CORRECTIONAL MANAGED HEALTH CARE

COMMITTEE

AGENDA

September 8, 2009

9:00 a.m.

Love Field Main Terminal
Multi-Purpose Conference Room
8008 Cedar Springs Road
Dallas, Texas

CORRECTIONAL MANAGED HEALTH CARE COMMITTEE
September 8 , 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, June 9, 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

1. Update: 81st Legislative Session

VI. CMHCC FY 2009 Third Quarter Performance and Financial Status Report

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EACH ITEM ABOVE INCLUDES DISCUSSION AND ACTION AS NECESSARY

VII. 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

VIII. Updates: Infection Control Manual Policies

1. B-14.11, Human Immunodeficiency Virus (HIV) Infection

IX. Purchase: H1N1 / Swine Flu Vaccines

X. Medical Director's Updates

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

2. Texas Tech University Health Sciences Center

3. The University of Texas Medical Branch
- CMC Reorganization

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

XII. TTUHSC Audit – Capital Asset Inventory System Controls

XIII. Financial Reports

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

XIV. Public Comment

XV. Date / Location of Next CMHCC Meeting

XVI. Adjourn

Consent Item 1

Approval of Minutes, June 9, 2009

MINUTES

CORRECTIONAL MANAGED HEALTH CARE COMMITTEE
June 9, 2009

Chairperson: James D. Griffin, M.D.

CMHCC Members Present: Elmo Cavin, Bryan Collier, William Elger, Gerard Evenwel, Cynthia Jumper, Lannette Linthicum, M.D.,

CMHCC Members Absent: Ben G. Raimer, M.D., Desmar Walkes, M.D.

Partner Agency Staff Present: Owen Murray, D. O., Karen Sexton, R.N., Ph.D., FACHE, Joe Penn, M.D., Lauren Neumann, Steve Alderman, The University of Texas Medical Branch; Denise DeShields, M.D., Texas Tech University Health Sciences Center; Nathaniel Quarterman, Ron Steffa, Robert Williams, M.D., George Crippen, R.N., MSN, Michael Kelley, M.D. Chris Black, RN, BSN, Texas Department of Criminal Justice; David Nelson, Janice Lord, Texas Board of Criminal Justice; Jeannie Frazier, Past CMHCC Member; Allen Hightower, David McNutt, Lynn Webb, Tati Buentello, CMHCC Staff.

Others Present: Lynne Baker, GSK; Cathy Corey, Abbott-Institutional Managing

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 9:00 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. Gerard Evenwel, recently appointed by the Governor to serve as the non-physician public member replacing Ms. Jeannie Frazier whose term expired on February 1, 2009. He further noted that Mr. Evenwel has close to 40 years experience in Human Resources and Benefits; and has been with the upper management of Fortune 50 and 500 companies. Mr. Evenwel recently retired from Pilgrim's Pride Corporation as Director, Compensation and Benefits and in that role, Mr. Evenwel consolidated and restructured self-insured health care and pharmacy benefit plans and case management programs to better manage employees with chronic illnesses. Dr. Griffin on behalf of the Committee and staff welcomed Mr. Evenwel to the meeting.		

Agenda Topic / Presenter	Presentation	Discussion	Action
Introductions / Recognitions Cont.	Dr. Griffin next stated that he introduced Mr. William Elger in-absentia at the last meeting as he was unable to attend due to scheduling conflicts. Dr. Griffin again noted that Mr. Elger was appointed by Dr. David Callendar, President, UTMB, to serve as the non-physician member representing the University of Texas Medical Branch replacing Mr. Larry Revill. Mr. Elger currently serves as the Executive Vice-President, Chief Business and Finance Officer for UTMB. He comes to UTMB from the University of Arizona College of Medicine where he was the Senior Associate Dean for Administration and Finance. Dr. Griffin welcomed Mr. Elger on behalf of the Committee. Dr. Griffin then acknowledged and thanked Mr. David Nelson and Ms. Janice Lord with the Texas Board of Criminal Justice and Dr. Karen Sexton, UTMB for attending the meeting. Dr. Griffin next stated that Ms. Jeannie Frazier was named to the CMHCC as one of the original three public members appointed by the Governor. He further noted that Ms. Frazier served for nine consecutive years and acknowledged her outstanding leadership, financial expertise and outstanding service to the Texas correctional health care program.	Dr. Griffin then read and asked the Committee to officially adopt the Resolution of Appreciation being presented to Ms. Frazier. (Attachment 1). Dr. Linthicum also presented Ms. Frazier with a gift in appreciation for her service and commitment to the TDCJ healthcare program on behalf of the Texas Department of Criminal Justice. Ms. Frazier thanked the Committee and stated that it was a pleasure to have served as one of the original three public members to be appointed by the Governor. She stated that all three partner agencies should be proud of the exemplary work they do in providing health care to the offender population which speaks well for the State of Texas.	Mr. Elmo Cavin moved that the Committee adopt the Resolution of Appreciation as presented by Dr. Griffin. Dr. Cynthia Jumper seconded the motion which prevailed by unanimous vote.

Agenda Topic / Presenter	Presentation	Discussion	Action
Recognition / Introductions (Cont.)	Dr. Griffin asked if there were any other introductions to be made?	Dr. Linthicum introduced Chris Black, Chief of Nursing, who will oversee compliance and access to care monitoring.	
III. Approval of Excused Absence - **James Griffin, M.D.**	Dr. Griffin then stated that he would entertain a motion to approve the excused absences of Mr. Bryan Collier and Mr. William Elger who were unable to attend the March 27, 2009 CMHCC meeting due to scheduling conflicts.		Mr. Cavin moved to approve Mr. Bryan Collier and Mr. William Elger's absence from the March 27, 2009 CMHCC meeting. Dr. Cynthia Jumper seconded the motion. The motion passed by unanimous vote.
IV. Approval of Consent Items - **James Griffin, M.D.**	Dr. Griffin stated next on the agenda is the approval of the consent items to include the Minutes from the March 27, 2009 CMHCC meeting; the TDCJ Health Services Monitoring Report; both UTMB and TTUHSC Medical Director's Report, and the Summary of Joint Committee Activities. He then asked the members if they had any specific consent item(s) to pull out for separate discussion? Hearing no further discussion, Dr. Griffin stated that he would entertain a motion on approving the consent items as presented in the agenda booklet.		Mr. Cavin moved to approve the consent items as presented at Tab A of the agenda booklet. Mr. Collier seconded the motion. The motion passed by unanimous vote.
V. Executive Director's Report - Allen Hightower	Dr. Griffin then called on Mr. Hightower to provide the Executive Director's report. Mr. Hightower stated that he would only briefly touch on the appropriations as Mr. McNutt will be providing the detailed version later on the agenda. For the new CMHCC members, Mr. Hightower noted that Senate Bill 1, the General Appropriations bill is where the operational funding for the correctional health care program under Article V is found. Mr. Hightower further reported that the total operational funding for the correctional health care program in FY 2010 is $466,370,463 and $468,303,484 in FY 2011. Mr. Hightower next noted that House Bill 4586 appropriated $48,144,918 in supplemental funding to help the university providers address projected losses during this current biennium.		

Agenda Topic / Presenter	Presentation	Discussion	Action
- **Executive Director's Report (Cont.)**	Mr. Hightower further noted that the Sunset bill did not pass before the Legislative Session ended which included changing the original 2011 Sunset date for the correctional health care program to 2013. Mr. Hightower felt sure that the Governor will be calling for a Special Session but until that time, he noted the Committee will assume that the Sunset review will start in August, 2009. Mr. Hightower concluded by stating that he would be happy to entertain any questions. Hearing no further discussion, Dr. Griffin called on Mr. McNutt to provide the performance review update.		
VI. Performance and Financial Status Report **- David McNutt**	Mr. McNutt noted that the Performance Dashboard is provided at Tab C of the agenda packet. He then reported that the offender population slightly decreased to 150,225 at the end of the second quarter FY 2009 compared to 151,723 for the same time period a year ago. The aging offenders continue to rise at a steady rate and Mr. McNutt reported that the number of offenders 55+ at the end of second quarter FY2008 was 10,211 compared to 10,824 this second quarter FY 2009 which is an increase of about 5.9%. The psychiatric inpatient census remained consistent at the 1,900 bed level which he noted, is governed largely to the number of available beds. The psychiatric outpatient numbers totaled at 18,583 for the month of December 2008; 18,413 for the month of January 2009 and 18,296 for the month February, 2009. Mr. McNutt again noted that the definition of the nine access to care indicators are included on page 84 of the agenda packet for use as a reference. He then reported that the medical access to care indicators remained within the 95% - 97% range; the mental health access		

Agenda Topic / Presenter	Presentation	Discussion	Action
- Performance and Financial Status Update (Cont.)	to care stayed within the 97% - 99% range; and dental access to care remained consistently between the 98% -99% range. Mr. McNutt continued by stating that the UTMB sector physician vacancy rate for this quarter was 15.15%; mid-level practitioners at 8.80%; RN's at 9.78%; LVN's at 14.35%, dentists at 10.77% and psychiatrists at 6.67% which he noted are slightly lower than what was reported for the previous quarter. TTUHSC sector physician vacancy rate for the same quarter averaged at 19.20%; mid-level practitioners at 10.95%; RN's at 18.9%; LVN's at 23.5%; dentists at 19.76%, and psychiatrists at 37.59%. The Texas Tech sector's percent of vacancies are higher but Mr. McNutt again noted that this is due to the smaller number of employees for each discipline and noted for example, a rate of 20% or more for the dentist category may only equate to three or four vacant dental positions. The timeliness in the Medically Recommended Intensive Supervision Program (MRIS) medical summaries was at 95% in December 2008, dropped to 94% in January, 2009 which is slightly below the targeted level of 95%, but went back up to 96% in February, 2009. Mr. McNutt next reported that for the statewide revenue v. expenses by month; the slide provided on page 91 of the agenda packet shows the revenue and expenses being close to even for the month of December 2008, but then goes into the red for the months of January and February, 2009. Mr. McNutt concluded by reporting that the overall health costs through the second quarter of FY 2009 totaled $243.8M. On a combined basis, this amount is above overall revenues earned by the university providers by approximately $6.2M or 2.6%.		

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- Financial and Performance Status Report (Cont.)	Dr. Griffin asked if there were any comments or questions for Mr. McNutt?	Dr. Linthicum asked whether the data used for the access to care indicators were based on the unit reporting data or the sick call verification audits. She stated that the verification audits is where the auditors take random samples of the sick call requests to be sure the methodologies used are the same. She recommended the staff change the report to focus on areas where they are seeing more challenges in terms of access to care as in the specialty care areas. Dr. Griffin asked the committee staff to get with Dr. Linthicum to further discuss this issue before the next meeting.	Mr. McNutt stated that he would work with Dr. Linthicum on the reporting method for the medical access to care.
VII. Funding Update and Approval	Dr. Griffin then asked Mr. McNutt to provide the funding updates.		
- **David McNutt**	Mr. McNutt stated that he would be referring to two documents that were handed out earlier and began with the document titled, "Review and Approval of Supplemental Appropriations Request, FY 2008-2009" (Attachment 2).		
- Supplemental Funding Allocations	Mr. McNutt stated that House Bill 4586, Section 16 as noted earlier by Mr. Hightower appropriated $48,144,918 in supplemental funding for the correctional health care program as the university providers experienced shortfalls in funding for the current biennium. For FY 2008, Mr. McNutt stated that UTMB reported a loss of $14,720,961 and TTUHSC reported that they had none. For FY 2009, UTMB reported an additional shortfall of $31,848,300 and Texas Tech reported a loss of $1,474,657 for a combined total loss in the amount of $33,423,957. Mr. McNutt further stated in order to address this shortfall, supplemental appropriations were requested during the 81st Legislative Session and asked that the committee authorize staff to distribute the supplemental funding amounts. Dr. Griffin hearing no further discussions, stated that he would entertain a motion.		Mr. Bryan Collier moved that pursuant to its authority under Section 501.148(a)(4) of the Texas Government Code, the

Agenda Topic / Presenter	Presentation	Discussion	Action
- Supplemental Funding Allocations (Cont.)			Committee allocate and authorize its staff to distribute the following supplemental funding amounts to UTMB: $46,569,261 and TTUHSC: $1,575,657. The distribution of these funds is to be made as soon as funds from HB 4586 are made available contingent upon the execution of contract amendments with the university providers that require the Chief Financial Officer for the university to certify the losses projected for the biennium. These allocations represent estimates that are: (1) calculated on projected end of year FY 2009 expenses; (2) based on actual data through the first seven months of the year; and (3) subject to a year end reconciliation to actual expenses incurred. Mr. Collier further moved that the staff be authorized to make a final adjustment and reconciliation of such allocations against final FY 2009 financial reports. Mr. Cavin seconded the motion. The motion passed by unanimous vote.
- FY 2010 – 2011 Budget Allocations	Mr. McNutt next referred to the second handout titled, "Review and Approval of FY 2010-2011 Budget Allocations" (Attachment 3). Mr. McNutt stated that Senate Bill 1, 81st Legislature provided the funding appropriations for the correctional health care program. He further noted that the allocations for the biennium were developed based on actual costs and projected needs. The distribution of funds in the FY 2010-2011 budget allocates all funding provided in the base appropriations for correctional health care contained in strategies C.1.7 and C.1.8 of the		

Agenda Topic / Presenters	Presentation	Discussion	Action
- FY 2010 – 2011 Budget Allocations (Cont.)	TDCJ's appropriations under Senate Bill 1. Mr. McNutt further reported that the method used by the Legislative Budget Board to get the base appropriations for FY 2010-2011 was by adding together what was appropriated for FY 2008 and FY 2009 then divided that amount by two. He noted this resulted with the base amount being short $4,182,138 going into the current legislative session. In addition to the adjustment to the base level of funding for the university providers at $48.46M for the biennium; the market adjustment totaled $20M; increased hospital / specialty care at $10M and capital equipment replacement at $5.7M. Mr. McNutt noted however that the request to implement Hepatitis biopsy in the amount of $4.4M; phased in implementation of the staffing study in the amount of $35.2M; and new initiatives in the amount of $3.2M were not funded. Mr. McNutt further reported that for the distribution of funds for the biennium; the sub-total allocated to the university providers for FY 2010 is $465,701,410 and the amount allocated for the Correctional Managed Health Care is $669,053 for a total distribution of $466,370,463. For FY 2011, the subtotal for the university providers is $467,634,356 and $669,128 for the Correctional Managed Health Care Committee for a total distribution of $468,303,484. Mr. McNutt concluded by stating that the last two pages details the budget allocation assumptions similar to what has been provided in the past.	Dr. Linthicum asked if the Rider listed in the Budget Assumption for Marlin VA was for dual mission? Mr. McNutt responded that the way the appropriation is cited, it is for psychiatric care in FY 2011 and that the funding is contingent upon completion of the renovation of the facility.	

Agenda Topic / Presenter	Presentation	Discussion	Action
- FY 2010 – 2011 Budget Allocation (Cont.)		Mr. Collier added that they are clarifying with state leadership on this. Dr. Linthicum then asked about the Rider for TDCJ to do a cost study on CMHCC? Mr. Ron Steffa stated that he would check into that. Dr. Linthicum further asked that the Committee continue to support the request for funds needed for the phased in implementation of the requested staffing study.	
	Hearing no further discussion, Dr. Griffin stated that he would entertain a motion for the budget allocation as presented by Mr. McNutt.		Mr. Elmo Cavin moved that pursuant to its authority under Section 501.148(1)(4) of the Texas Government Code, the Committee approve the FY 2010-2011 budget allocations and accompanying budget assumptions as presented. He further moved that the CMHCC authorize its staff to make any final adjustments to the projected populations used in developing these allocations that may be necessary and to adjust the projected allocation accordingly; and that the Committee authorize the staff to finalize the contracted arrangements for the next biennium in accordance with these budget allocation. Mr. Collier seconded the motion The motion is approved by unanimous vote.
	Dr. Griffin thanked Mr. McNutt for the update then called on Dr. Linthicum to provide the Critical Personnel Vacancy Updates for TDCJ.		
VIII. Summary of Critical Personnel Vacancies - Dr. Linthicum (TDCJ)	Dr. Linthicum stated for TDCJ Health Services, the Physician II position is still vacant but has been contracted as a part-time position. She further reported that there are still three nursing vacancy positions to be filled at this time.		

