic Factors

Generally, more than half of all inmates who commit suicide in prison are between 25 and 34 years of age.[27–29,32] They are often single with no job or family support. Very young prisoners (below age 21) are especially at risk.[22] In fact, the suicide rate among juvenile offenders placed in adult detention facilities is almost eight times greater than the rate in juveniles housed in juvenile detention facilities.[33] Although blacks are overrepresented in prisons, they are underrepresented among suicide completers as well as attempters.[11,27,29] Toch[34] found that blacks were also underrepresented in the self-mutilation group, whereas whites and Hispanics were overrepresented. Some researchers suggest that the differences among black, white, and Hispanic suicide rates can be explained by sociocultural factors such as better preparation for prison life by blacks as opposed to that of whites and Hispanics.[35] Haycock[5] disputes this theory, indicating that the factors that lead to inmate suicide are complex and personal and do not simply depend on sociocultural background.

Upper socioeconomic status and high degree of social and family integration before incarceration increase the risk of suicide in prison.[36] Suicides in prison fall into two groups: egoistic and fatalistic (Durkheim typology). Egoistic suicide occurs when an individual has a low level of integration into society, while fatalistic suicide occurs in a highly regulated, social environment where the individual sees no possible way to improve his or her life. Accordingly, most suicides in prison are egoistic, whereas those by death row inmates may be both egoistic and fatalistic, because they are socially isolated and heavily regulated, and at the same time, weakly integrated.[17]

Clinical Factors

Psychiatric Disorders: Eight to 15 percent of prisoners have a serious and persistent mental illness,[12,18] and the proportion is even higher in max-

imum-security prisons.[1] Many prisoners have multiple psychiatric disorders with co-morbid substance abuse.[37,38] Using the NIMH Diagnostic Interview Schedule (DIS) III–R, Teplin *et al.*[39] studied a randomly selected stratified sample of 1272 female arrestees in Cook County and found that 80 percent had one or more lifetime psychiatric disorders. Using similar methodology, Daniel *et al.*[40] found that 90 percent of consecutively admitted female prisoners had an Axis I disorder and 67 percent had more than one disorder. As far as the prevalence of psychiatric disorders among suicidal inmates is concerned, studies show a wide range from 33 to 95 percent.[3,22,28–30,41,42]

Although mood,[3,43] psychotic,[29] and personality disorders dominate diagnoses[30] among mentally ill prisoners, depressive disorders are more often linked to suicide than is any other psychiatric illness.[3,43] The onset of the mental disorder may be either before or during incarceration with most having a preincarceration diagnosis with onset before age 18. Other commonly found characteristics of suicidal inmates include a family history of mental illness, substance abuse, incarceration, suicide, psychiatric care, and medication treatment, though such factors are not uncommon among other inmates or the mentally ill in the community.

Depression, Hopelessness, and Anxiety: Depression and hopelessness seem to be the two most common psychological states at the time of a suicidal act.[44] Although depression and suicide are co-occurring phenomena, hopelessness and suicide have a stronger correlation than do depression and suicide. Ivanoff and Jang[45] developed a multivariate model to predict suicide by inmates studying the relationship between depression, hopelessness, suicidality, social desirability and other factors. Although age and visitors have no significant effect on suicidality, juvenile delinquency and violent crime directly increase it, as does higher education and income levels. Negative life events and sentence length indirectly impact suicidality by affecting depression. Both violent crime and previous income level affect hopelessness. Inmates with higher social desirability had lower levels of depression; thus, they had lower levels of suicidality.

Anxiety experienced by inmates at various times of incarceration, particularly on entry into the prison or just before release, may act as a risk factor. Anxiety symptoms mixed with agitation, depression, and hopelessness increase the risk further.

Personality Traits and Disorders: Although antisocial personality disorder is "endemic to correctional settings,"[46] the relationship between antisocial personality disorder and suicide risk seems to be somewhat complex. Verona *et al.*[47] used the Psychopathy Checklist-Revised (PCL-R) to study 313 male inmates in a federal institution in Florida and found a positive correlation between antisocial deviance (Factor 2) and suicidal tendencies in male inmates. Borderline Personality Disorder (BPD) increases the risk for suicide attempts and completions due to poor interpersonal skills, impulsivity, and affective instability. Impulsive suicide attempts under intoxication are more common among arrestees[48] and therefore intoxication is a significant factor in jails. In prison, impulsivity can be a factor in young prisoners with personality and depressive disorders and those who are victims of cluster suicides. Although a direct link between impulsivity and suicide cannot be established, only a few prepare to attempt suicide during the days preceding the act.[25]

Psychosocial Stressors: Institutional stressors such as undesired unit placement, work assignment, disciplinary confinement, interpersonal conflicts, legal processes, parole setbacks, and chronic medical conditions may act as precipitators of suicidal behavior. Nearly 50 percent of those who commit suicide experience acute stressors at the time of the suicide, whereas most suffer from chronic stressors.[3,27] Institutional conflict is seen as the most common acute stressor, whereas interpersonal conflict and chronic medical conditions are the most common chronic stressors.

The severity and type of crime seem to act as risk factors in certain prisoners, though not universally. Perhaps the guilt, shame, and stigma associated with the offenses may be the determining factor. Marital separation,[30] divorce,[49] or death of a loved one may precipitate serious suicide attempts. A prisoner is not usually able to participate in rituals associated with the funeral of a loved one. Mourning is difficult to accomplish[50] and expression of grief is likely to be viewed by others as a sign of weakness and vulnerability.

Loss or absence of one or both parents for more than 12 months before the age of 15 is correlated with attempted suicide.[51] Other risk factors include losing contact with one's children,[27] inability to

communicate due to language barriers,[25,28] or learning disability.[22] Mental retardation *per se* is not correlated with increased risk.

Substance Abuse as a Risk Factor: Being under the influence of an illegal drug heightens the risk of self-harm.[52] Inmates who suffer from Antisocial Personality Disorder, Schizophrenia, or Bipolar Disorder[53] are more likely to abuse substances. The risk of suicide is highest among opiate dependents who also have psychiatric disorders.[54] Opiate users are 10 times more likely to die from suicide than are non-users of the same age and gender.[55] Weitzel and Blount[56] did not find any significant difference between the type of drug and risk of suicide, and non-users were not significantly different from heavy users in the number of suicidal thoughts or attempts. However, when drug abusers are incarcerated, the ensuing forced abstinence and not having developed coping skills due to years of dependency may precipitate suicidal thinking.[25]

Medical Condition and Its Relation to Suicide: Salive *et al.*[11] found an increased risk of suicide among inmates with AIDS due to potential hopelessness, victimization, and threats by other inmates. No studies have been found that link hepatitis C and suicide, although interferon treatment is associated with depression and possible suicidal behavior. If a medical condition is chronic and causes intractable pain, it can be a risk factor. Prisoners with epilepsy are more likely than their non-epileptic peers to have depression and suicidal ideation.[57]

Institutional Factors

Stages and Setting of Confinement: In jails, the high-risk period is the first 24 to 48 hours. While there is no such period in prison, the first 30 days at reception centers are generally deemed to be critical for those with a history of suicide attempts.[29,48] Interfacility transfer of mentally disordered offenders seems to raise suicide risk, which may be related to the inmate's adjustment difficulties at the new site. Findings regarding length of incarceration and suicide risk are contradictory—some indicating a positive correlation,[36,58] whereas others indicate none[11] after 180 days of incarceration.

With regard to setting, most inmate suicides occur in maximum-security facilities, in single cells[11,28] or in isolation. Special treatment centers for addiction and sexually dangerous persons have a lower rate than in the general community, whereas it is much greater at inpatient hospitals for the "criminally insane"[18] and in supermaximum-security facilities.[17]

Time of the Day, Month, and Season: Contrary to general belief, suicides are not more likely to occur on weekends, religious holidays, or during holiday seasons.[42] However, the time of day seems to have some significance, in that most suicides occur between 7:00 p.m. and 7:00 a.m.,[27,31] possibly due to lower staff supervision during the night.[25] For unknown reasons, the most common time of year to commit suicide is between July and September.[22,30,59]

Prison Condition and Experience: Almost all departments of corrections in the United States have recorded an increase of prisoners in recent years, possibly due to the dramatic influx of drug offenders.[52] An overcrowded and short-staffed prison is likely to increase suicide risk due to lack of access to medical care, increase in assaults, lower staff-offender ratio, lack of opportunity for activity, lack of food and clothing, unwanted interactions, and rapidly changing social structures within the prison. As prisons become more crowded, the number of inmates who reside in single cells may decrease, a fact often cited as preventive, since the chance of committing suicide in multiple-occupant cells is limited.

Understandably, the transition from the outside world leads to loss of individual autonomy. As a result, inmates often engage in conflict with the prison staff as well as fellow inmates. Inmates of all ages with mental disorders and youthful inmates are at greater risk of abuse and victimization by other inmates. Threats and attacks may make a younger inmate act impulsively to take his or her life. A study of sexual coercion in prison noted that approximately 20 percent of inmates are reportedly pressured or forced into sexual contact with another person. One third of the male targets (36 percent of those subjected to sexual coercion) experience thoughts of suicide.[60]

Method of Suicide

Over 80 percent of suicides are completed by hanging. The feet of the hanging victim need not be off the floor for the attempt to end in fatality. Only 2 kg of pressure has to be applied to the neck to cut off blood flow to the brain. Hanging can be accomplished while kneeling, sitting, standing, or lying down. The fastening anchor can be close to the floor, such as a window bar, window crank, air duct vent, handrail on the wall, bedrail, cell bar, or lock box, or higher points such as light fixtures or shower heads.

Death occurs in five to seven minutes, but permanent brain damage takes as little as three minutes. Bed sheets, shoelaces, jump ropes, belts, socks, elastic waist bands, and wound bandages can all be used as a ligature. Asphyxia is the most common cause of death in hanging.[30] Although hanging does not always communicate a serious intent to die, the effectiveness of the method yields a high mortality rate.

Overdose of psychotropic drugs, especially tricyclic antidepressants, is the next most common method, followed by antihypertensives and over-the-counter pain medications.[28,29] Self-immolation is uncommon, yet it has a mortality rate of 33 percent in the groups studied. Victims tend to be female and to have severe psychopathology.[61] Other uncommon methods include hunger strike, swallowing sharp objects, and jumping from a height. Occasionally, homicidal hanging may masquerade as suicide.[62]

In summary, studies confirm that the most significant risk factors of suicide among prisoners consist of mental illness—particularly depressive disorder, psychological states of depression and hopelessness, prior suicide attempts, a preincarceration history of psychiatric disorder and substance abuse, and a recent psychosocial stressor acting as a precipitant. These findings are consistent with those reported recently by Kovasznay *et al.*[63] Other risk factors include being a young white male, placement in a maximum security prison, single-cell living or isolation, and interfacility transfer. These factors and the methods used should be taken into account in planning suicide-prevention strategies.

Suicide-Prevention Strategies

Suicide prevention must be the collaborative responsibility of administrative, custodial, and clinical staff and should be a top administrative and clinical priority in every prison. A comprehensive mental health and psychiatric service delivery system[64,65] supported by the administration forms the foundation of preventive efforts. A well-designed suicide-prevention program incorporates all aspects of identification, assessment, evaluation, treatment, preventive intervention, and training of all medical, mental health, and correctional staff.[64,65] Comprehensive mental health services in prisons are slowly being established in departments of corrections, largely due to successful class-action suits, legislative actions, and progressive-thinking administrators and clinicians. Fully trained mental health and correctional staff in prisons are rare because of lack of qualified professional pools, budgetary constraints, National Guard deployment, and the nature of correctional work. Creation of a specific division of administration dedicated to offender rehabilitation that oversees and coordinates medical, mental health, vocational, and educational services is important to ensure an adequate staff-patient ratio, a multidisciplinary treatment team approach, timely treatment planning, staff training, and overall rehabilitative services.

Administrative Steps

Policy Development and Implementation

Legally sound and defensible policies and procedures that are rigorously and systematically implemented form the basis of appropriate administrative and clinical practice. Key policies ensuring good clinical care and suicide prevention include those covering (1) suicide assessment, observation, and intervention; (2) psychotropic medication use; (3) involuntary/forced medication and involuntary medical treatment; and (4) inpatient hospitalization of the mentally ill. The policies must be reviewed with all medical, mental health, and correctional staff.

Implementation of Suicide Risk Rating Program

If properly implemented, a suicide risk rating program can capture high-risk individuals. A commonly used risk rating instrument is the Multi-Dimensional Risk Assessment.[66] The goal of this program is to identify suicidal inmates (on their arrival) and to monitor them as they move through the system. Inmates are given a Suicide Risk Rating score of 1, 2, or 3, indicating the severity of suicide potential. Visible placement of the SR score in the medical record and registering the high-risk inmates in chronic care clinics enable systematic tracking of them. An inmate is registered in a clinic at a specific facility, and the generated database follows him/her, even when the inmate is transferred to another facility, making data available for future mental health and psychiatric contacts. Many prisons have established a clinical/administrative-level committee consisting of medical director, psychiatrist, health services administrator, and assistant superintendent of administration, to discuss high-risk inmates.

Procedures for Administration of Psychotropic Medication

Policies and procedures covering the length and quantity of prescriptions, medication renewal, and nursing practices must address the type and mode of administration to avoid opportunities for hoarding of medications with lethal potential. Medications with non-lethal potential should be preferentially prescribed, reducing the frequency of overdose with such medications. The watch-take policy for administration of psychotropic medication instituted in many correctional systems is an effort to cut back on the instances of "cheeking" or hoarding. However, the watch-take practice does not eliminate fatal overdoses of somatic medications—an occurrence that is not uncommon in prisons. As an alternative, crushing of medications or administration in liquid form has been implemented. Although crushing medications seems to be a good addition to any psychotropic medication practice, in reality, this method is full of pitfalls. For example, some medications are in capsule or time-release form and cannot be crushed before ingestion. Furthermore, there is no guarantee that every granule of a crushed pill makes it into the inmate's mouth, which may alter the dosages.

A structured protocol for dealing with medication of noncompliant offenders and those who consistently refuse medications is a significant step in preventing suicide. Furthermore, if a suicidal inmate is incompetent to make a rational decision regarding medication and if he or she is gravely disabled, involuntary administration of medication may be implemented.

Administrative Management of Institutions

Four concerns relevant to suicide prevention deal directly with management of individual institutions and the correctional system as a whole. These include (1) segregation monitoring; (2) offender assignment; (3) out count and interfacility movement; and (4) cell design.

As a suicide-prevention measure, suicidal inmates should not be placed in segregation units, because such placement does not promote improved mental health. The National Commission of Correctional Health Care Prison Standards stipulate that suicidal inmates should not be housed or left alone unless constant supervision can be maintained.[64] If it is necessary to house an inmate alone, provision should be made for uninterrupted supervision and human contact. In addition, regular rounds in the segregation area to screen inmates for suicidal intent and mental illness should be a standard procedure.

Offenders must also be given housing assignments that are appropriate for the level of threat they present to themselves and/or others. Careful placement of younger inmates in appropriate facilities where their security and mental health needs can be met has the potential to lower the suicide rate in this group.

Inmates on "out count" for a court hearing may be temporarily placed in a county jail. The potentially suicidal inmate may find in the transfer a golden opportunity for self-harm, because of the laxity of supervision in jails. Vulnerability to suicide increases if the court hearing results in an unexpected outcome such as an additional long sentence. As a preventive measure, a copy of relevant records must always accompany the inmate with a history of suicidal ideation or attempt when placed on out count. Suicidal inmates should be treated in county jails just as they would be treated in prison (i.e., increased monitoring, evaluation by mental health staff, no access to harmful objects, and a watch-take medication policy).

A formal procedure to seek input or clearance from mental health staff before a mentally ill prisoner is transferred to another facility must be established. If the system does not have an electronic medical record system, the inmate's mental health records should be transferred promptly to the receiving facility. The transferred prisoner must be seen by a mental health professional within 24 hours and by a psychiatrist within 72 hours and, thereafter, on a regular basis. Finally, as a precautionary step, no prisoner on suicide watch should be transferred.

Designing a protrusion-free cell or a cell window-frame in a way that does not permit fastening a ligature band would help decrease suicides, although in practice such a design would be difficult to achieve. However, with a little planning the number of obvious anchors can be drastically reduced. Air vents can be designed with holes too small to permit threading of a sheet. Use of break-away shower heads and raised concrete slabs that hold mattresses off the floor are helpful. Many efforts to create suicide-proof cells have proven inadequate for the clever inmate seeking a way to kill himself. While a perfectly designed suicide-proof cell is unlikely, it is important that the entire interior of each cell be visible from the walkway. Frequent monitoring of inmates in their cells is

more important than any cell design. Nothing can replace human supervision as a deterrent to suicide.

Training and Education

Training correctional officers and mental health and medical staff to deal with suicidal inmates is crucial. If prison staff are given adequate training in recognizing, dealing with, and understanding the motivations behind suicidal behavior, they are less likely to feel that suicidal inmates are being manipulative. Training topics must include (1) identification of high-risk offenders; (2) how to identify signs and symptoms of mental illness; and (3) how to handle communication of intent. Training must occur regularly. Any staff can be trained to spot certain "warning signs" of suicide. Correctional officers and clinicians may observe slightly different warning signs, simply because these two groups deal with the inmate in different situations. With regard to clinicians, the training must also include steps to complete the Multidimensional Risk Assessment Form, modalities of intervention, and referral to appropriate professionals including the psychiatrist. It is helpful for correctional officers and mental health professionals to be familiar with the general profile of a suicidal inmate, although there are exceptions to every situation and this "profile" should be used with discretion. New York State has developed a model training program for identifying suicidal inmates[67] that uses a video, handbook, and tests to teach and evaluate the correctional officers. Any successful training program must emphasize good communication between correctional officers and mental health staff. Individuals from mental health staff and ranking administrative personnel should participate in the training. Also, having a corrections officer serve as a trainer makes other correctional officers feel that the training is worthwhile and applicable to their jobs.

Peer Groups and Inmate Training

Correctional facilities have attempted to create peer groups for populations who are often targeted for victimization, such as child sex offenders. When inmates are surrounded by those who have had similar experiences, they may be less likely to feel suicidal. Having a trained inmate to work with high-risk inmates may drastically reduce the likelihood of suicide.[29] The effectiveness of peer support groups and inmate training programs have not been properly studied, and anecdotal information questions the usefulness of these programs.