Agenda Topic / Presenter	Presentation	Discussion	Action
- Denise DeShields, M.D. (TTUHSC)	Dr. Griffin then called on Dr. DeShields to provide the Texas Tech's critical personnel vacancy updates. Dr. DeShields reported that Texas Tech started hiring part-time practitioners interested in working 20 hours a week which they arrange accordingly to fill in the 40 hour work week. She was also pleased to report that the PAMIO Director position has been filled and the person is set to start on July 1st. She concluded by stating that Texas Tech continues to utilize recruiting agencies and enhanced advertisements to recruit qualified applicants.		
- Owen Murray, D. O. (UTMB) Nursing Market Adjustment	Dr. Griffin thanked Dr. DeShields for the update then called on Dr. Murray for the UTMB update. Dr. Murray reported that UTMB vacancy rates as noted earlier by Mr. McNutt continues to be an area of concern. He stated that he would like to take this opportunity to get support from the Committee concerning market increases for UTMB nursing staff adjustment that were budgeted to begin on January 1, 2009 but was put on hold due to Hurricane Ike. He further stated that the current statewide nursing shortages are projected to double by the year 2013 and the number is projected to quadruple by the year 2020. This is partly due to the availability of nursing schools in Texas and their ability to expand classes. Dr. Murray then referred to the handouts that were provided. The first sheet shows a graph of the UTMB-CMC 2009 nursing vacancy rates broken out by the six districts (Attachment 4). He then noted that certain geographical areas have higher vacancy rates such as Beaumont at 32% and San Antonio at 37% compared to Houston at 12%. He next reported that the contract agency cost is approximately $4M and approximately $1.5M is spent on salary overtime. He further added that staff working overtime is not cost effective as it leads to staff burnout resulting in higher turnover and vacancy rates.		

Agenda Topic / Presenter		Discussion	Action
- Nursing Market Adjustment (Cont.)	Dr. Murray stated that the requested market adjustment would be $1.2M over an annualized basis and approximately $400,000 for the last quarter of FY 2009. He further noted that this salary adjustment will not only help recruit qualified health care providers but would be a good retention tool. He then referred to the second sheet of his handout which shows the UTMB-CMC Turnover Rates again broken out by the six geographical districts which shows both the involuntary and voluntary turnover rates. He added that two of the most common reasons for the high percentage of turnover rates are (1) they can be making more out in the community and (2) they do not like working in the prison environment. Dr. Murray added that nursing vacancies have increased significantly over the last five months due to increasing market competitiveness of the available nursing skills that are needed throughout Texas. He concluded by asking for the Committee's support of a 6% nursing market adjustment increases and again stated that this is something that had already been budgeted.	Dr. Karen Sexton added that they are not only looking at market adjustments but management is also looking to improve employee satisfaction in the working environment. She further indicated that as the national shortages of nurses increases, the harder it will be to recruit and retain nursing staff. Dr. Murray further added that market adjustments have had a positive impact and recalled that when the dental market adjustment was requested at the December 2008 CMHCC meeting and implemented; five of the ten dental vacancy positions were filled. Mr. David Nelson asked if the loan repayment bill recently passed by the legislature expanded to nurses? Dr. Murray responded that he did not know if nurses were included in that particular bill but that UTMB and TTUHSC got excluded because of the nature of the population being served. Dr. Linthicum again noted that the physicians working for TDCJ are able to participate in the Texas Higher Education Program to get assistance on their loans.	

Agenda Topic / Presenter	Presentation	Discussion	Action
- Nursing Market Adjustment (Cont.)		Dr. Griffin recalled that the legislature had set what the appropriated budget amount was for FY 2009 and wanted to be certain that the $400,000 was available in the UTMB budget and that additional funds were not needed to implement this request for the end of this quarter. Dr. Murray responded that this was correct. Mr. McNutt added that Dr. Murray did relay to the Committee staff that the nursing market adjustment amount for the end of this quarter would be $400,000 and over $1M on an annualized basis, and because of that, UTMB is bringing this to the Committee's attention. Mr. Hightower clarified that the only additional funding UTMB requested for FY 2009 is the amount submitted for the Supplemental Appropriations Request (SAR) and that the FY 2010-2011 budget is what was requested in the Legislative Appropriation Request (LAR). Dr. Griffin noted then that the amount approved for FY 2010-2011 LAR would be $12.3M for UTMB's market adjustment and that would include the different disciplines such as physicians and unit based nurses. Mr. Cavin asked if the Committee would look at market adjustments on a state-wide basis since Texas Tech is also seeing the nursing staff shortages within their own healthcare clinics as well as the TTUHSC correctional health care system. He further emphasized the need to maintain a balance where you do not start competing and recruiting staff away from one another.	

Agenda Topic / Presenter	Presentation	Discussion	Action
- Nursing Market Adjustment (Cont.) -		Dr. Linthicum agreed and noted that 15 years ago, John Sharpe in his role as Comptroller reported in his Performance Review that the managed health care model would benefit TDCJ. The report further stated that the partnership with the university medical schools would contribute with access to health care; retain costs; and the university providers would be able to recruit and retain the necessary professional health care staff that TDCJ was not able to accomplish at that time. Dr. Linthicum then noted that the university providers are now having the same difficulties recruiting and retaining the necessary professional health care staff and this challenge has become not just a correctional or free-world issue but an issue across the board in the health care profession. Dr. Griffin agreed that this is a national health care crises and asked if there were any other comments. Dr. Murray asked if any action would be taken by the Committee on the nursing market adjustment request? Dr. Linthicum added that the contract does state that any expenditures over $1M be brought before the Committee. Dr. Griffin responded that the $400,000 requested for the end of the quarter FY 2009 was reported as already included in the UTMB budget. In terms of how the Committee will go forward in looking at market increases for FY2010-2011 in the amount of $12.3M for UTMB and $7.6M for TTUHSC will be discussed further at future meetings. Dr. Griffin then asked if there were any other comments or questions? Hearing none, thanked Dr. Murray for the update.	

Agenda Topic / Presenter	Discussion	Conclusion	Action
X. Updates: Infection Control Manual Policies - Mike Kelley, M.D.	Dr. Griffin next called on Dr. Kelley to provide the updates to the Infection Control Manual Policies. Dr. Kelley noted that the changes requested for the Infection Control Manual Policy B-14.11, HIV and Policy B-14.13, Hepatitis are indicated by underline and strikeout text of the draft policies that are provided at Tab E of the agenda packet. He stated that the first change in the HIV policy is the policy statement under Procedure II, to clarify to medical staff that pre-test counseling is no longer required. This is in accordance with the recommendation from the Center for Disease Control and the Department of State Health Services to eliminate pre-test counseling to reduce barriers to testing. Changes in Procedures I.A and I.B are proposed in order to separate medical staff from the unit disciplinary process. The discipline should not be part of the provider-patient relationship and this separation is recommended in a guideline from the US Department of Justice. Dr. Kelley then noted that the next change in Procedure III.C which deletes toxoplasmosis and cytomegalovirus titers; second CD4 count and viral load from baseline testing requirements should have been a strike-out in the draft policy included in the agenda book. Dr. Kelley next stated that the changes requested for Policy B-14.13, Hepatitis were reviewed and recommended by the Infection Control Committee and the Pharmacy and Therapeutics Committee. These changes update the policy to the most current national guidelines on the management of Hepatitis B		

Agenda Topic/Presenter	Presentation	Discussion	Action
	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. Dr. Kelley concluded by stating that the changes are to reduce the ALT threshold for considering treatment from twice the upper limit of normal to simply an elevated level and also simplifies the disease management pathway. Hearing no further discussion, Dr. Griffin stated that he would entertain a motion.		Dr. Linthicum moved to approve the changes made to the CMHC Policy B-14.11, HIV and Policy B-14.13, Hepatitis as presented by Dr. Kelley. Mr. Bryan Collier seconded the motion. The motion passed by unanimous vote.
XI. Medical Director's Report **- Lannette Linthicum, M.D. (TDCJ)** - Office of Professional Standards - Grievances and Patient Liaison Correspondences. - Quality Improvement / Access to Care	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. During the second quarter of FY 2009, Dr. Linthicum reported that ten facilities were audited and those results are available on pages 138 – 139 of the agenda packet. She then reported that the Patient Liaison Program and the Step II Grievance Program received a total of 2,651 correspondences. Of the total number of correspondences received, 331 or 12.49% action requests were generated. Quality Improvement / Quality Monitoring staff performed 115 access to care audits for this quarter. A total of 1,035 indicators were reviewed and 41 indicators fell below the 80% threshold.		

Agenda Topic/Presenter	Presentation	Discussion	Action
- Capital Assets Monitoring	The Capital Assets Contract Monitoring Office audited ten units during 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 next reported that the Office of Preventive Medicine monitors the incidence of infectious diseases for TDCJ. For the second quarter of FY 2009, there were 217 cases of suspected syphilis; 842 Methicillin-Resistant Staphylococcus Aureus (MRSA) cases were reported compared to 915 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 18 per month during the second quarter of the FY 2008. Dr. Linthicum then stated that the Office of Preventive Medicine's Sexual Assault Nurse Examiner (SANE) Coordinator provided 3 training sessions, attended by 2 facilities with 23 medical staff trained. She then recalled that she reported for the first quarter of FY 2009, that all 112 Correctional Institutions Division (CID) facilities had a 100% Peer Education Programs in place and wanted to make a correction. Currently, Peer Education Programs are available at 108 of the 112 facilities housing CID offenders.		
- Mortality and Morbidity Committee	The Mortality and Morbidity Committee reviewed 76 deaths. Of those 76 deaths, 11 were referred to peer review committees and those breakdowns are found on page 141 of the agenda packet.		

Agenda Topic / Presenter	Presentation	Discussion	Action
- Mental Health Services Monitoring	The Mental Health Services Monitoring and Liaison with County Jails identified 35 offenders with immediate mental health needs prior to TDCJ intake. Dr. Linthicum added that the MHMR history was reviewed for 18,009 offenders brought into TDCJ-ID/SJ through the intake process. She further noted that 366 offenders with high risk factors (very young or old or have long sentences) transferred into TDCJ-ID were interviewed which resulted in 20 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 second quarter of FY 2009, 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.		
- Accreditation	Dr. Linthicum next reported that the American Correctional Association Panel of Commissioners awarded ACA accreditation to the Cotulla, Jester I, Vance and Jester III facilities and re-accreditation was awarded to Briscoe, Cole, C. Moore, Gist, Luther, Polunsky and Smith facilities.		
- Biomedical Research Projects	Dr. Linthicum concluded by stating that the summary and pending research projects as provided by the TDCJ Executive Services are included in the consent items on pages 52-57 of the agenda packet.		
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- Medical Director's Report Denise DeShields, M.D. (TTUHSC)	Dr. Griffin hearing no other comments, thanked Dr. Linthicum for the report and called on Dr. Deshields to provide the TTUHSC Medical Director's report. Dr. DeShields stated that she would briefly update the Committee on specialty care initiatives mentioned at the last meeting. She reported that staff from TDCJ, CMHCC, TTUHSC and Dr. Cynthia Jumper met with officials at the Grace Highland Clinic who used to provide ancillary services, outpatient services and ambulatory services from		

Agenda Topic / Presenter	Presentation	Discussion	Action
- Medical Director's Report (TTUHSC – Cont.)	October of 2007 through May of 2008. This hospital was taken over by a new group shortly afterwards and Dr. DeShields stated that they are in the process of getting those services back again with the submittal of a draft proposal. Grace Highland Clinic officials requested additional information which was has been provided and are now waiting on their response. Dr. DeShields further reported that the Grace Highland Clinic primarily provided services to include general surgery, orthopedics, GI (gastrointestinal) services but hoped to expand on the types of services as clinically needed. She stated that they are seeing an increase of patients with end-stage liver disease and gastrointestinal complications. Dr. DeShield concluded by stating that she would keep the Committee updated on this issue.		
- UTMB Medical Director's Report	Hearing no further questions, Dr Griffin thanked Dr. DeShields then called on Dr. Murray to provide the UTMB Medical Director's Report.		
- Owen Murray, D.O.	Dr. Murray stated that he would brief the Committee on the general surgery cases reviewed by Dr. Robert Williams as an ongoing quality assurance effort. Dr. Murray stated there were 216 cases of individuals with potential hernia conditions that needed to be addressed and were brought in for evaluation. He further reported that 51 of those 216 patients had their hernia repaired; 104 appointments scheduled (45 of those appointments scheduled for June; 54 scheduled for July and 5 scheduled for August); 27 paroled out of the system and 28 patients refused surgery. Dr. Murray concluded by stating that he would continue to update the Committee then thanked Dr. Williams for reviewing the cases. Dr. Griffin asked if there were any questions?	Dr. Linthicum requested that Dr. Murray provide the data on the 216 cases of individuals with potential hernia conditions to her office.	

Agenda Topic / Presenter	Presentation	Discussion	Action
UTMB Medical Director's Report (Cont.)		Dr. Murray stated that he would provide the data as requested. Dr. Griffin noted that there are still some concerns in the sub-specialty areas that need to be addressed further by the partner agencies. He further noted that there is currently an ongoing dispute resolution between TDCJ and UTMB on dialysis patients which they have been working on and are certainly seeing improvements after re-assessing those cases. Dr. Griffin thanked the university providers and TDCJ on their cooperative efforts in improving the care to those patients with sub-specialty care issues.	
	Hearing no further comments, thanked Dr. Murray for the report, then called on Dr. Kelley to provide the update on the Joint Infection Control Committee.		
X. Joint Infection Control Committee Update - Mike Kelley, M.D.	Dr. Kelley stated that his presentation is included at Tab G of the agenda packet. Dr. Kelley reported that the function of the Joint Infection Control Committee is to monitor the incidence of infectious diseases in the system; to determine factors related to occurrences of infectious diseases; recommend control measures; and to develop infection control policies. The membership includes TDCJ / TTUHSC / UTMB representatives in various discipline to include the Preventive Medicine staff; university Medical Directors, Dental Directors, Director of Nursing, and Director of Pharmacy. He further noted that the position of the TDCJ Director of Preventive Medicine serves as the Chair for the Committee as defined by policy. Dr. Kelley stated that one of the most tangible product is the Infection Control Manual used as a resource reference. The policies are reviewed annually and are divided into sections pertaining to employee health; management and control of specific diseases; disease reporting and infection control practices; offender occupational and housing		

Agenda Topic / Presenter	Presentation	Discussion	Action
- Joint Infection Control Committee (Cont.)	issues; and food-borne outbreak procedures. Dr. Kelley stated that during their review process, the Joint Infection Control Committee tries to keep the policies evidence based by reviewing literature and following national and state guidelines such as those published by the Centers for Disease Control, Department of State Health Services, National Commission on Correctional Health Care and American Correctional Association. He further noted that two special policies, one for HIV and the other on Hepatitis are both managed within the Infection Control Manual but the final approval is reserved by the CMHCC. These policies are reviewed by the joint working committee with the involvement of a medical specialist such as a gastroenterologist for the Hepatitis policies. Dr. Kelley next reported that the legislature required mandatory pre-release HIV testing and have found that there are some concerns on the sero-conversions of the total HIV positives. He clarified by stating that the offender was HIV positive when tested at the pre-release HIV testing even though they came into the system as HIV negative. He then referred back to the Pandemic Flu plan that was initiated in 2007 and noted that staff worked and trained with the Department of State Health Services as to how the strategic national stockpile which is the emergency supply of drugs would be managed in the event of a bio-terrorist attack. Dr. Kelley also recalled that 2 years ago, TDCJ and CMHC purchased a stockpile of Tamiflu in the event of Pandemic Flu outbreak. Dr. Kelley next stated that other diseases of special interest include Norovirus that causes gastroenteritis; some reported cases of Varicella or chicken pox; and Parotitis or the swelling of the cheeks which they had sporadic cases of, but was never able to		

Agenda Topic / Presenter	Presentation	Discussion	Action
- Joint Infection Control Committee (Cont.)	establish a diagnosis, and eventually went away before the State Health Department of Health was able to determine what the cause was. Dr. Kelley next stated that approximately a month ago, there were cases of swine flu or H1N1 which is a seasonal variety that was first reported in Mexico. The case fatality ratio reported at first was about 7% to 8% which is extremely high but as of last week the reported ratio was more like in the 1.8% range. He stated that the 1.8% percentage rate was still high and noted that the researchers had estimated the case fatality ratio for the 1918 Spanish flu outbreak was between 2% - 2.5%. The first Swine Flu case was reported on April 5th in Texas but that particular case was retrospectively reported. After the April 22nd case was reported, a meeting was held with Mr. Quarterman and staff to initiate the Pandemic Flu plan in response to those initial reports. The staff performed daily surveillance of influenza like illnesses; gathered and provided information being sent out by CDC to the unit staff. Dr. Kelley noted that one of the most disruptive portion of this process was to quarantine new intakes for up to seven days to be sure they were not infected. Other preventive measures included checking incoming staff and visitors; and isolating those with possible influenza type symptoms to keep it from getting it into the prison system. He then reported there were not enough swabs available on the units for cultures and even after redistributing swabs to the units from the Medical Warehouse, they ran out and could not get additional swabs as they were on back-order. Dr. Kelley also noted that CDC and DSHS got so far behind in their testing that they could not give a real time picture and had to read the daily CDC press conference transcript to get the most current data.		