Handling Inmate Communication of Intent

Approximately 60 percent of inmates may communicate their intent to kill themselves either verbally or nonverbally. Verbal communication is either spoken or written but nonverbal communication can be much more ambiguous, such as giving away important possessions, refusing medication or asking for more medication, and cutting off contact with family members. An inmate may communicate his or her intent to a corrections officer, mental health staff, a friend, family member, judge, or cell-mate. It is often difficult to learn of communications to outsiders, because the recipient may not report it. If an inmate commits suicide after such a communication, the friend or family member usually denies knowing that the inmate was serious about committing suicide. It is not easy to convince other inmates to report communications; however, a confidential system for reporting, preferably in written form, must be established so that inmates do not feel they are putting themselves in danger when making a report. In view of the fact that correctional officers and clinicians have a higher degree of responsibility than do other recipients, they should make a report of the communication and forward it to a mental health professional, who in turn should confer with prison administration. The report should be added to the inmate's file and appropriate steps taken to ensure that the inmate is not at risk of self-harm.

Clinical Procedures

The primary focus up to this point has been administrative and custody staff responsibility. Suicide prevention must be a clinical priority as well.

Mandatory screening of all inmates for suicidal intentions has been instituted in almost all reception centers. Metzner *et al.*[2] proposed three different types of mental health screenings and evaluations that include initial screening at reception, mental health and medical evaluation within 7 days, and psychiatric evaluation on referral by a mental health professional. The screening ensures triaging of inmates for proper treatment and placement. Screening, a crucial step in the identification of suicidal inmates, involves face-to-face contact by intake staff. The screening tool must be a comprehensive and standardized measure that is valid and reliable. The

screening process must capture a complete history of any suicidal behavior, including all prior suicide attempts and/or periods of suicidal ideation, even if the inmate is not suicidal at the time of intake. After screening, if an inmate evidences suicidal ideation or behavior, a Multidimensional Suicide Risk Assessment form, modified for application in corrections, is completed to obtain a Suicide Rating (SR) score. Suicide risk assessment is a continual process performed by all mental health and psychiatric staff and should be performed at every clinical encounter. Such an assessment will allow the psychiatrist and other clinicians to take specific intervention steps, which may include placing the patient on suicide watch, modifying medications, and arranging to have one-to-one sessions, and will also alert correctional officers to keep an eye on the prisoner.

Those who are identified to be at some risk of suicide, as noted by an SR score, require intensive clinical monitoring. Since many inmates who commit suicide have contact with mental health staff before the suicide, warning signs and behavioral changes suggestive of self-harm must translate into increased watchfulness, careful monitoring, and intervention. Regular contacts by the clinician and systematic counseling can help the inmate with problems that may contribute to suicidal thoughts and/or attempts. Furthermore, the clinician is able to recognize normal patterns of behavior for that inmate and will be more closely attuned to any future changes than other staff members who interact with the inmate only sporadically.

Based on suicide risk assessment, a prisoner may be placed on suicide watch—a heightened state of observation where he/she is subjected to frequent checks by correctional staff. Documentation must include the reason for the suicide watch, details of what the prisoner is allowed to have in his or her cell during suicide watch, frequency of cell checks (for instance, every 15 minutes), and a procedure for termination of the watch. Records become critical from a forensic point of view in the event of suicide and possible litigation. Though video monitoring is an excellent tool for ensuring uninterrupted observation, it may not be as effective as the direct personal observation by staff (author's observation).

Treatment of Psychiatric Disorders and Substance Abuse

Prisoners with psychiatric problems must be placed in a proper treatment program.[12] Diagnostic specificity and accuracy and clarity of Axis I and II disorders are critical in determining appropriate psychotropic medications. Psychiatric manpower resources are very limited in corrections, and therefore reliance on psychotropic drugs as the sole suicide-prevention strategy is common.[66] Psychiatrists occasionally use suicide-prevention contracts as opposed to taking time to develop a therapeutic alliance. These contracts should be used as only a part of a greater treatment plan and not in lieu of suicide risk assessment and intervention. Specific procedures must be in place to facilitate the admission to a psychiatric hospital administered by the State Department of Mental Health of acutely mentally ill offenders, civil commitment of those who are likely to pose a danger to themselves or others to the Department of Mental Health on release,[68] and transition of mentally ill prisoners to community-based treatment programs.

Although detoxification programs are crucial in jails, a comprehensive substance abuse treatment program is important in the care of suicidal prisoners with a history of substance abuse. Most substance abusers undergo forced abstinence while incarcerated but on release may relapse due to "rekindling" resulting from exposure to personal triggers. Therefore, systematic treatment while incarcerated may reduce immediate post-release suicides.

Information Management System

The administrative and clinical aspects of a sound suicide-prevention program should be linked by an effective information-management system. Screening instruments, risk assessment forms, suicide watch reports, classification files, medical records, mental health records, psychiatric evaluations and progress notes, medication entries, the medication administration record, Suicide Risk Rating level 3 (SR 3) debriefing reports, and suicide debriefing and mortality reports all form essential components of the program for effective communication. A uniform system of documentation will assure seamless communication between staff and facilities. Forms provide a simple way to insure that certain pieces of information are documented every time. Some correctional departments use computerized systems that provide easy but confidential access to information from any location. Last but not least is the willingness of all staff to document observations, decisions, and actions adequately and thoroughly.

Psychological Autopsy and Mortality Review

Suicide prevention is an area that is constantly evolving. Following a suicide, a complete mental health debriefing (psychological autopsy) must be completed. This process involves drawing together pieces of information from the inmate's medical and mental health records, classification files, toxicology reports, and autopsy. The psychological autopsy should include basic demographic information, life history before incarceration (including family, mental health, and medical histories), criminal history, mental health contacts within the correctional facility, psychotropic drugs used, and pattern of prescriptions and other health concerns while in the facility. The psychological autopsy should be reviewed to highlight any patterns or areas of concern for prison staff. Policy and procedure changes may result from this process. Unlike the psychological autopsy, which is written primarily by mental health and correctional representatives, a mortality review is undertaken by a committee consisting of physicians, psychiatrists, and administrators. The committee discusses the incidents leading up to and including the suicide. The report includes a brief history of the inmate's psychological history, but most of it is focused on the suicidal act itself. The mortality review reports the last time the inmate was seen alive, the time that the inmate was found, who found the inmate, efforts that were made to resuscitate the inmate, when additional help arrived, whether the inmate was taken to a hospital, heroic measures taken at the hospital, and time of death. Every person who was involved in the suicide—from the discovery of the inmate until the inmate was pronounced dead—is interviewed so that a complete scene can be described. The mortality review is often used to evaluate the system's response to the suicide. Any difficulties that arise with prison staff response can be addressed so that similar situations are handled more effectively in the future. A detailed description of cause of death is completed as well.

Continuous Program Evaluation

It is difficult to determine whether specific suicide-prevention strategies actually decrease the number of suicides.[48] Empirical research cannot be conducted on suicide in prison, simply because it would be unethical to withhold certain preventive strategies from suicidal individuals for the sake of research. However, after implementation, the suicide-prevention program must be evaluated continually by standardized auditing, which allows necessary adjustments to be made in a timely manner. Both administration and service providers must evaluate individual components as well as the system as a whole. Therefore, a systematic program evaluation and quality-assurance plan should be developed and implemented. Indirectly, lower mental health scores, fewer incidents of suicidal behavior, or use of less psychiatric medication may denote improvement in the program. Of course, it would be necessary to perform a well-designed study to make sure that the improvements were not connected with other similarly timed events. Although studies of suicide in prisons are retrospective, prospective studies using comparison groups of non-suicidal inmates are needed. Women who commit suicide in prison should be studied extensively,[69] because data on that topic are minimal. Another area of research is to determine the effectiveness of timely medical intervention with serious suicide attempters.

Conclusion

When fully operational, the comprehensive suicide-prevention program outlined herein may not only save lives but also may reflect adequacy and thoroughness of overall mental health and psychiatric services delivery systems as well as correctional practices. Nearly 30 percent of inmates who commit suicide have no psychiatric illness and provide no warning signs. Mental health and correctional service providers may fail to identify this population. The program described is also a roadmap to avoid any malpractice or deliberate-indifference claims by a third party.

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Correctional Managed Health Care

Quarterly Report
FY 2009 Second Quarter

September 2008 – February 2009

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 second quarter of FY 2009. Following this summary are individual data tables and charts supporting this report.

Background

During Fiscal Year 2009, approximately $427.7 million within the TDCJ appropriation has been allocated for funding correctional health care services. This funding included:

- $384.9M in general revenue appropriations in strategy C.1.8 (Managed Health Care, medical services)
- $42.8M in general revenue appropriations in strategy C.1.7. (Psychiatric Care).

Of this funding, $427.1M (99.9%) was allocated for health care services provided by UTMB and TTUHSC and $587K (0.1%) for the operation of the Correctional Managed Health Care Committee.

In addition and based on the 80th Legislative Session, UTMB did receive $10.4M in General Obligation Bonds for repairs to the TDCJ Hospital in Galveston in FY 2008. Included in the strategy C.1.7 Psychiatric Care Funding above is the amount $4.8M for FY 2009 for psychiatric care at the Marlin VA Hospital contingent upon transfer of the facility to the State. Also, included in the strategy C.1.8 Medical Services Funding above is the $1.9M authorized under Amendment #1 for the new Marlin and San Saba facilities. These payments are made directly to the university providers according to their contracts. Benefit reimbursement amounts and expenditures are included in the reported totals provided by the universities.

Report Highlights

Population Indicators

- Through the second quarter of this fiscal year, the correctional health care program has slightly decreased in the overall offender population served by the program. The average daily population served through the second quarter of FY 2009 was 150,659. Through this same quarter a year ago (FY 2008), the average daily population was 151,671, a decrease of 1,012 (0.66%). 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 second quarter of FY 2009, the average number of older offenders in the service population was 10,821. Through this same quarter a year ago (FY 2008), the average number of offenders age 55 and over was 10,211. This represents an increase of 610 or about 5.9% 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 2,472 (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 1,933 through the second quarter of FY 2009, as compared to 1,956 through the same quarter a year ago (FY 2008). The inpatient caseload is limited by the number of available inpatient beds in the system.
    - Through the second quarter of FY 2009, the average number of mental health outpatients was 18,697 representing 12.4% of the service population.

Health Care Costs

- Overall health costs through the second quarter of FY 2009 totaled $243.8M. This amount exceeded overall revenues earned by the university providers by $6.2M or 2.60%.
  - UTMB's total revenue through the quarter was $188.3M. Their expenditures totaled $193.4M, resulting in a net loss of $5.1M. On a per offender per day basis, UTMB earned $8.62 in revenue and expended $8.85 resulting in a shortfall of $0.23 per offender per day.

- TTUHSC's total revenue through the second quarter was $49.3M. Expenditures totaled $50.3M, resulting in a net loss of $1.0M. On a per offender per day basis, TTUHSC earned $8.85 in revenue, but expended $9.04 resulting in a shortfall of $0.19 per offender per day.

- Examining the health care costs in further detail indicates that of the $243.8M in expenses reported through the second quarter of the year:
  - Onsite services (those medical services provided at the prison units) comprised $120.8M representing about 49.5% of the total health care expenses:
    - Of this amount, 79.8% was for salaries and benefits and 20.2% for operating costs.
  - Pharmacy services totaled $24.8M representing approximately 10.2% of the total expenses:
    - Of this amount 16.9% was for related salaries and benefits, 3.7% for operating costs and 79.4% for drug purchases.
  - Offsite services (services including hospitalization and specialty clinic care) accounted for $68.4M or 28.0% of total expenses:
    - Of this amount 64.4% was for estimated university provider hospital, physician and professional services; and 35.6% for Freeworld (non-university) hospital, specialty and emergency care.
  - Mental health services totaled $22.9M or 9.4% of the total costs:
    - Of this amount, 97.1% was for mental health staff salaries and benefits, with the remaining 2.9% for operating costs.
  - Indirect support expenses accounted for $6.9M and represented 2.8% of the total costs.

- The total cost per offender per day for all health care services statewide through the second quarter of FY 2009 was $8.89. The average cost per offender per day for the prior four fiscal years was $7.86.
  - For UTMB, the cost per offender per day was $8.85. This is higher than the average cost per offender per day for the last four fiscal years of $7.94.
  - For TTUHSC, the cost per offender per day was $9.04, significantly higher than the average cost per offender per day for the last four fiscal years of $7.58.
  - 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 second quarter of FY 2009 indicates that offenders aged 55 and over had a documented encounter with medical staff a little over 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 $1,634 per offender. The same calculation for offenders under age 55 totaled about $260. In terms of hospitalization, the older offenders were utilizing health care resources at a rate more than six times higher than the younger offenders. While comprising about 7.2% of the overall service population, offenders age 55 and over account for more than 32.7% of the hospitalization costs received to date.
    - A third examination of dialysis costs found that, proportionately, older offenders are represented over four times more often in the dialysis population than younger offenders. Dialysis costs continue to be significant, averaging about $20.8K per patient per year. Providing medically necessary dialysis treatment for an average of 188 patients through the second quarter of FY2009 cost $1.9M.

Drug Costs

- Total drug costs through the second quarter of FY 2009 totaled $18.2M.
    - Pharmaceutical costs related to HIV care continue to be the largest single component of pharmacy expenses.
        - Through this quarter, $9.1M in costs (or just over $1.5M per month) for HIV antiretroviral medication costs were experienced. This represents 50.0% of the total drug cost during this time period.
        - Expenses for psychiatric drugs are also being tracked, with $567K being expended for psychiatric medications through the second quarter, representing 3.1% of the overall drug cost.
        - Another pharmacy indicator being tracked is the cost related to Hepatitis C therapies. These costs were $623K and represented by 3.4% of the total drug cost.

Reporting of Fund Balances

- In accordance with Rider 46, page V-20, Senate Bill 1, 79th Legislature, Regular Session 2005, both the University of Texas Medical Branch and Texas Tech University Health Sciences Center are required to report if they hold any monies in reserve for correctional managed health care. UTMB reports that they hold no such reserves and report a total shortfall of $5,122,993 through this quarter. TTUHSC reports that they hold no such reserves and report a total shortfall of $1,062,600.

- A summary analysis of the ending balances, revenue and payments through the second quarter for all CMHCC accounts is included in this report. That summary indicates that the net unencumbered balance on all CMHCC accounts on February 28, 2009 was a negative $106,423,092.52. It should be noted that this negative balance is due to the advanced third quarter payments and that this balance will increase over the course of the third quarter.

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.

The testing of detail transactions performed on TTUHSC's financial information for January and February 2009, found no discrepancies.

The testing of detail transactions performed on UTMB's financial information for January and February 2009 has also found no discrepancies.

Concluding Notes

The combined operating loss for the university providers through the second quarter of FY 2009 is $6,185,593. The university providers are continuing to monitor their expenditures closely, while seeking additional opportunities to reduce costs in order to minimize their operating losses.

Listing of Supporting Tables and Charts

Table 1

Correctional Managed Health Care

FY 2009 Budget Allocations

Distribution of Funds

Allocated to	FY 2009
University Providers	
The University of Texas Medical Branch	
Medical Services	$303,959,987
Mental Health Services	$25,619,350
Marlin VA (contingent upon facility transfer)	$4,843,986
Subtotal UTMB	$334,423,323
Texas Tech University Health Sciences Center	
Medical Services	$80,308,354
Mental Health Services	$12,337,000
Subtotal TTUHSC	$92,645,354
SUBTOTAL UNIVERSITY PROVIDERS	$427,068,677
Correctional Managed Health Care Committee	$586,750
TOTAL DISTRIBUTION	**$427,655,427**

Source of Funds

Source	FY 2009
Legislative Appropriations	
HB 1, Article V, TDCJ Appropriations	
Strategy C.1.8. Managed Health Care	$382,901,675
Strategy C.1.7 Psychiatric Care	$37,956,350
Marlin VA (contingent upon facility transfer)	$4,843,986
Amendment #1 Marlin and San Saba Facilities	$1,953,416
TOTAL	**$427,655,427**

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

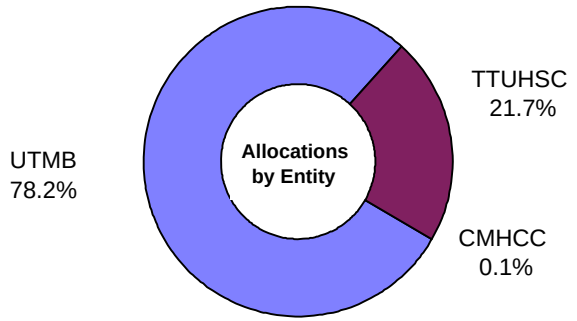


Table 2
FY 2009
Key Population Indicators
Correctional Health Care Program

Indicator	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Population Year to Date Avg.
Avg. Population Served by CMHC:							
UTMB State-Operated Population	108,091	108,181	108,404	108,525	107,950	107,945	108,183
UTMB Private Prison Population*	11,882	11,897	11,894	11,880	11,873	11,894	11,887
UTMB Total Service Population	119,973	120,078	120,299	120,405	119,824	119,839	120,070
TTUHSC Total Service Population	30,590	30,644	30,695	30,638	30,583	30,386	30,589
CMHC Service Population Total	**150,563**	**150,722**	**150,994**	**151,043**	**150,406**	**150,225**	**150,659**
Population Age 55 and Over							
UTMB Service Population Average	8,728	8,769	8,868	8,899	8,993	9,046	8,884
TTUHSC Service Population Average	1,937	1,928	1,941	1,947	1,934	1,933	1,937
CMHC Service Population Average	**10,665**	**10,697**	**10,809**	**10,846**	**10,927**	**10,979**	**10,821**
HIV+ Population	**2,566**	**2,460**	**2,451**	**2,450**	**2,458**	**2,449**	**2,472**
Mental Health Inpatient Census							
UTMB Psychiatric Inpatient Average	1,045	1,014	1,014	1,023	1,034	1,016	1,024
TTUHSC Psychiatric Inpatient Average	941	930	907	890	891	892	909
CMHC Psychiatric Inpatient Average	**1,986**	**1,944**	**1,921**	**1,913**	**1,925**	**1,908**	**1,933**
Mental Health Outpatient Census							
UTMB Psychiatric Outpatient Average	13,919	16,222	14,456	14,657	15,100	14,521	14,813
TTUHSC Psychiatric Outpatient Average	4,356	4,294	3,645	3,926	3,313	3,775	3,885
CMHC Psychiatric Outpatient Average	**18,275**	**20,516**	**18,101**	**18,583**	**18,413**	**18,296**	**18,697**