Agenda Topic / Presenter	Presentation	Discussion	Action
- Joint Infection Control Committee (Cont.)	As of last week, Dr. Kelley reported that things are back to normal operations but there are future concerns on control measures in the event of an outbreak. He noted for example, determining whether or not they have enough access to swabs, protective attires and supplies; making sure that the right information gets relayed to the unit staff without any confusion as to whether or not it was something being sent out by UTMB campus or through UTMB-CMC; not being sure of how to handle large number of cases where they may have to convert cellblocks into an infirmary or dorms to be used to quarantine offender patients; and how to operate and staff shifts in the event the employee has symptoms of the flu. He further stated that there was also the issue of whether or not to distribute Tamiflu as this was not really considered pandemic from the stockpile that was purchased two years ago as there were no clarification or guidelines during the short Swine Flu outbreak. Dr. Kelley stated that those are the types of issues that still need to be looked at and he recalled that the 1918 Spanish Flu came in waves. It started in March, 1918 like a regular flu season and the case fatality ratio was low and quickly diminished. Then in November of 1919, the second wave hit with a more deadly case fatality ratio which was ten times higher because the virus had mutated. Dr. Kelley concluded by stating that the same can be said of the Swine Flu coming in waves as this is flu season in the Southern Hemisphere where it originated and would recommend that the Pandemic Flu epidemic plan be reviewed by medical, security and CMHCC staff to better protect both the work force and the offender patients.	Dr. Linthicum added that the direction on how to use the stockpile comes from the Center for Disease Control and through the State Department of Health Services. Dr. Kelley agreed and stated that he had written the SDHS for clarification and was given guidance for use in the future. Mr. Nelson asked what the shelf life of Tamiflu was and who had the stockpile? Dr. Kelley responded that the shelf life is five years but there is a possibility that the shelf life will be re-certified to last longer. He further responded that TDCJ has about 9,000 or 10,000 courses of treatment for employees and CMHCC has about 15,000 courses of treatment. Dr. Griffin also addressed the question of how effective the vaccine would be for the different strain of flu.	

Agenda Topic / Presenter	Presentation	Discussion	Action
XIII. Suicide Prevention Effort - Joe Penn, M.D.	Hearing no further comments, Dr. Griffin thanked Dr. Kelley for the report then called on Dr. Penn to brief the Committee on the suicide prevention efforts. Dr. Penn introduced himself by stating that he was the Director of Mental Health for UTMB and also serves as Chair of the Mental Health Subcommittee at the request of Dr. Linthicum. Dr. Penn reported that suicide is the number one leading cause of death within jails. He further noted that suicide ranks as the third leading cause of death between natural causes and AIDS within the US prisons. He then noted that a good national data base on suicides does not exist at this time as it is not a legal duty or is it mandated to report suicides in the United States compared to other countries such as Scandinavia that have mandated reporting of suicides. The data that is available suggest that the annual suicide rate is approximately 11 to 12 per 100,000 which is the commonly accepted national general population number for the free-world. This number however is distorted when you look at the breakout of about 5 to 6 per 100,000 completed suicides for females and the males being at a higher risk at about 18 per 100,000. The suicide rate data currently available for the last three decades for state prisons range from 18 – 40 per 1000,000 which shows that the suicide risk is much higher in prison settings compared to the general population. Dr. Penn added that data provided by his colleague in the State of New Jersey shows the annual suicide rate of 16.3 per 100,000. Dr. Penn next referred to the chart on page 151 of the agenda booklet titled, “Suicides 2000 – May 2009” that shows the number of suicides at TDCJ. Through Dr. Linthicum and Mr. Quarterman’s initiatives for		

Agenda Topic / Presenter	Presentation	Discussion	Action
	the suicide prevention programs, Dr. Penn noted that the number of suicides reported dropped from 32 in 2007 down to 19 in 2008; but there has been 14 suicides in 2009 to date. Dr. Penn added that the NCCHC standards on suicide prevention policies are provided at Tab H of the agenda packet. He further stated that the majority of these policies have been implemented through the collaborative efforts of the partner agencies. Dr. Penn then recalled at the December 2008 meeting, he had reported that the Joint Mental Health Committee held two retreats on suicide prevention to look over policies and procedures. The next such meeting is scheduled for June 19th to discuss topics directly related to security, crisis management, suicide prevention, constant supervision and the use of plexi-glass for observation. Dr. Penn again requested that the Committee consider having an outside consultant come in to see how they are doing and make recommendations on the suicide prevention program in our correctional setting. He further recommended increasing inpatient psychiatric beds as the Montford Unit built in 1994 currently provides the largest mental health care for the state with only 1500 inpatient bed capacity. Dr. Penn then recommended the concept of having the dually diagnosed patients that have both medical issues such as HIV, Hepatitis C or diabetes who are also schizophrenic; and also having a specialized unit for treating females with mental health issues at the Murray Unit. He added that the geriatric component of the dementia patients also need to be placed in specialized housing as they require more of an assisted living and sheltered housing area type environment.	Dr. Griffin asked what the suicide ratio was between males and females that were reported? Dr. Penn responded the majority being males.	

Agenda Topic / Presenter	Presentation	Discussion	Action
XIV. Financial Report - Lynn Webb	Dr. Penn appreciated the cost issues relating to his recommendations but noted that they will be advocating more funding for mental health services in the upcoming biennium with the support of the Committee. He concluded by stating that he would be happy to answer questions. Hearing no further discussions, Dr. Griffin thanked Dr. Penn for the report. Dr. Griffin next called on Lynn Webb to provide the financial update. Mr. Webb noted that the financial summary will cover data for the second quarter of FY 2009 ending February 28, 2009 and that the report is provided at Tab I of the agenda packet. The average daily offender population has declined slightly to 150,659 for the second quarter FY 2009 compared to 151,671 for the same quarter in FY 2008; which is a decrease of 1,012 or 0.66%. 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 10,821 this quarter compared to 10,211 for the same quarter a year ago which is an increase of 610 or 5.9%. The overall HIV+ population has remained stable throughout the last two years at 2,472 through this quarter or about 1.64% of the population served. The average number of psychiatric inpatients within the system was 1,933 and this inpatient caseload is limited by the number of mental health beds available. The average number of psychiatric outpatient visits was 18,697 representing 12.4% of the service population.	Dr. Griffin noted that he would like to get more specific information on Dr. Penn's recommendations to include costs. Dr. Linthicum added that they are looking at putting a ward for dual medical and psychiatric patients at Marlin VA and not just those with Alzheimer but also for those with co-morbidity issues. They are looking at around 60 beds for both males and females which will then free the beds in mental hospitals for the truly psychotic patients.	

Agenda Topic / Presenter	Presentation	Discussion	Action
- Financial Report (Cont.)	Mr. Webb further reported that the overall health care costs through the second quarter of FY 2009 totaled $243.8M. On a combined basis, this amount is above overall revenues earned by the university providers by approximately $6.2M or 2.6%. UTMB's total revenue through the second quarter was $188.3M; expenditures totaled $193.4M, resulting in a net loss of $5.1M. Texas Tech's total revenue through the same quarter was $49.3M; expenditures totaled $50.3M, resulting in a net loss of $1.0M. Mr. Webb then noted that of the $243.8M in expenses reported through the second quarter FY 2009, onsite services comprised of $120.8M or about 49.5% of expenses; pharmacy services totaled $24.8M or about 10.2% of total expenses; offsite services accounted for $68.4M or 28.0% of total expenses; mental health services totaled $22.9M or 9.4% of the total costs and indirect support expenses accounted for $6.9M or about 2.8% of the total costs. Table 5 on page 182 shows that the total cost per offender per day for all health care services statewide through the second quarter FY 2009 was $8.89; compared to $8.40 through the same quarter in FY2008. The average cost per offender per day for the last four fiscal years was $7.86 Mr. Webb next noted again that the older offenders access the health care delivery system at a much higher acuity and frequency than younger offenders. Hospital costs received to date this fiscal year for older offenders averaged approximately $1,634 per offender vs. $260 for younger offenders. While comprising only about 7.2% of the overall service population, older offenders account for 32.7% of the hospitalization costs. Older offenders are represented four times more often in the dialysis population averaging about $20.8K per patient per year. Providing dialysis treatment for an average of 188 patients through this quarter cost $1,961,176.		

Agenda Topic / Presenter	Presentation	Discussion	Action
- Financial Report **(Cont.)**	The total drug costs through the second quarter FY 2009 totaled $18.2M. Of this, $9.1M was for HIV medication costs which was about 50% of the total drug costs; psychiatric drug costs were approximately $567K or about 3.1%; and Hepatitis C drug costs were $623K and represented about 3.4% of the total 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 shortfall of $5,122,993 through the end of this quarter. 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) but as of May 15, 2009, UTMB is projecting to have a shortfall of $29.3M in FY 2009. Texas Tech reports that they hold no such reserves and report a total operating shortfall of $1,062,600 through this second quarter. Texas Tech 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 February 28, FY 2009 is provided at Table 10 on page 187. The summary indicates that the net unencumbered balance on all CMHCC accounts on February 28, 2009 was negative $106,423,092.52 due to the net effect of the third 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. Hearing no further discussions, Dr. Griffin thanked Mr. Webb for the report.		

Agenda Topic / Presenter	Presentation	Discussion	Action
- XV. 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.		
- XVI. 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 September 8, 2009 to be held at the Dallas Love Field Main Terminal Conference Room. Dr. asked if there were any other comments or discussions?		
- XVII. Adjournment	Hearing no further comments, Dr. Griffin thanked Mr. Nelson and Ms. Lord for attending; then adjourned the meeting.		

_____

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

_____

Date:

ATTACHMENT 1

Resolution of Appreciation

Jeannie Frazier

WHEREAS, Ms. Jeannie Frazier was appointed to the Correctional Managed Health Care Committee on March 27, 2000 and faithfully serving in that role for nine years; and,

WHEREAS, Ms. Frazier was appointed by Governor George W. Bush as one of the original three public member appointees pursuant to SB 371 of the 76th Legislature and has served continuously as an active member of the CMHCC through four legislative sessions; comprehensive state audits; and Sunset review; and,

WHEREAS, she has been actively involved in the correctional health care program, contributing her time, experience and expertise unselfishly in an ongoing effort to improve and promote the correctional health care program; and,

WHEREAS, the program has benefited greatly from her demonstrated leadership, consistent, thoughtful and dedicated guidance and financial expertise through a period of unprecedented growth and achievement; and,

WHEREAS, Ms. Frazier's distinguished professional career include serving as the former Senior Vice-President of Micher Healthcare; former Senior Vice President of Strategic Planning and Marketing at Memorial Hermann Health Care System; served as Chief Financial Officer at Hermann Hospital; and is currently Chief Financial Officer for the Southwest Foundation for Biomedical Research in San Antonio; and,

WHEREAS, Ms. Frazier excelled academically having attained her bachelor's and master's degree from Stanford University; and past president of the Gulf Coast Chapter of the Healthcare Financial Management Association; and,

WHEREAS, the Correctional Managed Health Care Committee, its staff and its partner agencies wish to gratefully acknowledge the leadership, expertise and contributions of Ms. Frazier;

THEREFORE BE IT RESOLVED, that the Committee adopt this resolution as an expression of our sincere appreciation for Ms. Frazier's professionalism, dedication and outstanding service to the Texas correctional health care program and as a token of our high esteem for her service, present to her a commemorative gavel inscribed with the dates of her service as member of the Correctional Managed Health Care Committee and a framed copy of this resolution with our collective best wishes for success.

Adopted this 9th day of June in the Year 2009, by the Correctional Managed Health Care Committee

ATTACHMENT 2

Supplemental Funding Allocations:

FY 2008 – 2009

Background:

The university providers experienced shortfalls in funding for the current biennium. Based on the latest available expense data, combined losses in excess of 48.1M are projected for the biennium. To address this shortfall, supplemental appropriations were requested during the 81st Legislative Session.

House Bill 4586, Section 16 appropriates $48,144,918 in supplemental funding for the correctional health care program.

The allocation of this supplemental funding to the university providers prior to August 31, 2009 as authorized by the 81st Legislature, will help address projected losses during this biennium. Allocations are based on universities estimates of loss used to formulate the supplemental appropriations requested as follows:

	FY 2008	FY 2009	Total
UTMB:	$14,720,961	$31,848,300	$46,569,261
TTUHSC:	_____	$ 1,575,657	$ 1,575,657
TOTAL:	$14,720,961	$33,423.957	$48,144,918

Statutory authority for CMHCC to allocate funds for correctional health care is found in Section 501.148(a)(4) of the Texas Government Code.

Requested Motion:

That pursuant to its authority under Section 501.148(a)(4) of the Texas Government Code, the Committee allocate and authorize its staff to distribute the following supplemental funding amounts to:

UTMB: $46,569,261 TTUHSC: $1,575,657

The distribution of these funds is to be made as soon as funds from HB 4586 are made available contingent upon the execution of contract amendments with the university providers that require the Chief Financial Officer for the university to certify the losses projected for the biennium. These allocations represent estimates that are:

(1) calculated on projected end of year FY 2009 expenses;

(2) based on actual data through the first 7 months of the year; and

(3) subject to a year end reconciliation to actual expenses incurred.

Further move that the staff be authorized to make a final adjustment and reconciliation of such allocations against final FY 2009 financial reports.

ATTACHMENT 3

FY 2010 – 2011 Budget Allocations

Background:

Senate Bill 1, 81st Legislature provides appropriations for the correctional health care program.

Allocations of the appropriations for the biennium have been developed based on actual costs and projected needs. These proposed allocations are outlined in the presentation and budget allocation materials accompanying this motion.

Statutory authority for the CMHCC to allocate funds for correctional health care is found in Section 501.148(a)(4) of the Texas Government Code.

Requested Motion:

That, pursuant to its authority under Section 501.148(a)(4) of the Texas Government Code:

1. The Committee approve the Fiscal Year 2010-2011 budget allocations and accompanying budget assumptions as presented;

2. That the CMHCC authorize its staff to make any final adjustments to the projected populations used in developing these allocations that may be necessary, and to adjust the projected allocations accordingly; and,

3. That the Committee authorize the staff to finalize the contracted arrangements for the next biennium in accordance with these budget allocations.

FY 2010 – 2011 Budget Allocation Assumptions

Correctional Managed Health Care

The distribution of funds for the correctional managed health care program in Fiscal Years 2010 and 2011 is predicated on the following assumptions:

1. The budget allocations are calculated using a projected average daily population, plus or minus four percent for each university provider sector. Payments for medical and mental health services will be made on a sum-certain basis as long as the overall sector population remains within the population limits established.

2. The TDCJ offender population is currently at or near capacity and is projected to remain so throughout the budget period. Any capacity additions beyond the official capacities for TDCJ facilities included in the contract documents require discussions between the CMHCC, the applicable university providers and TDCJ on additional funding needs.