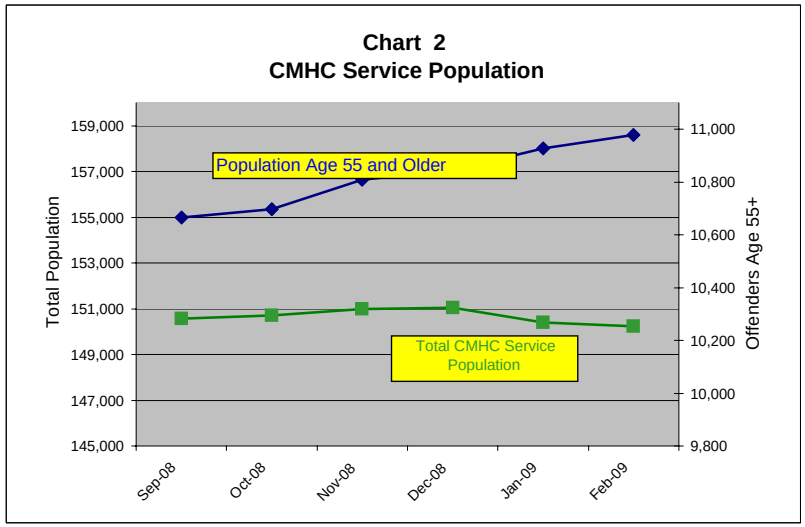


Chart 2
CMHC Service Population
Total Population
Offenders Age 55+
159,000
157,000
155,000
153,000
151,000
149,000
147,000
145,000
11,000
10,800
10,600
10,400
10,200
10,000
9,800
Population Age 55 and Older
Total CMHC Service Population
Sep-08
Oct-08
Nov-08
Dec-08
Jan-09
Feb-09

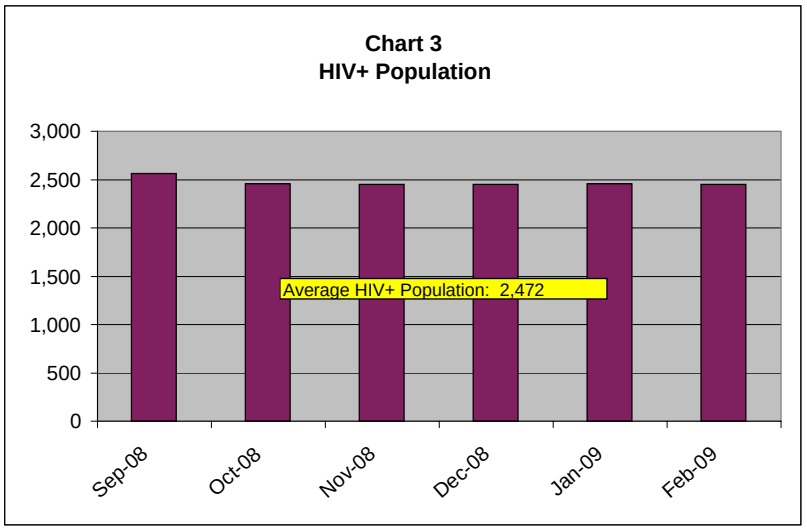


Chart 3
HIV+ Population
3,000
2,500
2,000
1,500
1,000
500
0
Average HIV+ Population: 2,472
Sep-08
Oct-08
Nov-08
Dec-08
Jan-09
Feb-09

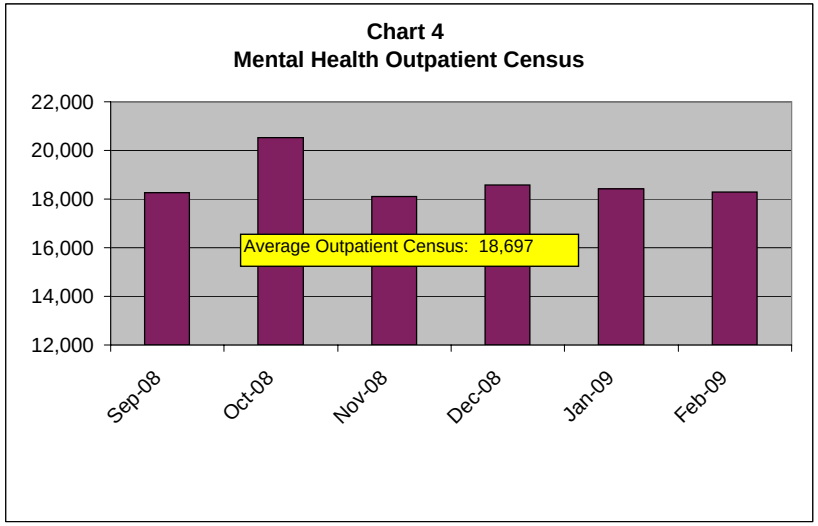


Chart 4
Mental Health Outpatient Census
22,000
20,000
18,000
16,000
14,000
12,000
Average Outpatient Census: 18,697
Sep-08
Oct-08
Nov-08
Dec-08
Jan-09
Feb-09

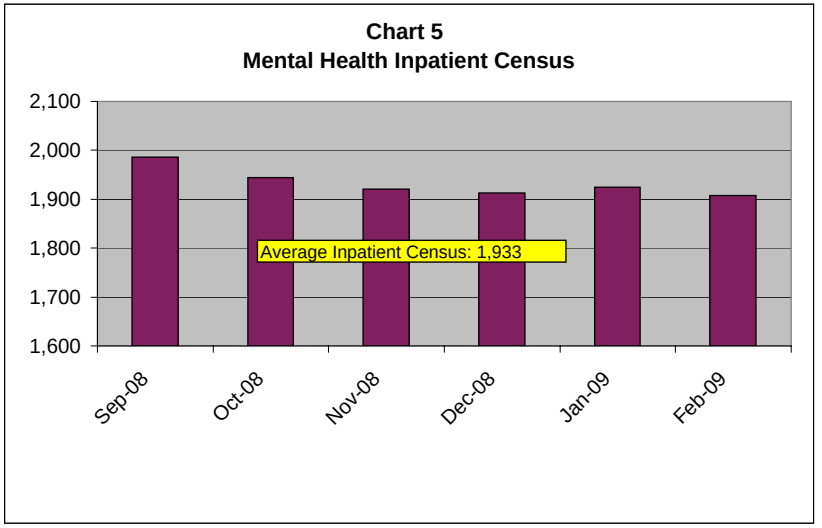


Chart 5
Mental Health Inpatient Census
2,100
2,000
1,900
1,800
1,700
1,600
Average Inpatient Census: 1,933
Sep-08
Oct-08
Nov-08
Dec-08
Jan-09
Feb-09

Table 3
Summary Financial Report: Medical Costs
Fiscal Year 2009 through Quarter 2 (Sep 2008 - Feb 2009)

Days in Year: 182

	Medical Services Costs			Medical Cost Per Day Calculations		
	UTMB	**TTUHSC**	**TOTAL**	**UTMB**	**TTUHSC**	**TOTAL**
Population Served	**120,070**	**30,589**	**150,659**			
Revenue						
Capitation Payments	$150,727,801	$39,599,145	$190,326,946	$6.90	$7.11	$6.94
State Reimbursement Benefits	$20,240,176	$2,017,360	$22,257,536	$0.93	$0.36	$0.81
Non-Operating Revenue	$1,745,376	$985	$1,746,361	$0.08	$0.00	$0.06
Total Revenue	**$172,713,353**	**$41,617,490**	**$214,330,843**	**$7.90**	**$7.48**	**$7.82**
Expenses						
Onsite Services						
Salaries	$71,161,309	$6,152,564	$77,313,873	$3.26	$1.11	$2.82
Benefits	$17,546,980	$1,523,577	$19,070,557	$0.80	$0.27	$0.70
Operating (M&O)	$10,103,497	$778,961	$10,882,458	$0.46	$0.14	$0.40
Professional Services	$0	$1,278,031	$1,278,031	$0.00	$0.23	$0.05
Contracted Units/Services	$0	$10,808,686	$10,808,686	$0.00	$1.94	$0.39
Travel	$550,472	$58,924	$609,396	$0.03	$0.01	$0.02
Electronic Medicine	$0	$178,962	$178,962	$0.00	$0.03	$0.01
Capitalized Equipment	$184,988	$400,000	$584,988	$0.01	$0.07	$0.02
Subtotal Onsite Expenses	$99,547,246	$21,179,705	$120,726,951	$4.56	$3.80	$4.40
Pharmacy Services						
Salaries	$2,586,927	$825,111	$3,412,038	$0.12	$0.15	$0.12
Benefits	$763,933	$26,209	$790,142	$0.03	$0.00	$0.03
Operating (M&O)	$558,999	$344,800	$903,799	$0.03	$0.06	$0.03
Pharmaceutical Purchases	$16,387,850	$3,296,968	$19,684,818	$0.75	$0.59	$0.72
Professional Services	$0	$0	$0	$0.00	$0.00	$0.00
Travel	$15,522	$5,506	$21,028	$0.00	$0.00	$0.00
Subtotal Pharmacy Expenses	$20,313,231	$4,498,594	$24,811,825	$0.93	$0.81	$0.90
Offsite Services						
University Professional Services	$3,033,261	$511,898	$3,545,159	$0.14	$0.09	$0.13
Freeworld Provider Services	$17,444,807	$6,903,096	$24,347,903	$0.80	$1.24	$0.89
UTMB or TTUHSC Hospital Cost	$16,171,337	$5,961,641	$22,132,978	$0.74	$1.07	$0.81
Estimated IBNR	$17,290,427	$1,042,797	$18,333,224	$0.79	$0.19	$0.67
Subtotal Offsite Expenses	$53,939,832	$14,419,432	$68,359,264	$2.47	$2.59	$2.49
Indirect Expenses	$3,755,482	$2,458,747	$6,214,229	$0.17	$0.44	$0.23
Total Expenses	**$177,555,791**	**$42,556,478**	**$220,112,269**	**$8.13**	**$7.64**	**$8.03**
Operating Income (Loss)	**($4,842,438)**	**($938,988)**	**($5,781,426)**	**($0.22)**	**($0.17)**	**($0.21)**