3. The distribution of funds in FY 2010-2011 budget allocated all funding provided in the base appropriations for correctional health care contained in Strategies C.1.7 and C.1.8 of the TDCJ Appropriations, SB1, 81st Legislature. These allocations acknowledge that funding for the Marlin VA Hospital is contingent upon completion of the renovation of the facility and occupancy.

4. The parties acknowledge that the funding provided by the 81st Legislature for the correctional health care program in addition to providing our adjustment to the base level of funding for services to reflect current costs, also includes increased funding for the following purposes; market adjustments to recruit and retain healthcare staff and funding for increased costs of hospital and specialty care and capital equipment.

5. As in prior budget cycles, the budget anticipates that the costs associated with psychiatric medications and the sharing of functions between medical and mental health services are paid from mental health funding and these allocations transfer funds from mental health to medical services for that purpose.

6. The university providers retain the flexibility to allocate the amounts paid pursuant to each capitation calculation in any manner necessary to meet their obligations under these arrangements.

7. Each partner agency will be responsible for any reimbursements for their employees required relating to unemployment benefits or worker's compensation payments as required by Article IX, SB 1, 81st Legislature.

8. Each partner agency will be responsible for providing financial data and assistance as necessary to comply with the financial reporting and financial monitoring responsibilities of the CMHCC relating to the correctional managed health care program.

9. The allocations are intended to fund the level of services outlined in the contracts for FY 2010 – 2011. Any change to these requirements must be considered based on their potential fiscal impact. Proposed changes to the services provided must include a fiscal estimate indicating the projected costs or savings involved and identifying a source of additional funding, if required.

10. Rider 42, TDCJ Appropriations, SB 1, 81st Legislature provides authority for the transfer of up to $5M additional funding from TDCJ to the correctional health care program to address operational shortfalls. Such transfers may be made upon agreement of TDCJ and the CMHCC, with supporting documentation provided to the Governor and Legislative Budget Board. In the event that TDCJ and CMHCC disagree on the amount of transfer necessary, the Governor and the Legislative Budget Board will make a final decision.

11. Rider 72, TDCJ Appropriations, SB 1, 81st Legislature, spells out that $4,843,986 is available in Strategy C.1.7, Psychiatric Care to provide mental health care in FY2011.

12. Rider 83, TDCJ Appropriations, SB 1, 81st Legislature states that the Correctional Managed Health Care Committee may transfer appropriations in an amount not to exceed $20,000,000 made for Fiscal Year 2011 to Fiscal Year 2010, subject to the following conditions:

    (a) if correctional managed health and psychiatric care populations exceed performance measure targets;

    (b) if expenditures for correctional managed health care and psychiatric care exceed amounts appropriated for this purpose; and

    (c) for any other emergency expenditure requirements including expenditures necessitated by public calamity.

    The transfer authority provided above only applies to appropriations for Strategy C.1.7, Psychiatric Care; and Strategy C.1.8, Managed Health Care.

    A transfer authorized by this section above must receive the prior approval of the Governor and the Legislative Budget Board.

    The Comptroller of Public Accounts shall cooperate as necessary to assist the completion of transfer and spending made under this section.

Consent Item 2

TDCJ Health Services
Monitoring Reports

ATTACHMENT 1

Rate of 100% Compliance with Standards by Operational Categories Third Quarter, Fiscal Year 2009 March, April, and May 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***
Billy Moore Facility	98%	51	52	33%	7	21	56%	19	34	85%	17	20	100%	10	10	100%	11	11
Bradshaw Facility	96%	52	54	50%	12	24	93%	26	28	85%	17	20	100%	12	12	100%	11	11
Coffield Facility	98%	53	54	19%	4	21	48%	14	29	90%	18	20	82%	9	11	100%	11	11
Dawson Facility	100%	53	53	41%	12	29	63%	17	27	75%	15	20	45%	5	11	70%	7	10
Eastham Facility	100%	53	53	36%	8	22	52%	13	25	85%	17	20	100%	10	10	80%	8	10
Estelle Facility	96%	52	54	44%	12	27	56%	18	32	70%	14	20	67%	10	15	100%	11	11
Estelle High Security	N/A	N/A	N/A	25%	3	12	N/A	N/A	N/A	70%	14	20	N/A	N/A	N/A	N/A	N/A	N/A
Estelle SAFP	N/A	N/A	N/A	45%	4	9	78%	21	27	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Estes Facility	100%	53	53	98%	10	21	56%	10	18	65%	13	20	20%	1	5	90%	9	10
Goodman Facility	98%	52	53	59%	13	22	90%	26	29	100%	20	20	100%	2	3	100%	11	11
Henley Facility	94%	50	53	30%	8	27	68%	19	28	100%	20	20	100%	8	8	70%	7	10
Hightower Facility	98%	51	52	29%	6	21	64%	18	28	95%	19	20	100%	10	10	100%	10	10
Huntsville Facility	100%	52	52	40%	8	20	80%	24	30	100%	20	20	55%	6	11	100%	11	11

n = number of applicable items audited.

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

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

100% Compliance Rate = $\frac{\text{number of audited items in each category that were 100\% compliance with the Standard}}{\textit{number of items audited.}}$

ATTACHMENT 2

Percent Compliance Rate on Selected Items Requiring Medical Records Review
Third Quarter, Fiscal Year 2009
March, April, and May 2009

Unit	Operations/ Administration			General Medical/Nursing			CID/TB			Dental			Mental Health		
	% Rate	Items in Compliance	*n*	% Rate	Items in Compliance	*n*	% Rate	Items in Compliance	*n*	% Rate	Items in Compliance	*n*	% Rate	Items in Compliance	*n*
Billy Moore Facility	100%	10	10	90%	346	385	83%	57	69	93%	88	95	100%	41	41
Bradshaw Facility	88%	22	25	97%	456	472	96%	92	96	90%	92	102	100%	267	267
Coffield Facility	91%	10	11	84%	423	503	60%	25	42	85%	88	104	98%	194	198
Dawson Facility	100%	52	52	76%	348	456	79%	60	76	89%	86	97	88%	168	190
Eastham Facility	100%	14	14	90%	334	372	90%	57	63	88%	90	102	100%	145	145
Estelle Facility	90%	38	42	93%	502	538	87%	77	89	90%	93	103	95%	225	236
Estelle High Security	N/A	N/A	N/A	84%	213	254	N/A	N/A	N/A	90%	93	103	N/A	N/A	N/A
Estelle SAFP	N/A	N/A	N/A	90%	123	137	100%	60	60	N/A	N/A	N/A	N/A	N/A	N/A
Estes Facility	100%	12	12	94%	469	500	89%	41	46	84%	57	68	90%	45	50
Goodman Facility	90%	26	29	97%	396	409	100%	79	79	100%	106	106	96%	26	27
Henley Facility	96%	25	26	85%	332	389	69%	24	35	100%	104	104	100%	80	80
Hightower Facility	77%	10	13	86%	318	368	45%	18	40	99%	198	200	100%	81	81
Huntsville Facility	100%	10	10	93%	320	343	100%	90	90	100%	178	178	94%	88	94

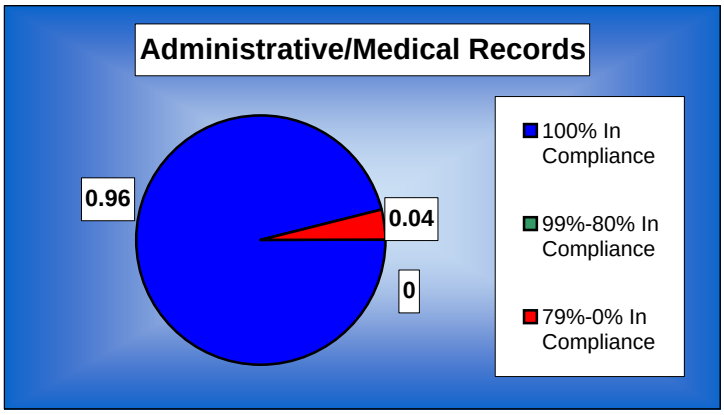
n **= number of records audited for each question.**

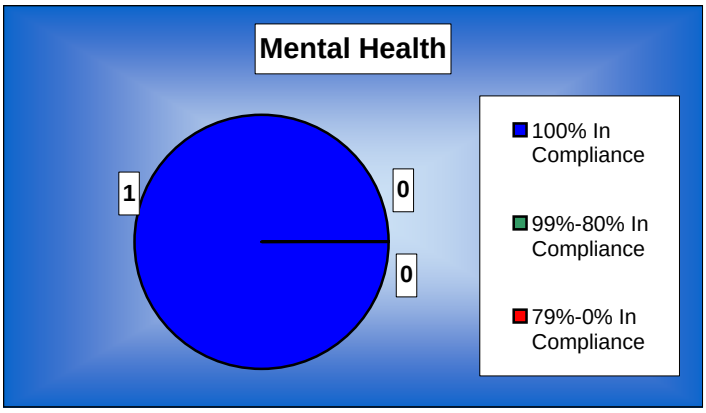
Note: Selected items requiring medical record review are reflected in this table.
The items were chosen to avoid having interdependent items counted more than once.

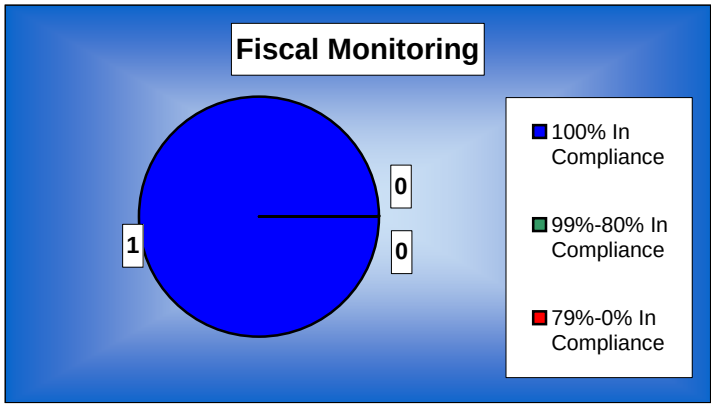
Average Percent Compliance Rate = Sum of medical records audited that were in compliance X 100
Number of records audited

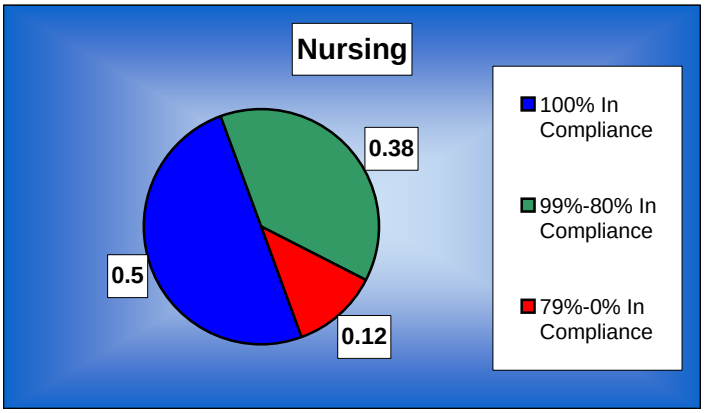
***The medical record review section of the Operations/Administration portion of the Operational Review Audit consists of only three questions, frequently with low numbers of applicable records.**

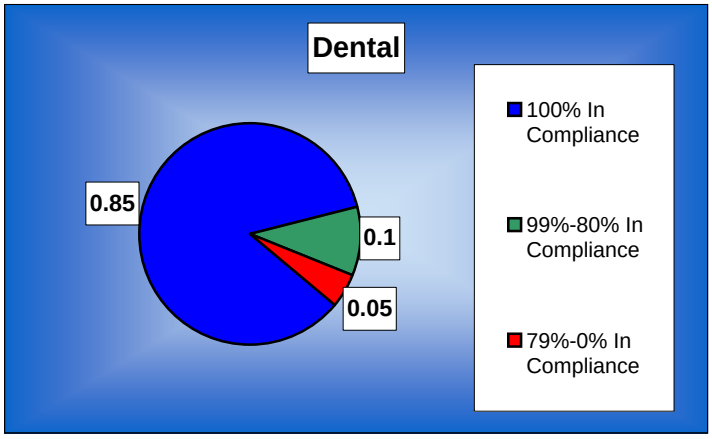
Quarterly Reports for
Compliance Rate By Operational Categories
Bradshaw Facility
March 4, 2009

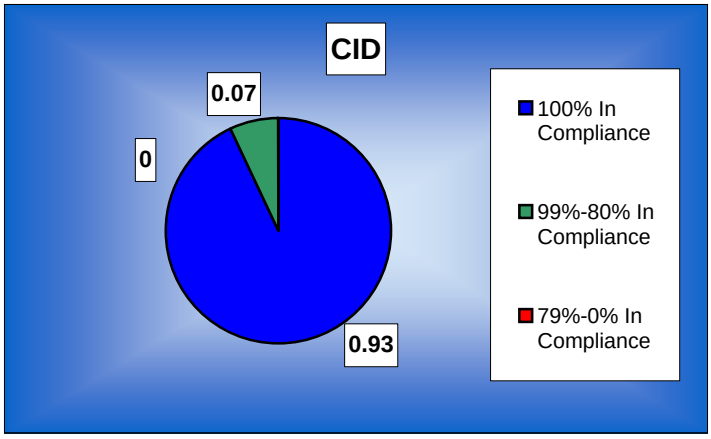




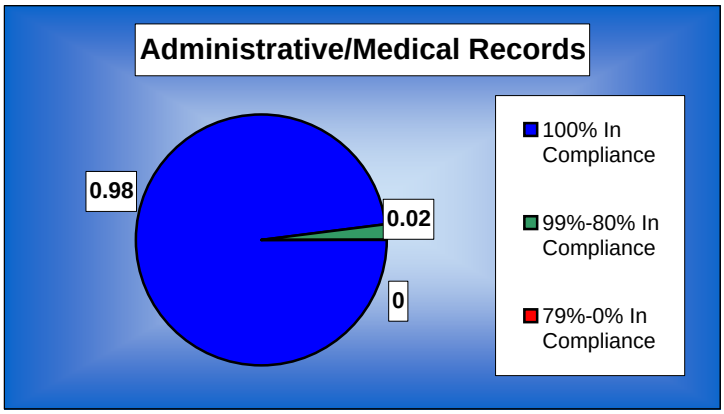


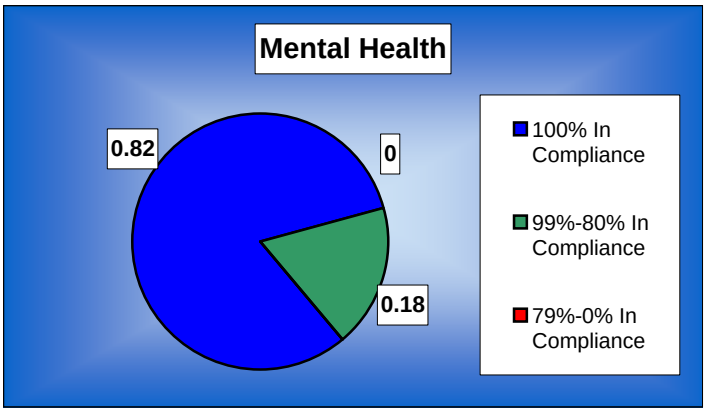


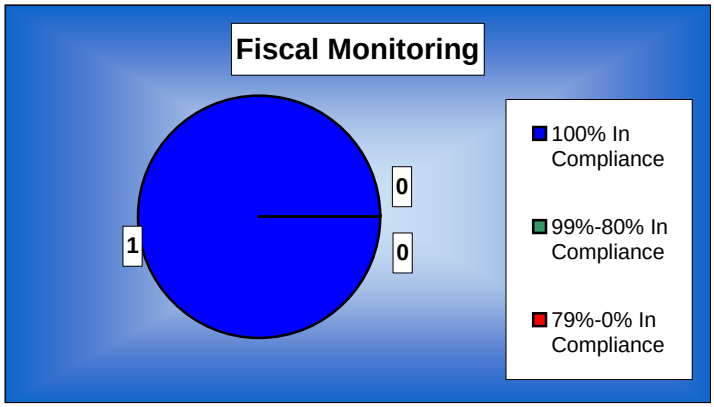


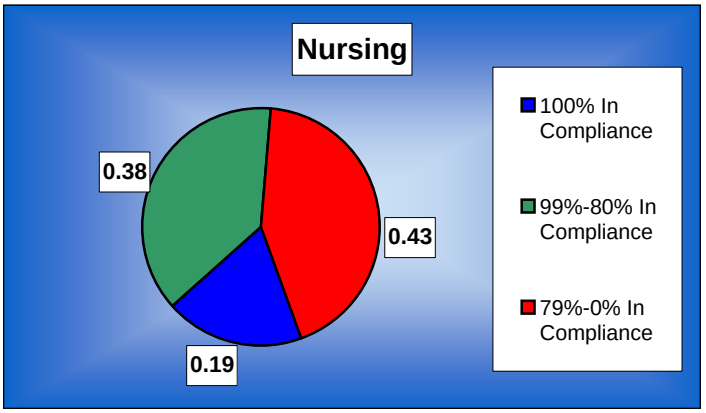


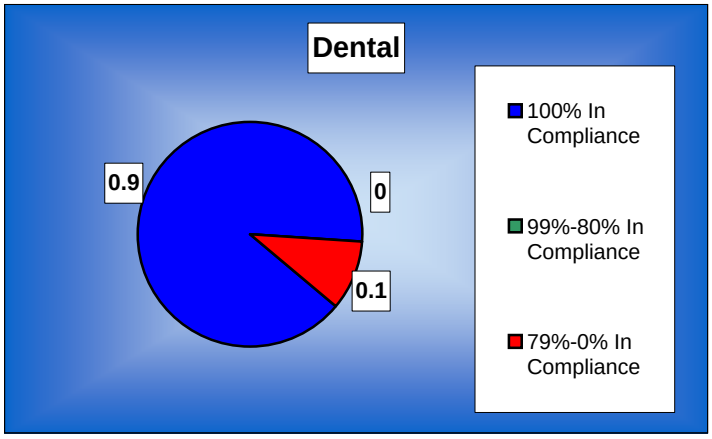
Quarterly Reports for
Compliance Rate By Operational Categories
Coffield Facility
March 10, 2009

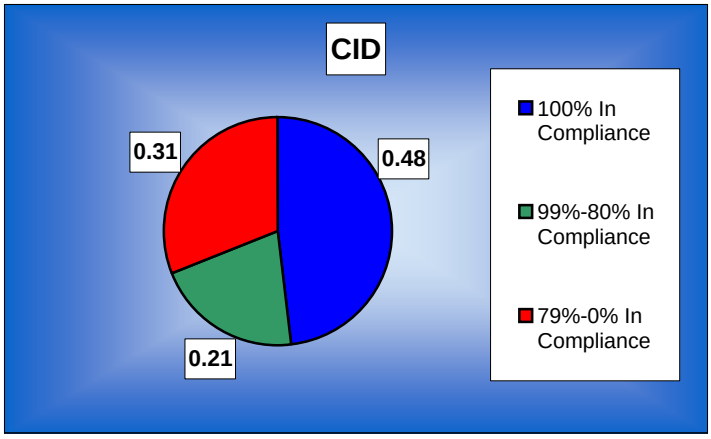




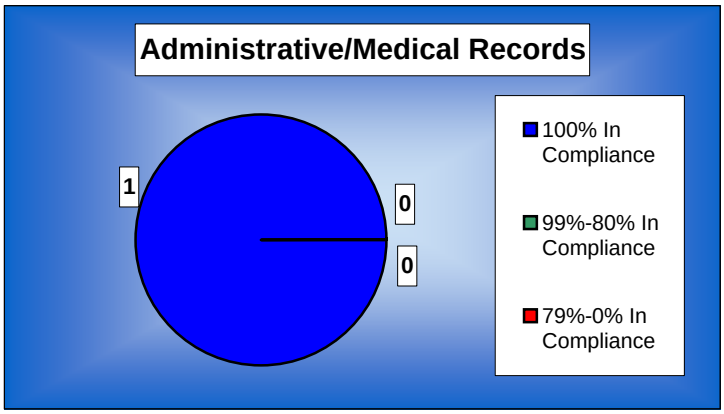


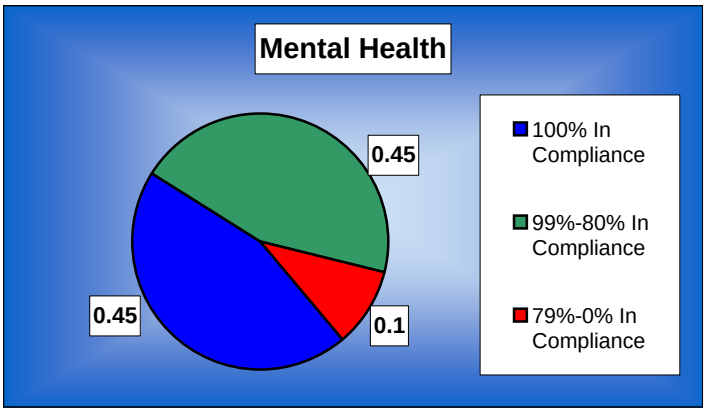


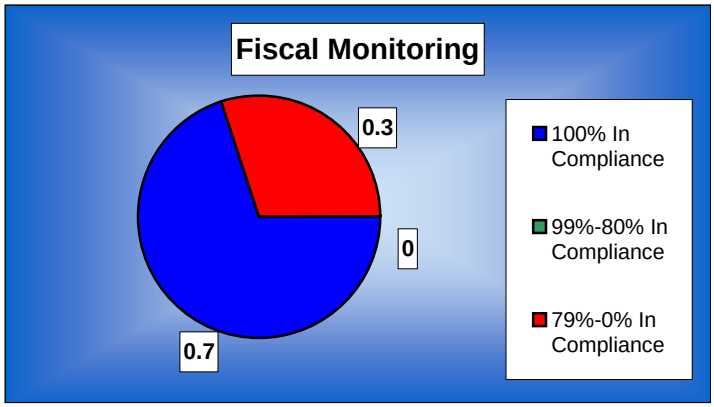


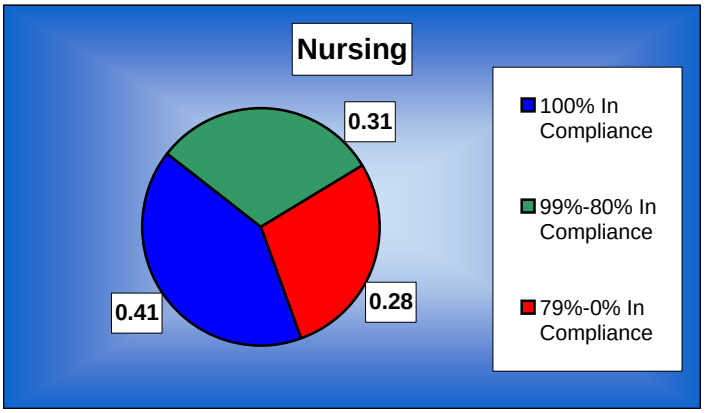


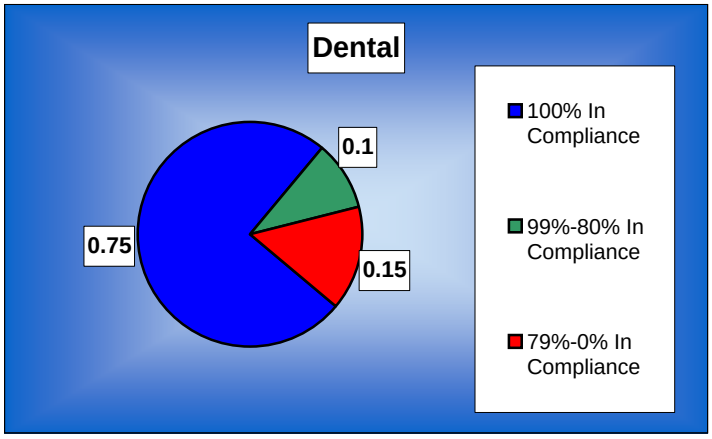
Quarterly Reports for
Compliance Rate By Operational Categories
Dawson Facility
May 5, 2009

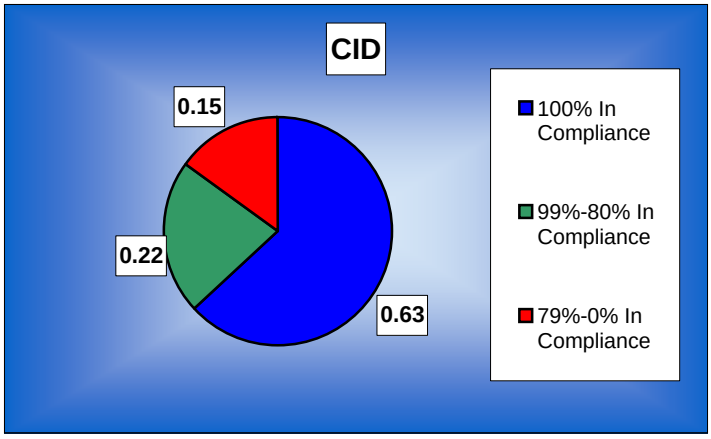




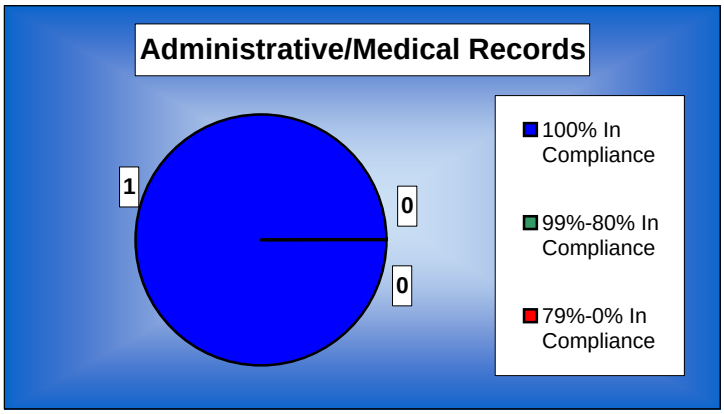


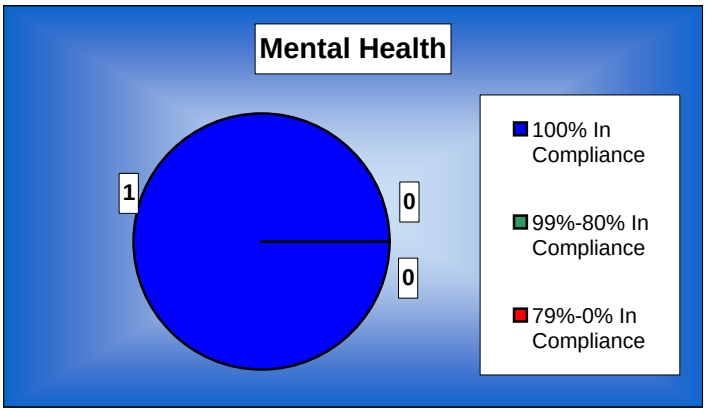


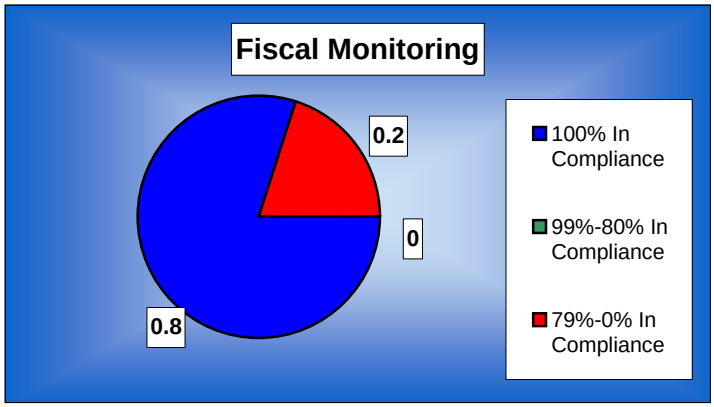


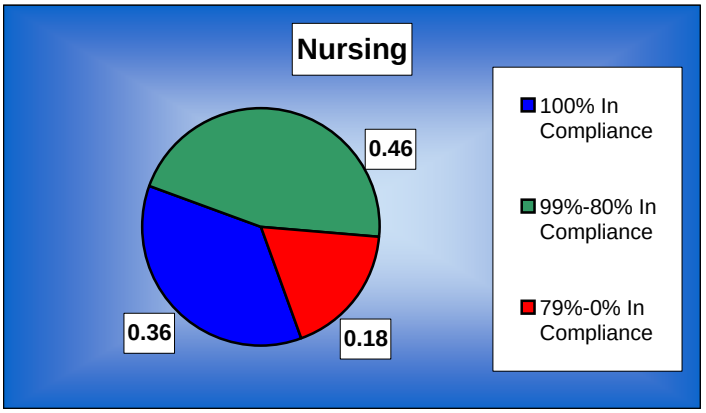


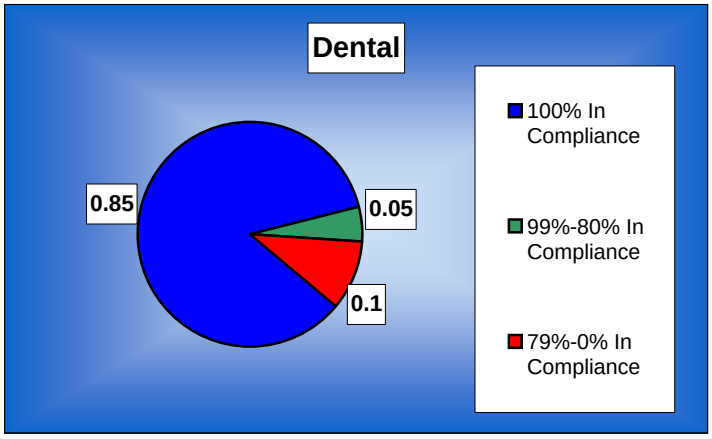
Quarterly Reports for
Compliance Rate By Operational Categories
Eastham Facility
April 1, 2009