Table 3 (Continued)
Summary Financial Report: Mental Health Costs
Fiscal Year 2009 through Quarter 2 (Sep 2008 - Feb 2009)

Days in Year: 182

	Mental Health Services Costs			Mental Health Cost Per Day Calculations		
	UTMB	TTUHSC	TOTAL	UTMB	TTUHSC	TOTAL
Population Served	**120,070**	**30,589**	**150,659**			
Revenue						
Capitation Payments	$12,704,390	$6,342,800	$19,047,190	$0.58	$1.14	$0.69
State Reimbursement Benefits	$2,874,963	$1,326,059	$4,201,022	$0.13	$0.24	$0.15
Other Misc Revenue	($4,813)	$0	($4,813)	($0.00)	$0.00	($0.00)
Total Revenue	**$15,574,540**	**$7,668,859**	**$23,243,399**	**$0.71**	**$1.38**	**$0.85**
Expenses						
Mental Health Services						
Salaries	$12,212,142	$5,661,667	$17,873,809	$0.56	$1.02	$0.65
Benefits	$2,943,847	$1,440,338	$4,384,185	$0.13	$0.26	$0.16
Operating (M&O)	$244,497	$133,924	$378,421	$0.01	$0.02	$0.01
Professional Services	$0	$179,679	$179,679	$0.00	$0.03	$0.01
Contracted Units/Services	$0	$0	$0	$0.00	$0.00	$0.00
Travel	$106,178	$9,795	$115,973	$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	$15,506,664	$7,425,403	$22,932,067	$0.71	$1.33	$0.84
Indirect Expenses	$348,431	$367,068	$715,499	$0.02	$0.07	$0.03
Total Expenses	**$15,855,095**	**$7,792,471**	**$23,647,566**	**$0.73**	**$1.40**	**$0.86**
Operating Income (Loss)	**($280,555)**	**($123,612)**	**($404,167)**	**($0.01)**	**($0.02)**	**($0.01)**

All Health Care Summary

	All Health Care Services			Cost Per Offender Per Day		
	UTMB	TTUHSC	TOTAL	UTMB	TTUHSC	TOTAL
Medical Services	$172,713,353	$41,617,490	$214,330,843	$7.90	$7.48	$7.82
Mental Health Services	$15,574,540	$7,668,859	$23,243,399	$0.71	$1.38	$0.85
Total Revenue	**$188,287,893**	**$49,286,349**	**$237,574,242**	**$8.62**	**$8.85**	**$8.66**
Medical Services	$177,555,791	$42,556,478	$220,112,269	$8.13	$7.64	$8.03
Mental Health Services	$15,855,095	$7,792,471	$23,647,566	$0.73	$1.40	$0.86
Total Expenses	**$193,410,886**	**$50,348,949**	**$243,759,835**	**$8.85**	**$9.04**	**$8.89**
Operating Income (Loss)	**($5,122,993)**	**($1,062,600)**	**($6,185,593)**	**($0.23)**	**($0.19)**	**($0.23)**

Table 4
FY 2009 2nd Quarter
UTMB/TTUHSC EXPENSE SUMMARY

Category	Expense	Percent of Total
Onsite Services	**$120,726,951**	**49.53%**
Salaries	$77,313,873	
Benefits	$19,070,557	
Operating	$24,342,521	
Pharmacy Services	**$24,811,825**	**10.18%**
Salaries	$3,412,038	
Benefits	$790,142	
Operating	$924,827	
Drug Purchases	$19,684,818	
Offsite Services	**$68,359,264**	**28.04%**
Univ. Professional Svcs.	$3,545,159	
Freeworld Provider Svcs.	$24,347,903	
Univ. Hospital Svcs.	$22,132,978	
Est. IBNR	$18,333,224	
Mental Health Services	**$22,932,067**	**9.41%**
Salaries	$17,873,809	
Benefits	$4,384,185	
Operating	$674,073	
Indirect Expense	**$6,929,728**	**2.84%**
Total Expenses	**$243,759,835**	**100.00%**

Chart 6: Total Health Care by Category

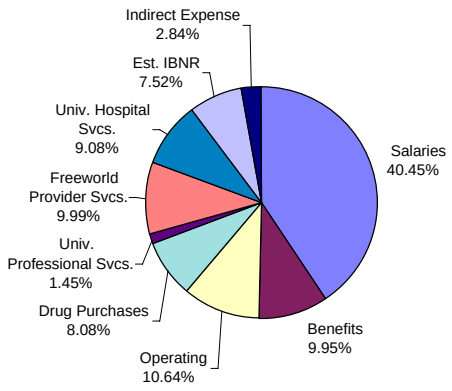


Chart 7: Onsite Services

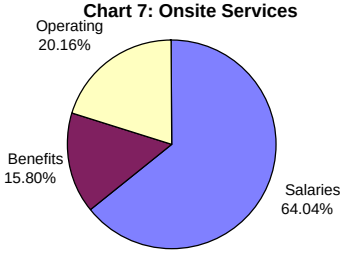


Chart 8: Pharmacy Services

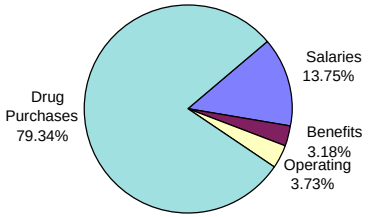


Chart 9: Offsite Services

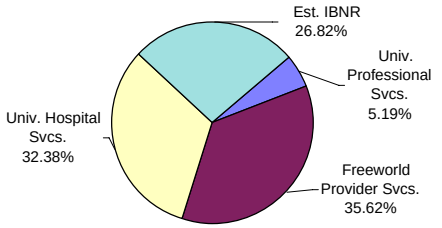


Chart 10: Mental Health Services

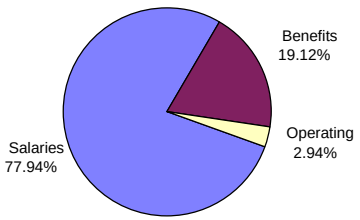


Table 5
Comparison of Total Health Care Costs

	FY 05	FY 06	FY 07	FY 08	4-Year Average	FYTD 09 1st Qtr	FYTD 09 2nd Qtr
Population							
UTMB	119,322	119,835	120,235	120,648	120,010	120,117	120,070
TTUHSC	31,437	31,448	31,578	31,064	31,382	30,643	30,589
Total	150,759	151,283	151,813	151,712	151,392	150,760	150,659
Expenses							
UTMB	$330,672,773	$336,934,127	342,859,796	381,036,398	347,875,774	92,490,864	193,410,886
TTUHSC	$80,083,059	$83,467,550	87,147,439	96,482,145	86,795,048	24,625,338	50,348,949
Total	$410,755,832	$420,401,677	430,007,235	477,518,543	434,670,822	117,116,202	243,759,835
Cost/Day							
UTMB	$7.59	$7.70	$7.81	$8.63	$7.94	$8.46	$8.85
TTUHSC	$6.98	$7.27	$7.56	$8.49	$7.58	$8.83	$9.04
Total	**$7.46**	**$7.61**	**$7.76**	**$8.60**	**$7.86**	**$8.54**	**$8.89**

* Expenses include all health care costs, including medical, mental health, and benefit costs.
NOTE: The FY08 calculation has been adjusted from previous reports to correctly account for leap year