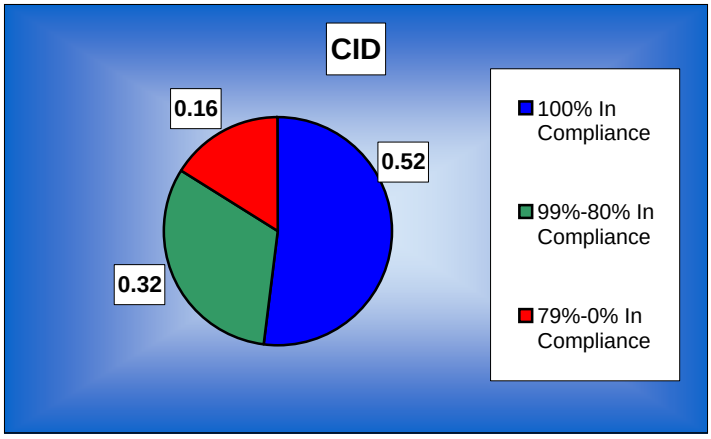




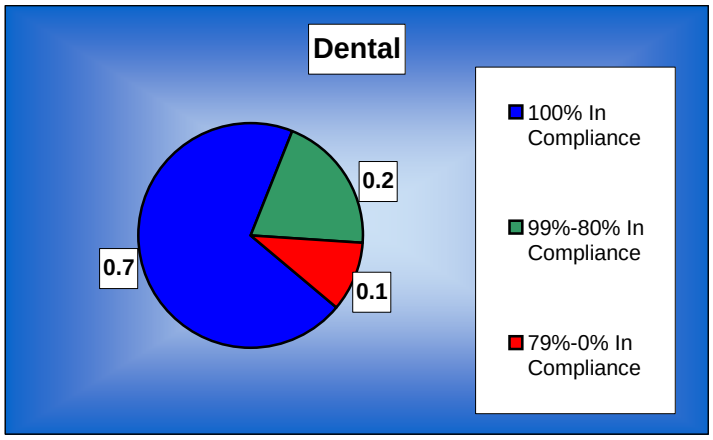


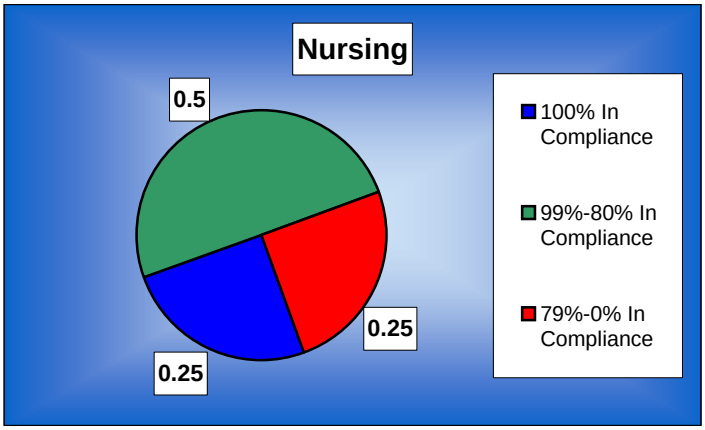




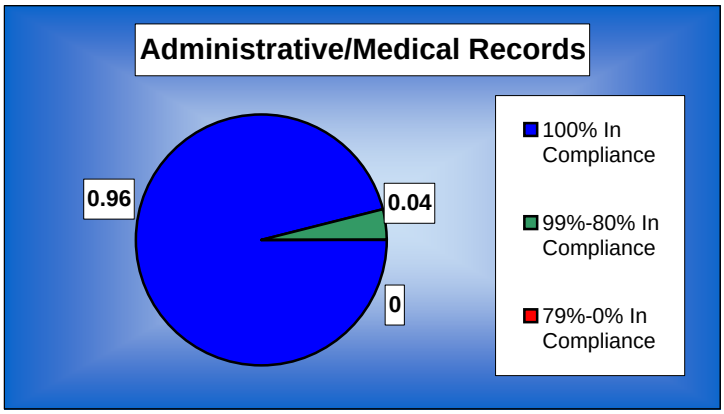


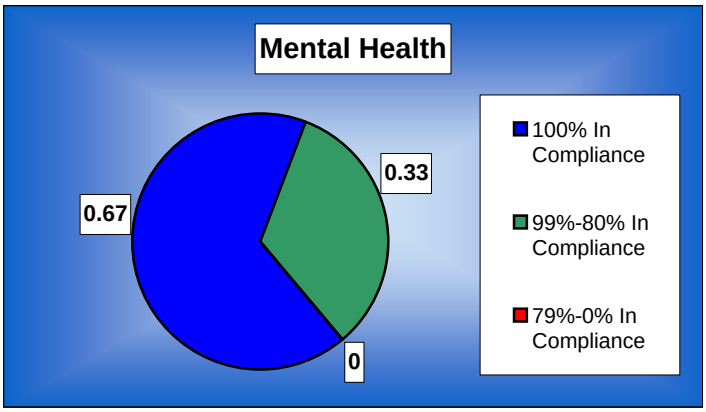
Quarterly Reports for
Compliance Rate By Operational Categories
Estelle High
Security Facility
May 7, 2009

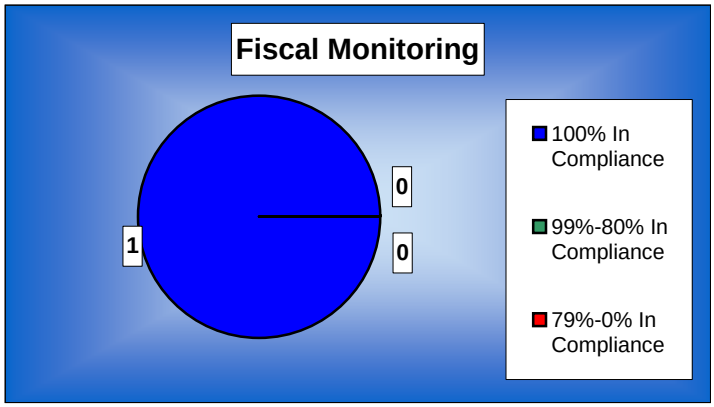


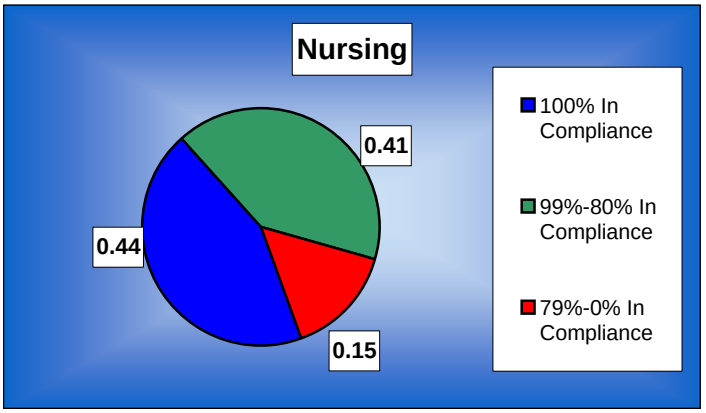


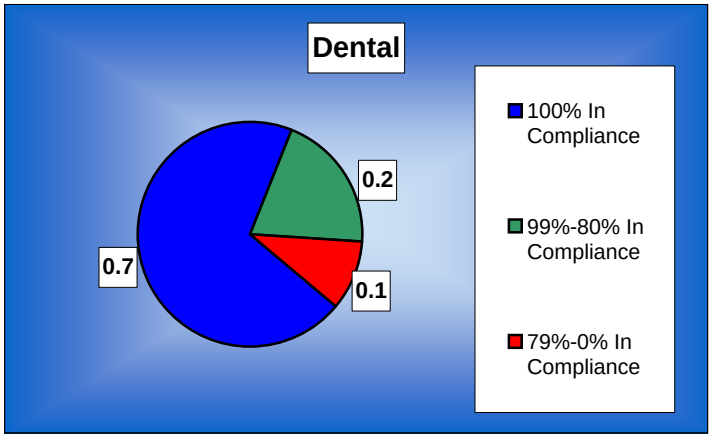
Quarterly Reports for
Compliance Rate By Operational Categories
Estelle Facility
May 7, 2009

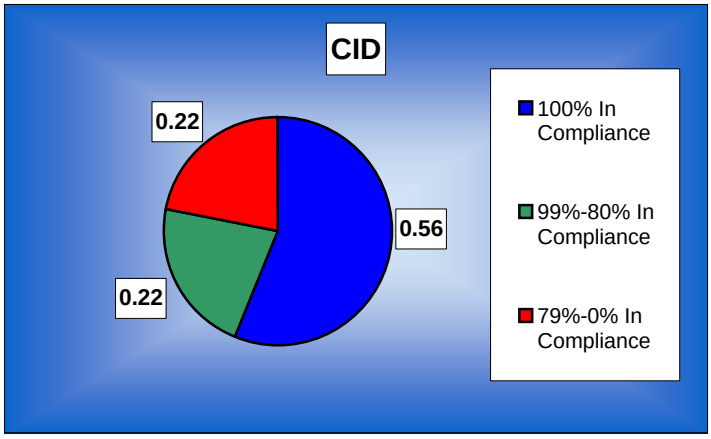




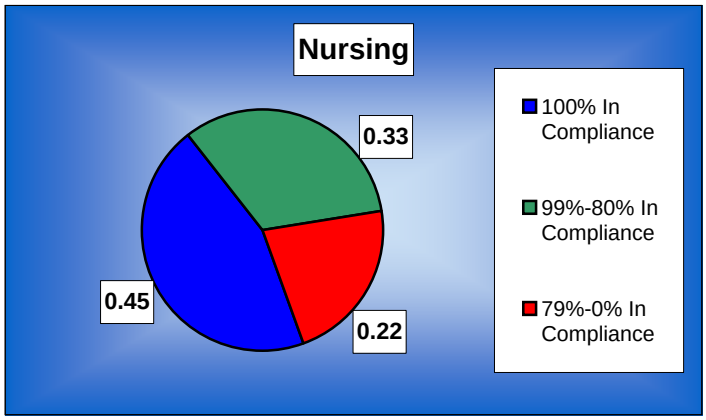


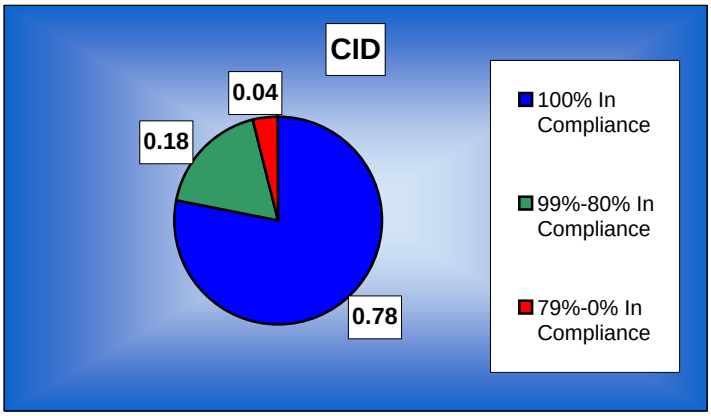




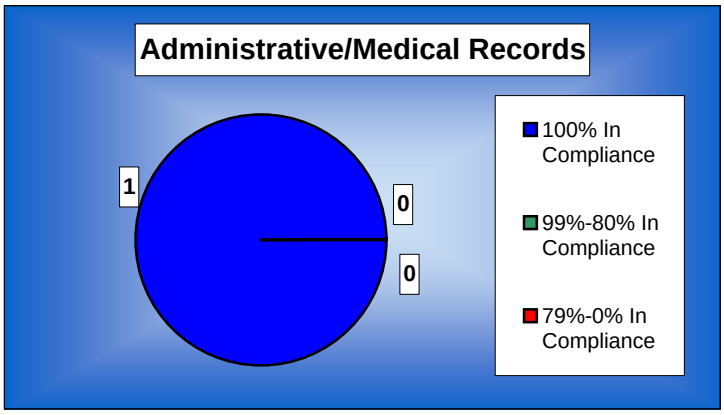


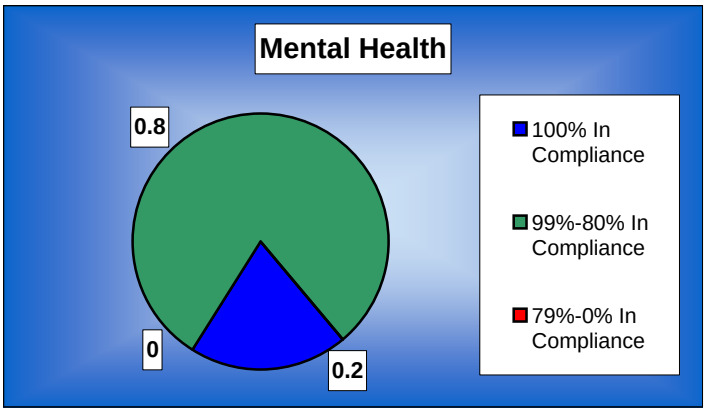
Quarterly Reports for
Compliance Rate By Operational Categories
Estelle SAFP Facility
May 7, 2009

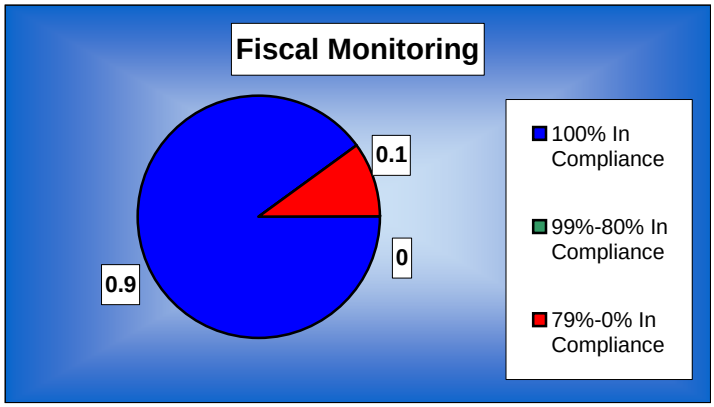


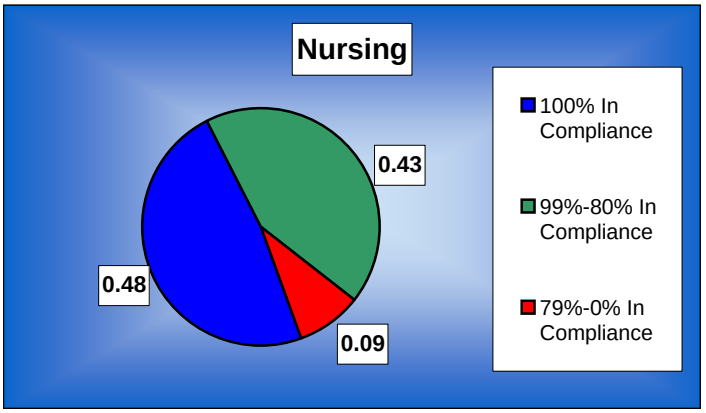


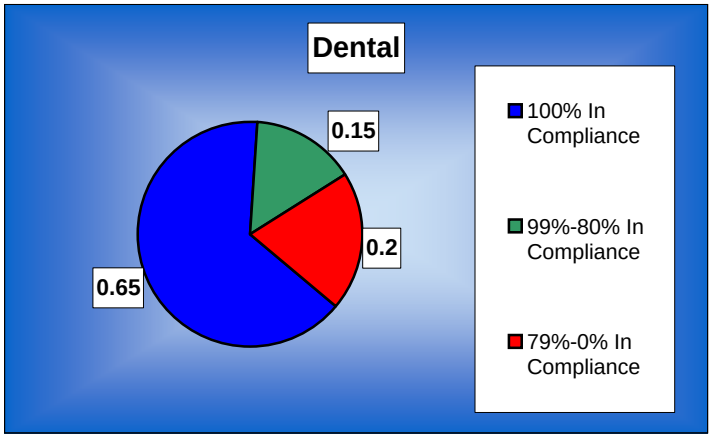
Quarterly Reports for
Compliance Rate By Operational Categories
Estes Facility
May 4, 2009

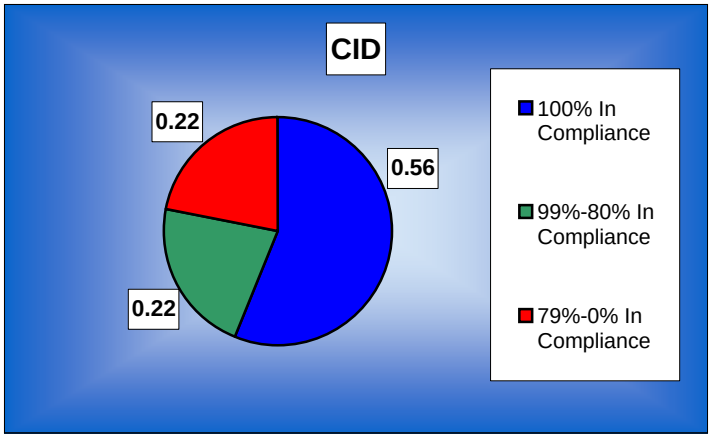




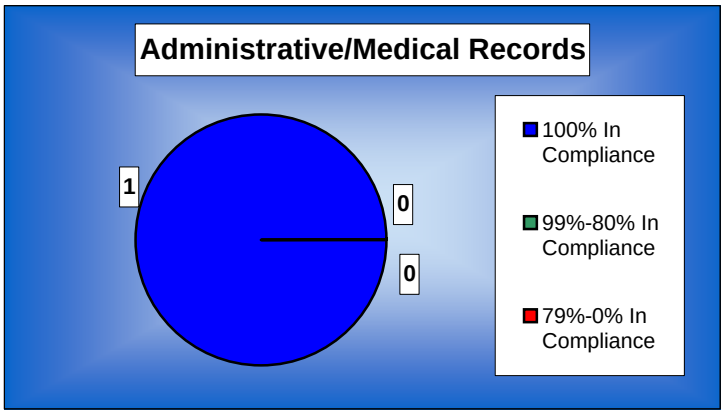


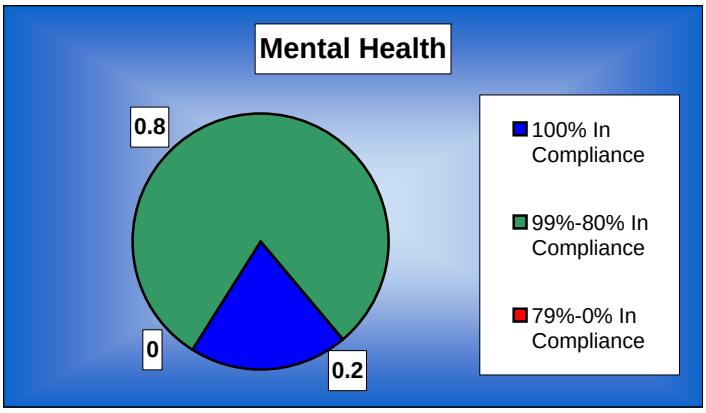


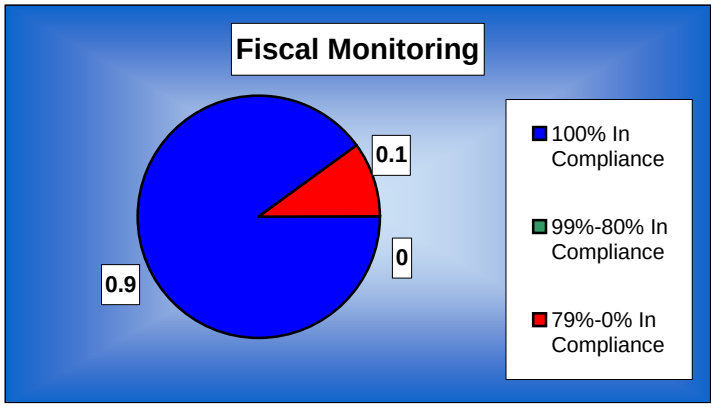


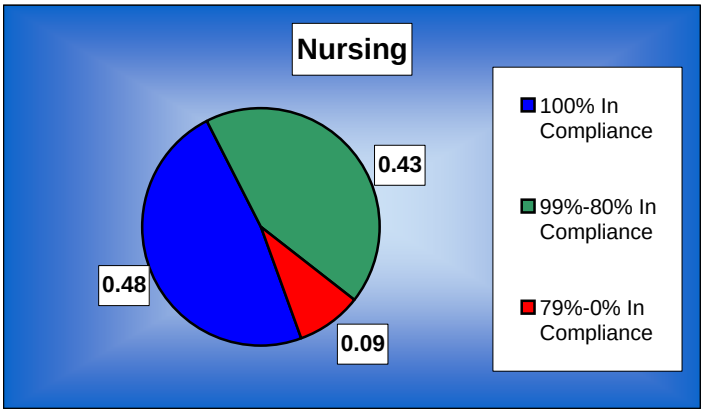


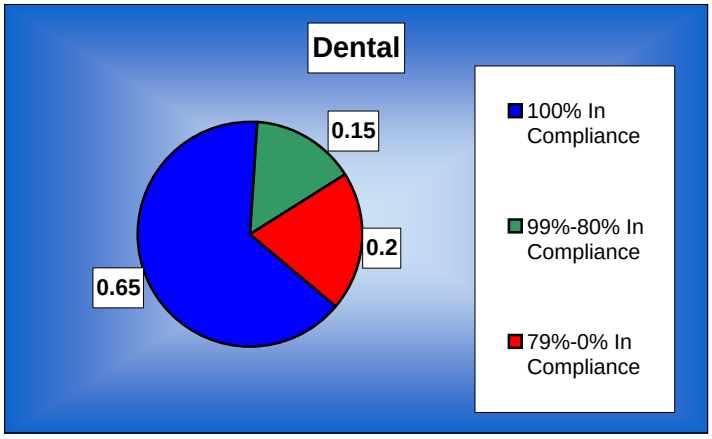
Quarterly Reports for
Compliance Rate By Operational Categories
Estes Facility
May 4, 2009

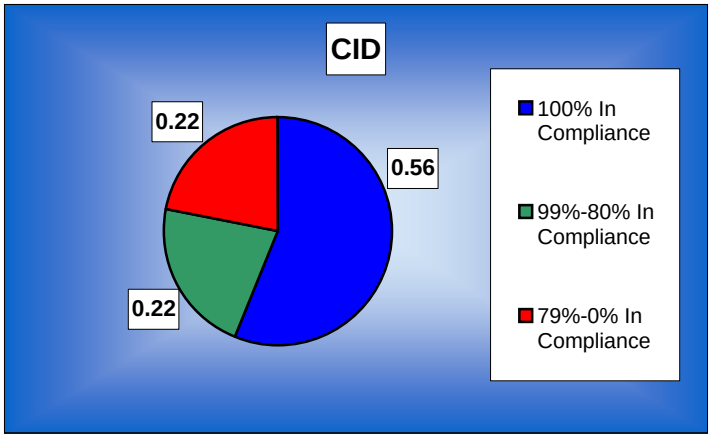




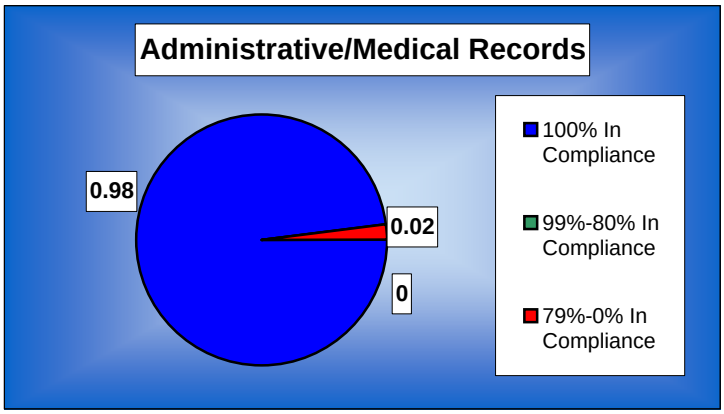


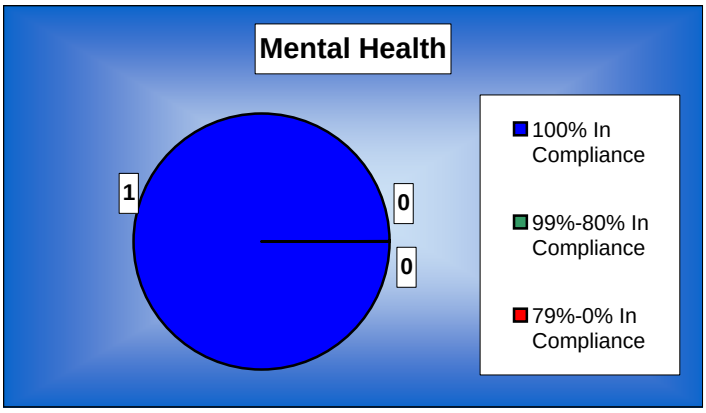


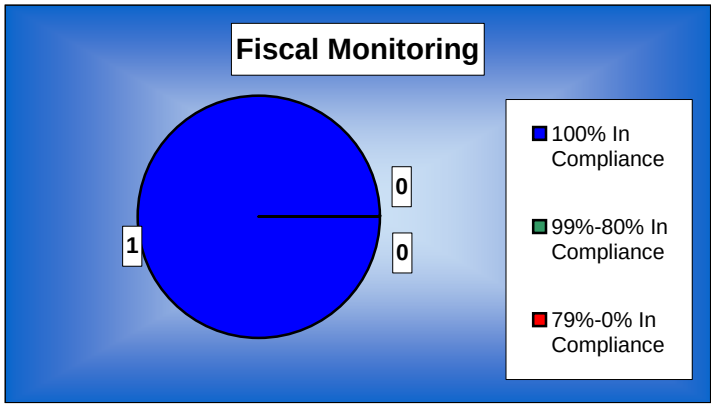


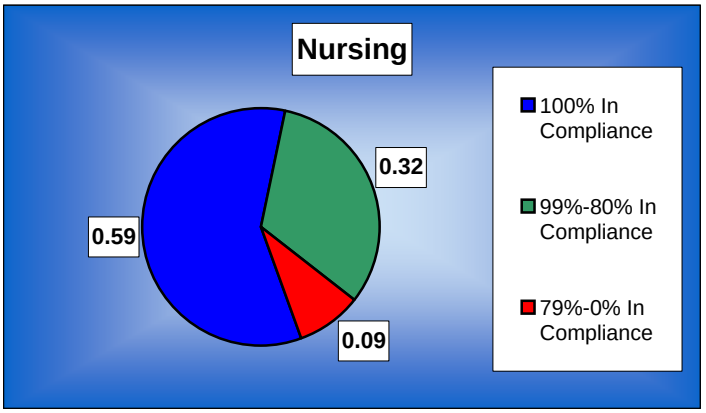


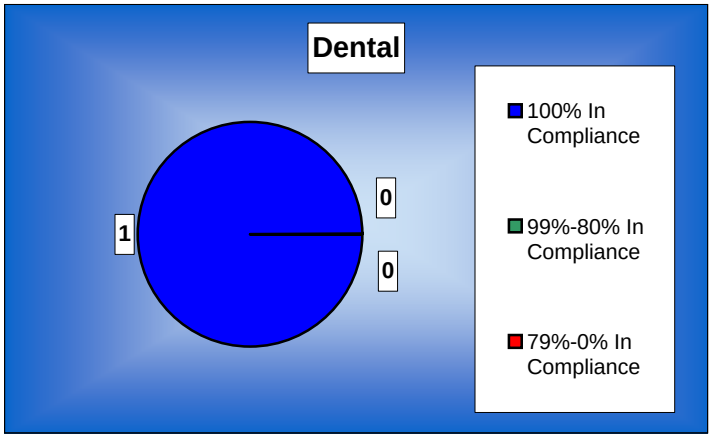
Quarterly Reports for
Compliance Rate By Operational Categories
Goodman Facility
April 7, 2009

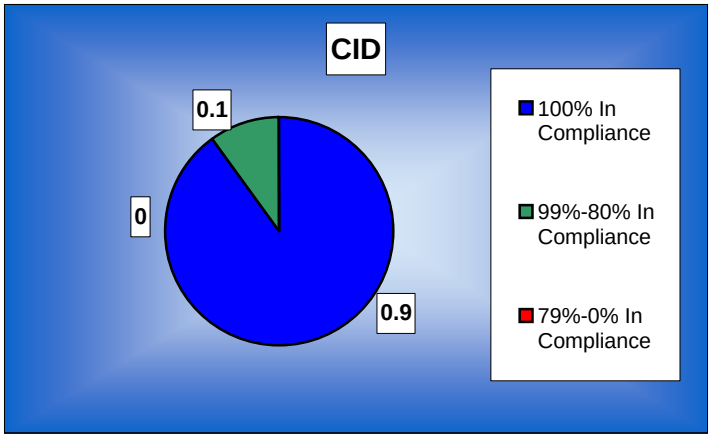




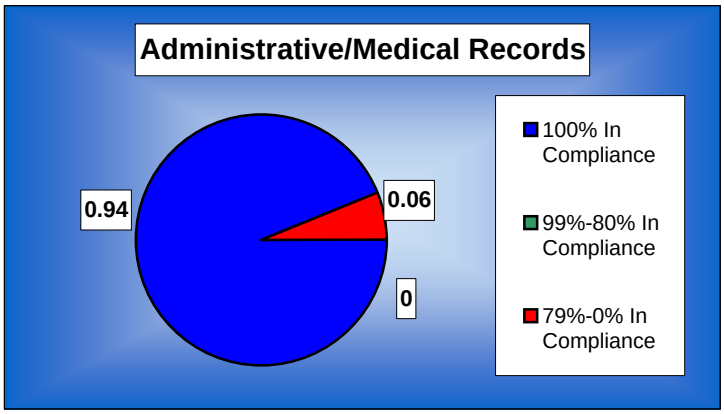


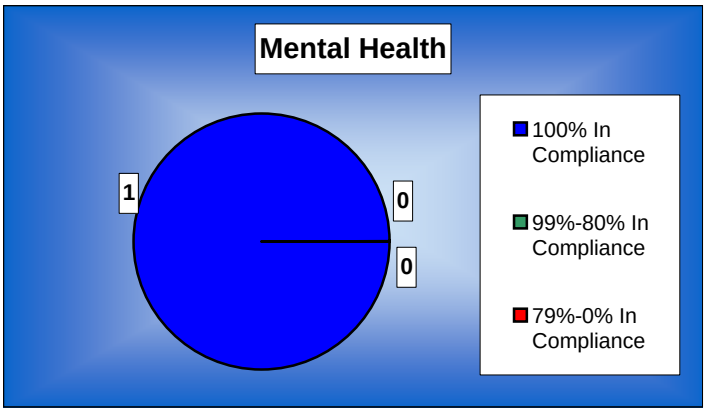


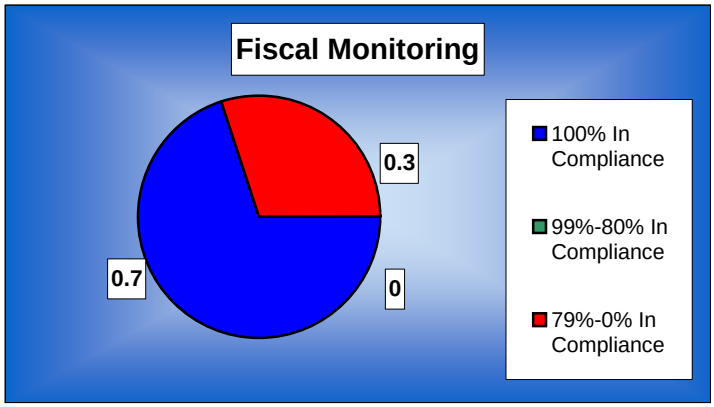


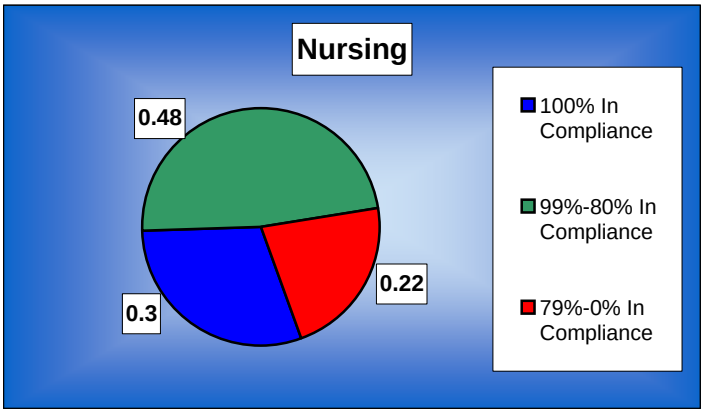


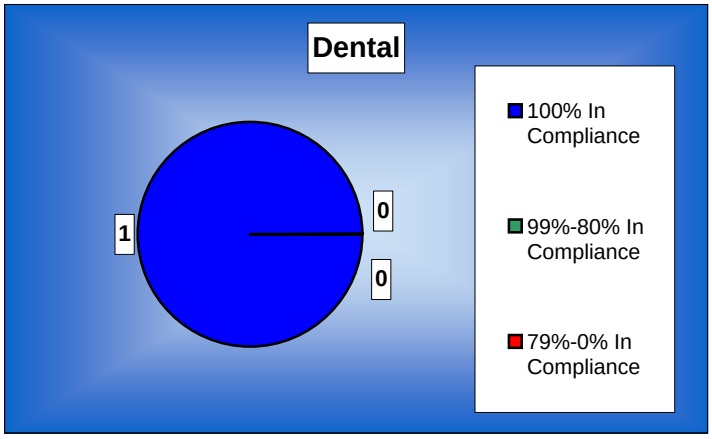
Quarterly Reports for
Compliance Rate By Operational Categories
Henley Facility
April 3, 2009