Chart 11: UTMB Cost Per Day

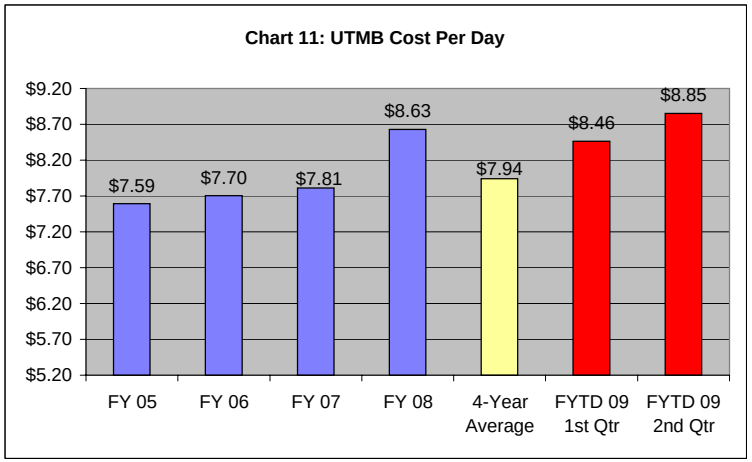


Chart 12: TTUHSC Cost Per Day

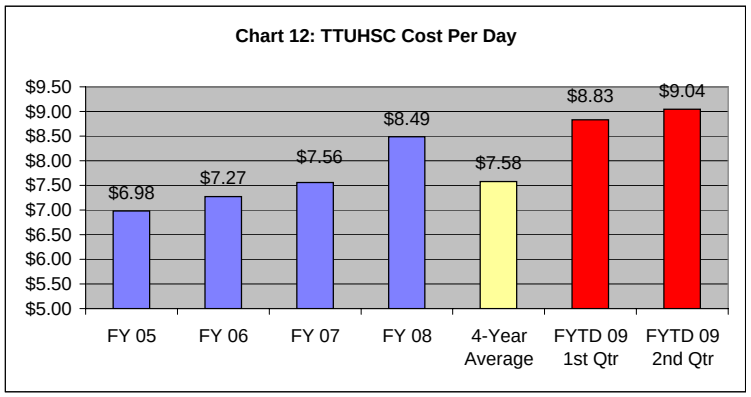


Chart 13: STATEWIDE Cost Per Day

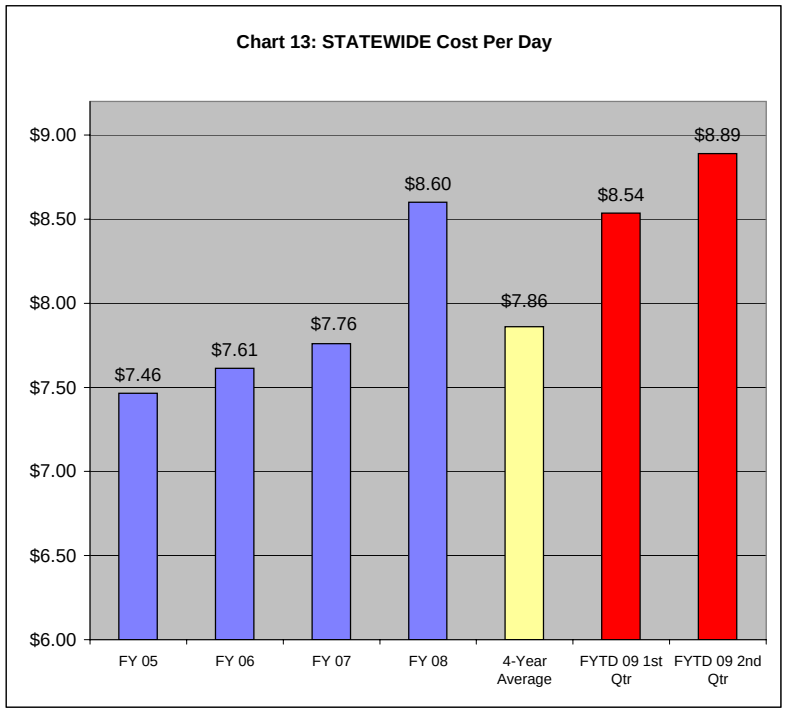


Table 6
Medical Encounter Statistics* by Age Grouping

6

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-08	29,123	127,500	156,623	8,728	111,245	119,973	3.34	1.15	1.31
Oct-08	37,742	163,950	201,692	8,769	111,309	120,078	4.30	1.47	1.68
Nov-08	34,982	148,122	183,104	8,868	111,431	120,299	3.94	1.33	1.52
Dec-08	37,640	161,618	199,258	8,899	111,506	120,405	4.23	1.45	1.65
Jan-09	38,637	166,958	205,595	8,993	110,831	119,824	4.30	1.51	1.72
Feb-09	36,356	159,892	196,248	9,046	110,793	119,839	4.02	1.44	1.64
Average	35,747	154,673	190,420	8,884	111,186	120,070	4.02	1.39	1.59

*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

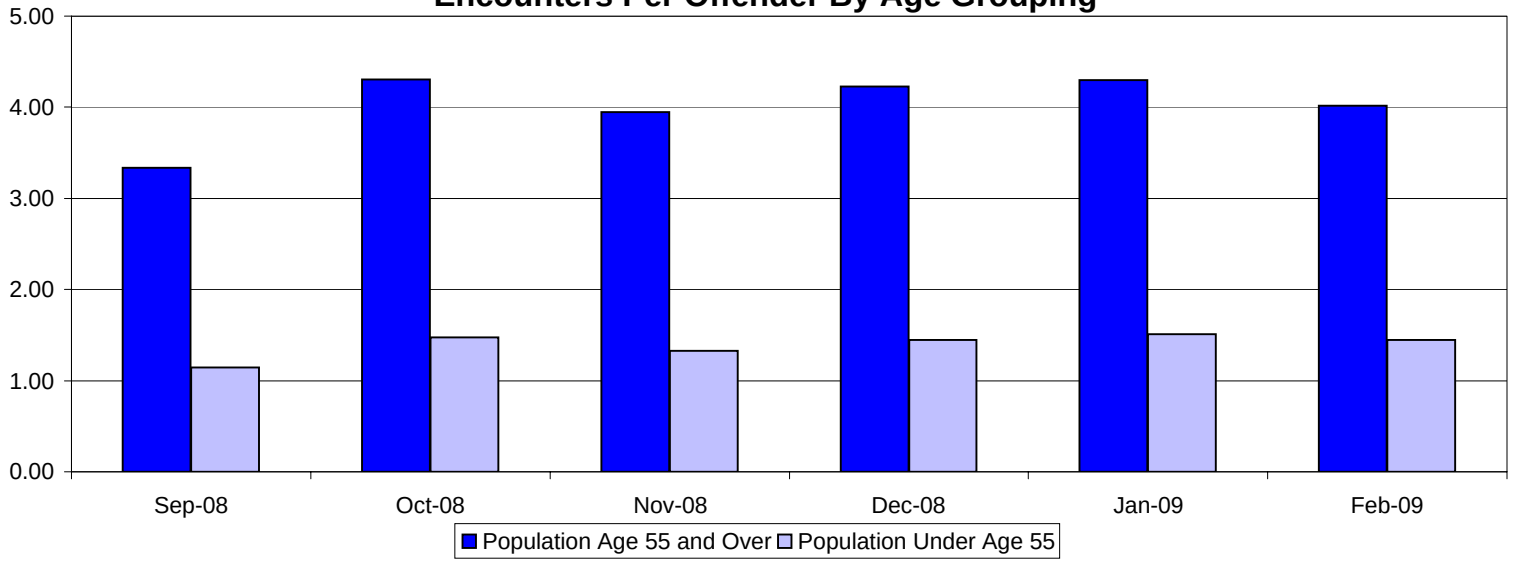


Table 7
FY 2009 2nd Quarter
Offsite Costs* To Date by Age Grouping

Age Grouping	Cost Data	Total Population	Total Cost Per Offender
Age 55 and Over	$17,680,984	10,821	$1,634.03
Under Age 55	$36,333,283	139,838	$259.82
Total	**$54,014,267**	**150,659**	**$358.52**

**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. Some cost were estimated due to Hospital Galveston closure during Hurr*

Chart 15
Hospital Costs to Date Per Offender
by Age Grouping

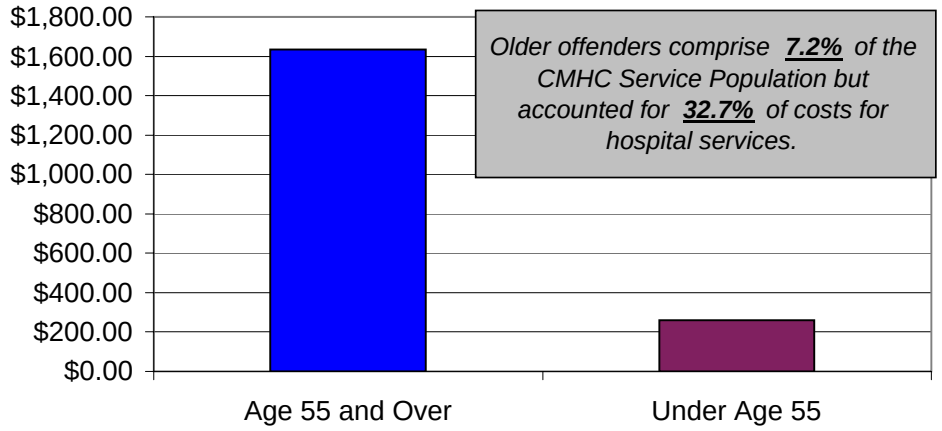
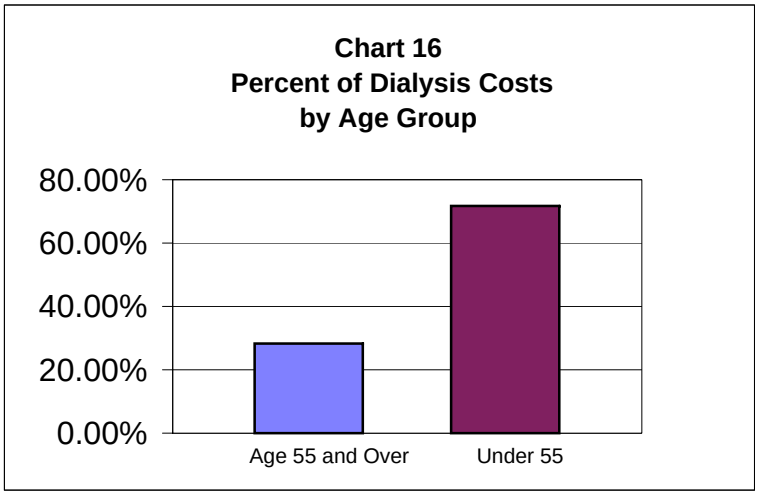


Table 8
Through FY 2009 2nd Quarter
Dialysis Costs by Age Grouping

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	$553,197	28.21%	10,821	7.18%	48	0.44%
Under Age 55	$1,407,979	71.79%	139,838	92.82%	140	0.10%
Total	**$1,961,176**	**100.00%**	**150,659**	**100.00%**	**188**	**0.12%**

Projected Avg Cost Per Dialysis Patient Per Year: $20,864



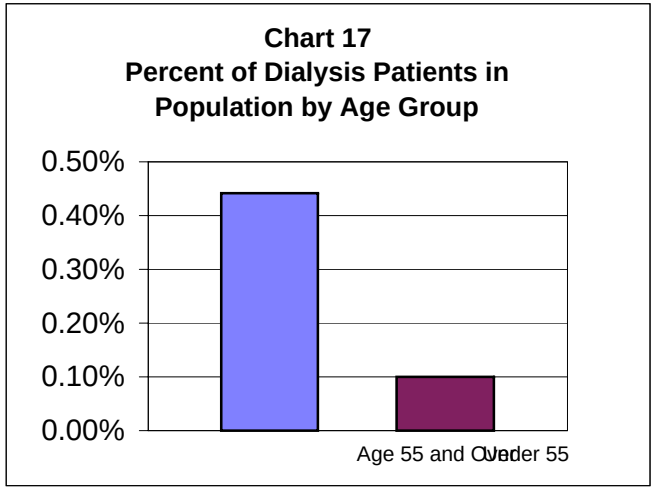


Table 9
Selected Drug Costs FY 2009

Category	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Total Year-to-Date
Total Drug Costs	$3,914,978	$2,803,459	$2,610,535	$4,162,628	$2,547,596	$2,144,655	$18,183,850
HIV Medications							
HIV Drug Cost	$2,232,714	$1,326,580	$1,470,304	$1,700,599	$1,131,214	$1,220,780	$9,082,191
HIV Percent of Cost	57.03%	47.32%	56.32%	40.85%	44.40%	56.92%	49.95%
Psychiatric Medications							
Psych Drug Cost	$145,692	$12,015	$130,147	$86,408	$104,690	$88,198	$567,148
Psych Percent of Cost	3.72%	0.43%	4.99%	2.08%	4.11%	4.11%	3.12%
Hepatitis C Medications							
Hep C Drug Cost	$203,994	$53,482	$86,963	$106,573	$93,261	$78,899	$623,172
Hep C Percent of Cost	5.21%	1.91%	3.33%	2.56%	3.66%	3.68%	3.43%
All Other Drug Costs	$1,332,578	$1,411,382	$923,122	$2,269,048	$1,218,432	$756,778	$7,911,340

Chart 18
Drug Costs by Selected Categories

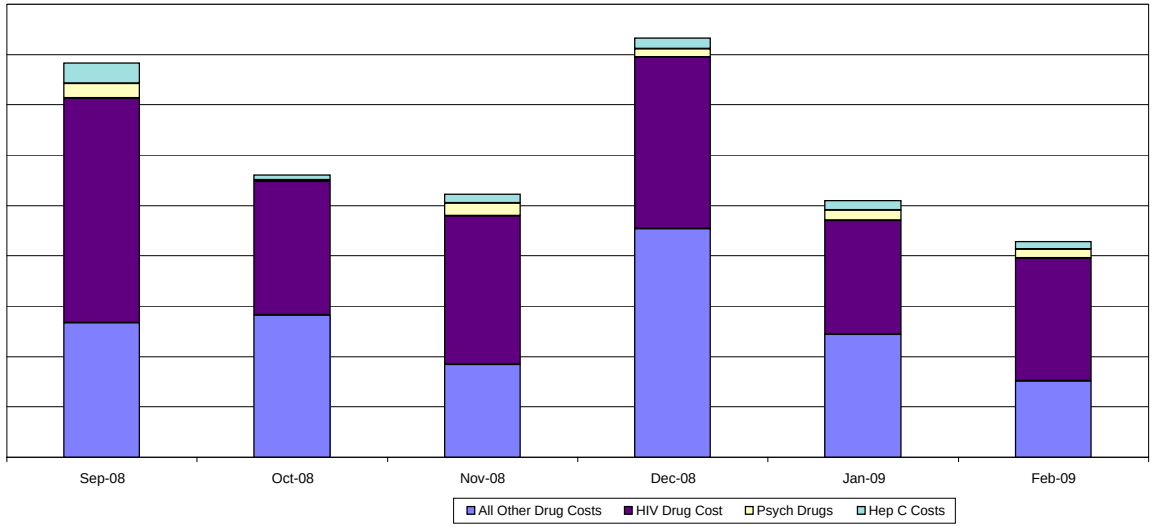


Table 10
Ending Balances 2nd Qtr FY 2009

	Beginning Balance September 1, 2008	Net Activity FY 2009	Ending Balance February 28, 2009
CMHCC Operating Funds	$31,702.52	$116,811.12	$148,513.64
CMHCC Medical Services	$46,317.13	($46,316.13)	$0.00
CMHCC Mental Health	$7,512.29	($7,467.44)	$44.85
Ending Balance All Funds	**$85,531.94**	**$63,027.55**	**$148,558.49**
3rd QTR Advance Payments			
From TDCJ - Medical			($96,856,678.00)
From TDCJ - Mental Health			($9,567,080.00)
From TDCJ - CMHCC			($147,893.01)
Total Unencumbered Fund Balance			($106,423,092.52)

SUPPORTING DETAIL

CMHCC Operating Account	
Beginning Balance	$31,702.52
FY 2008 Funds Lapsed to State Treasury	($31,702.52)
Revenue Received	
1st Qtr Payment	$146,286.33
2nd Qtr Payment	$144,677.65
3rd Qtr Advance Payment	$147,893.01
Interest Earned	$167.31
Subtotal Revenue	$439,024.30
Expenses	
Salary & Benefits	($237,830.31)
Operating Expenses	($52,680.35)
Subtotal Expenses	**($290,510.66)**
Net Activity thru this Qtr	**$116,811.12**
Total Fund Balance CMHCC Operating	**$148,513.64**

RECONCILIATION:	
Less: 3rd Qtr Advance Payment from TDCJ	($147,893.01)
Total Unencumbered Fund Balance	$620.63

SUPPORTING DETAIL

CMHCC Capitation Accounts	**Medical Services**	**Mental Health**
Beginning Balance	$46,317.13	$7,512.29
FY 2008 Funds Lapsed to State Treasury	($46,317.13)	($7,512.29)
Revenue Detail		
1st Qtr Payment from TDCJ	$95,803,887.00	$9,463,090.00
2nd Qtr Payment from TDCJ	$94,751,098.00	$9,359,100.00
3rd Qtr Advance Payment from TDCJ	$96,856,678.00	$9,567,080.00
Interest Earned	$0.00	$44.85
Revenue Received	**$287,411,663.00**	**$28,389,314.85**
Payments to UTMB		
1st Qtr Payment to UTMB	($75,781,805.00)	($6,387,290.00)
2nd Qtr Payment to UTMB	($74,949,038.00)	($6,317,100.00)
3rd Qtr Payment to UTMB	($76,614,571.00)	($6,457,480.00)
Subtotal UTMB Payments	**($227,345,414.00)**	**($19,161,870.00)**
Payments to TTUHSC		
1st Qtr Payment to TTUHSC	($20,022,083.00)	($3,075,800.00)
2nd Qtr Payment to TTUHSC	($19,802,060.00)	($3,042,000.00)
3rd Qtr Payment to TTUHSC	($20,242,105.00)	($3,109,600.00)
Subtotal TTUHSC Payments	**($60,066,248.00)**	**($9,227,400.00)**
Total Payments Made thru this Qtr	**($287,411,662.00)**	**($28,389,270.00)**
Net ActivityThrough This Qtr	**($46,316.13)**	**($7,467.44)**
Total Fund Balance	**$0.00**	**$44.85**

RECONCILIATION:		
Less: 3rd Qtr Advance Payment from TDCJ	($96,856,678.00)	($9,567,080.00)
Total Unencumbered Fund Balance	($96,856,678.00)	($9,567,035.15)