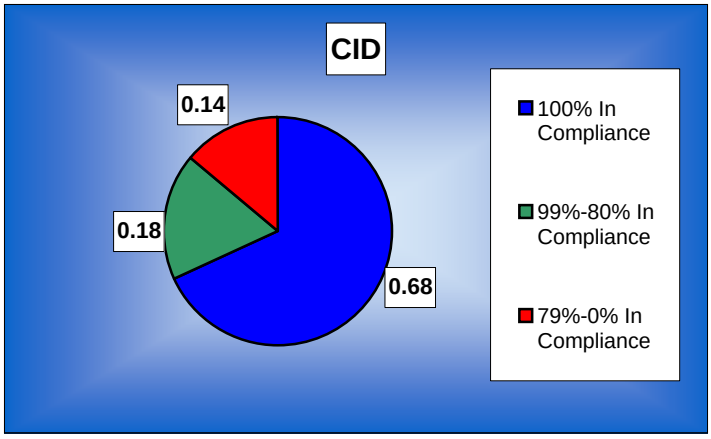




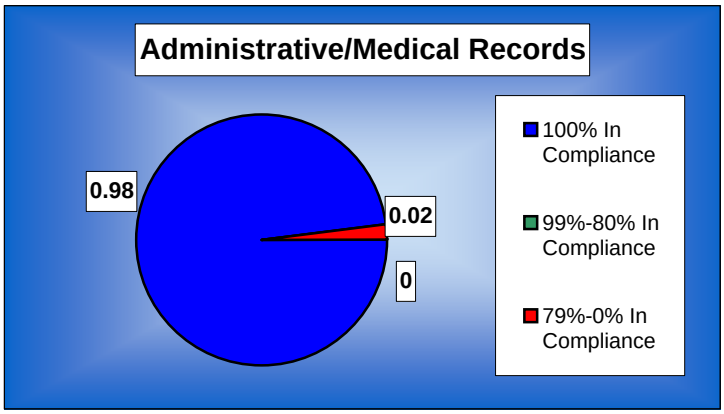


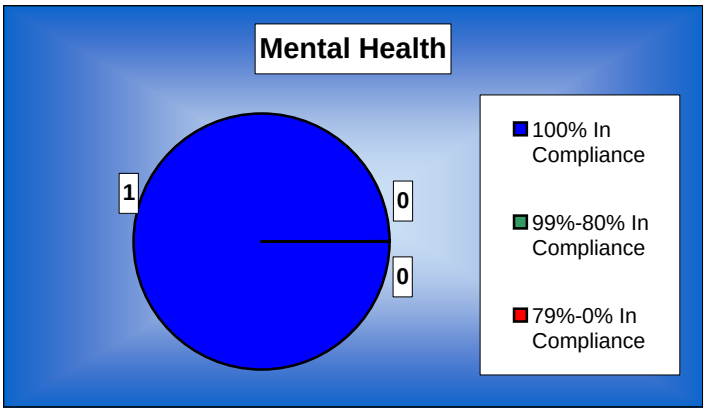


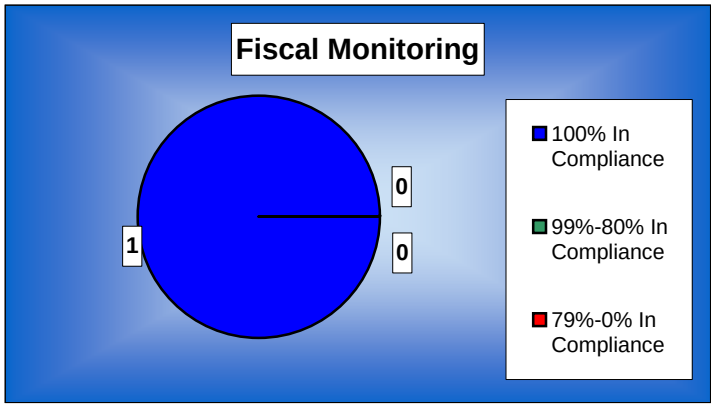


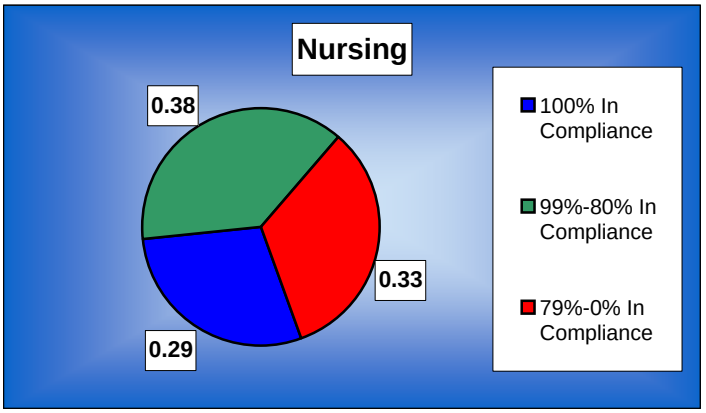


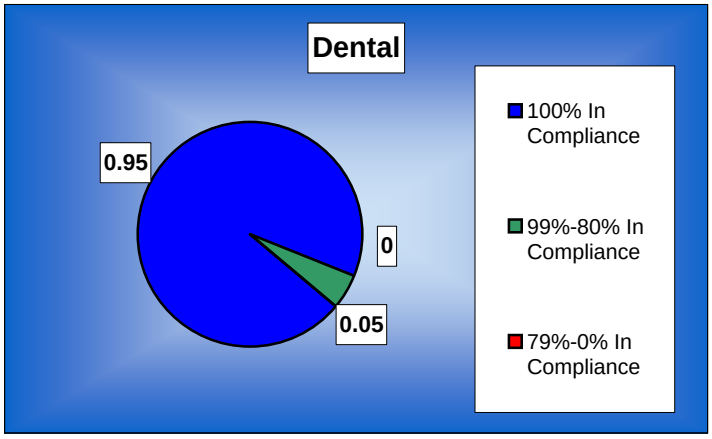
Quarterly Reports for
Compliance Rate By Operational Categories
Hightower Facility
April 2, 2009

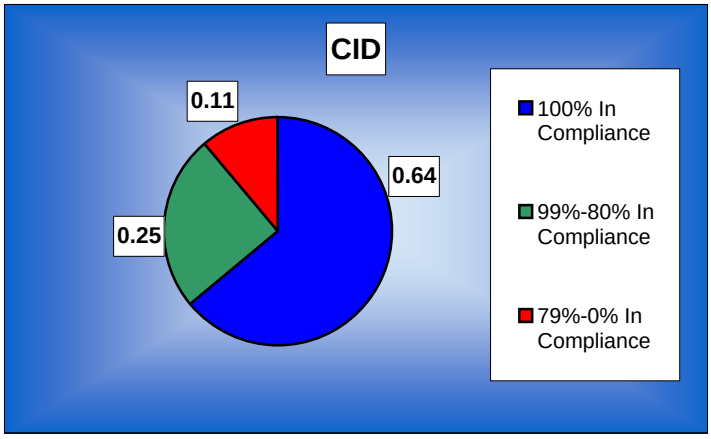




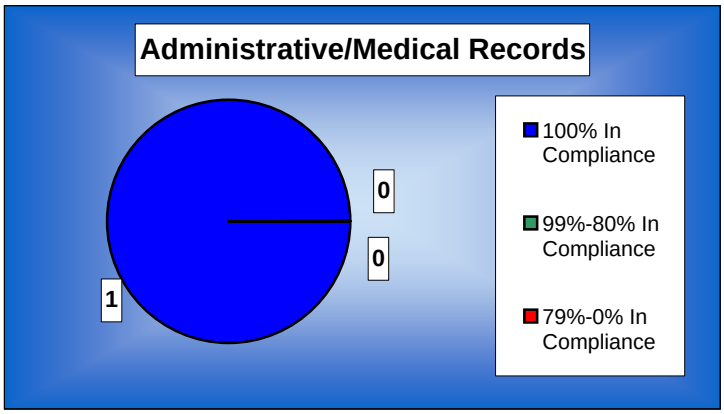


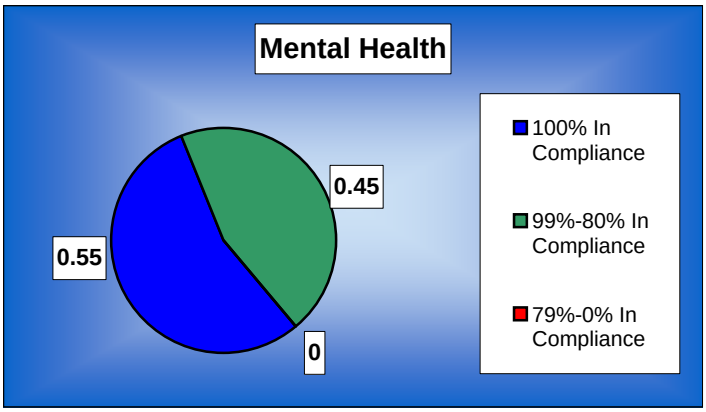


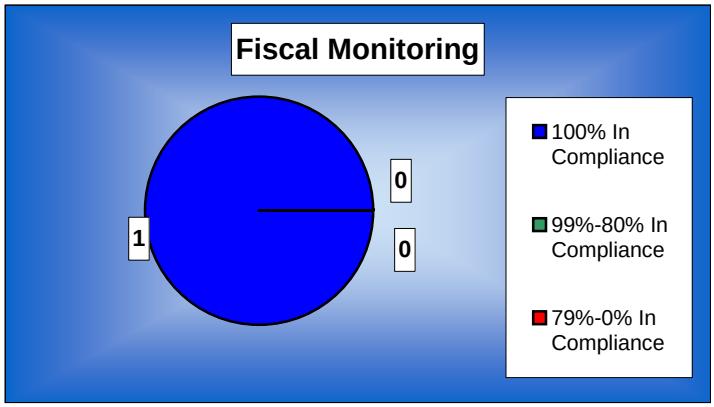


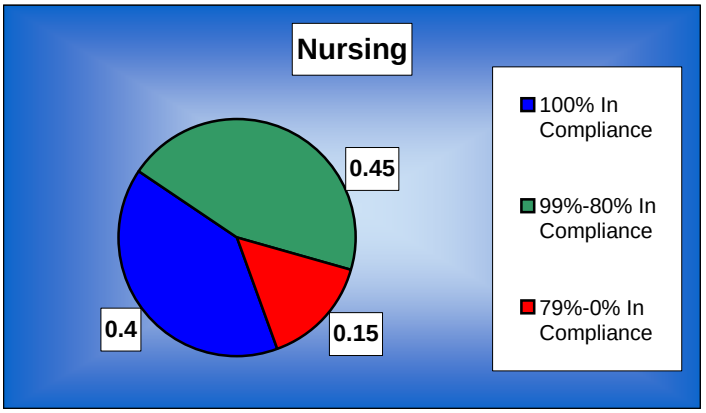


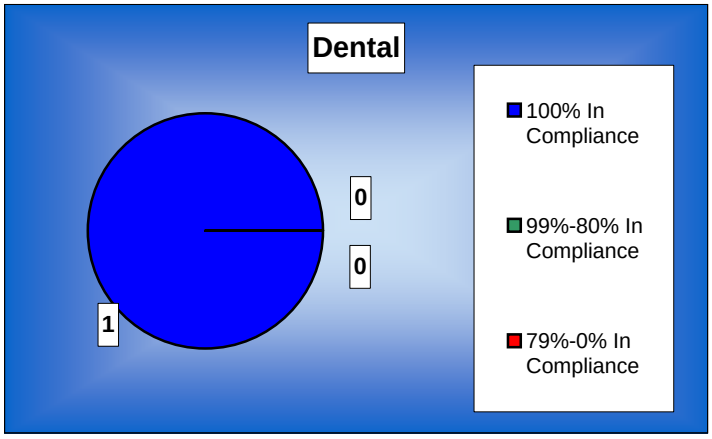
Quarterly Reports for
Compliance Rate By Operational Categories
Huntsville Facility
March 3, 2009

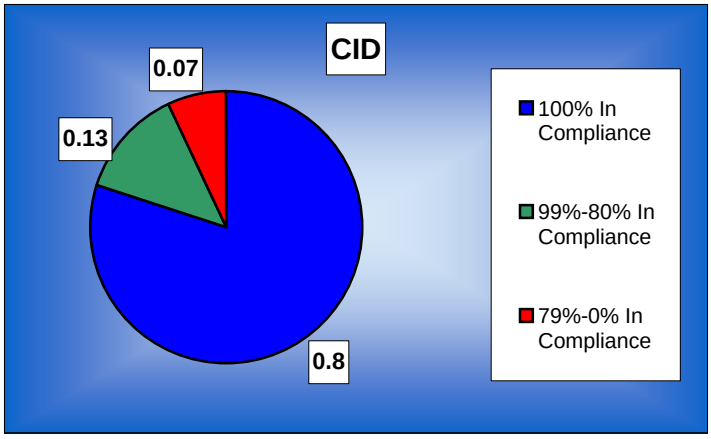




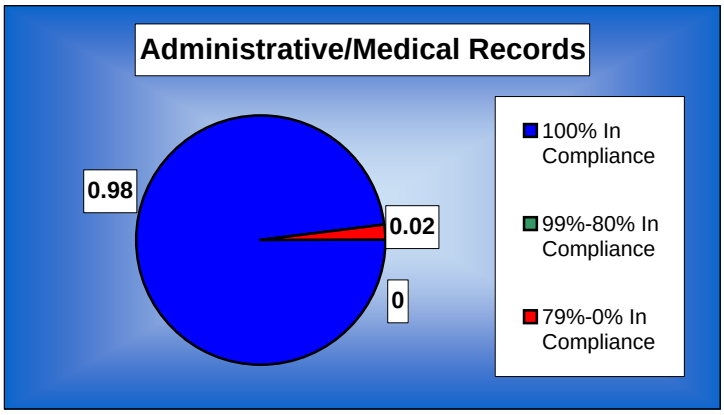


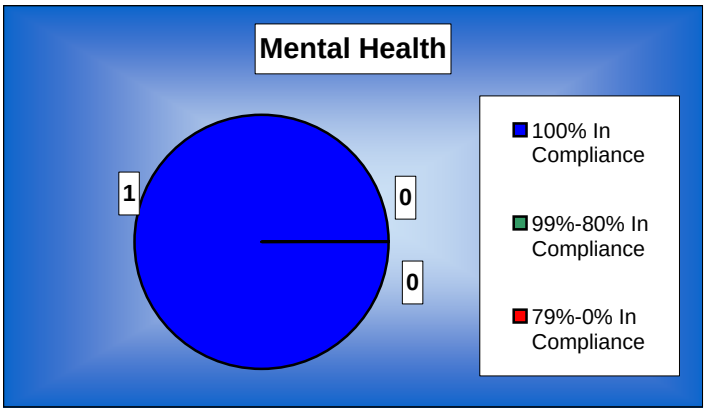


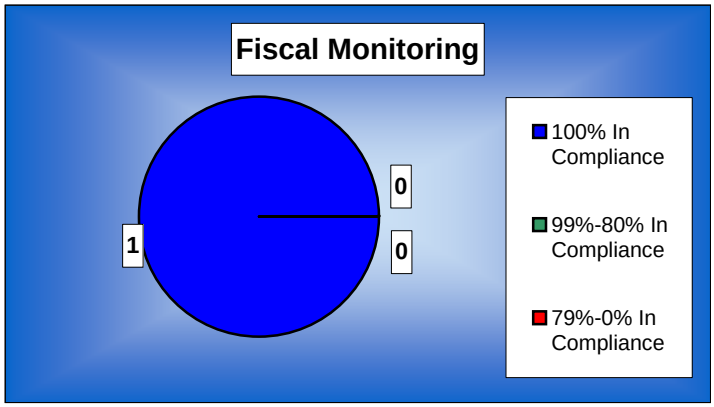


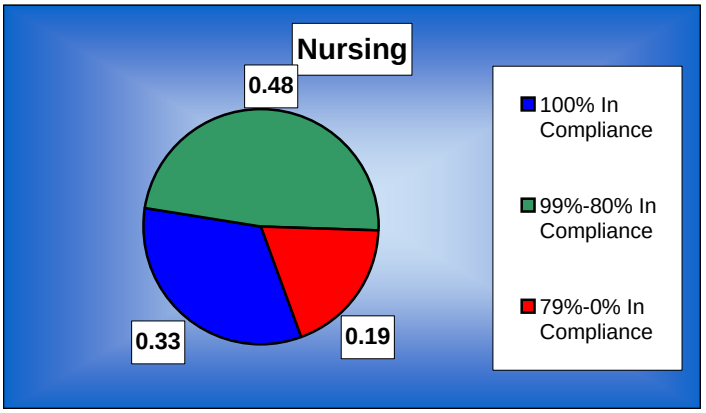


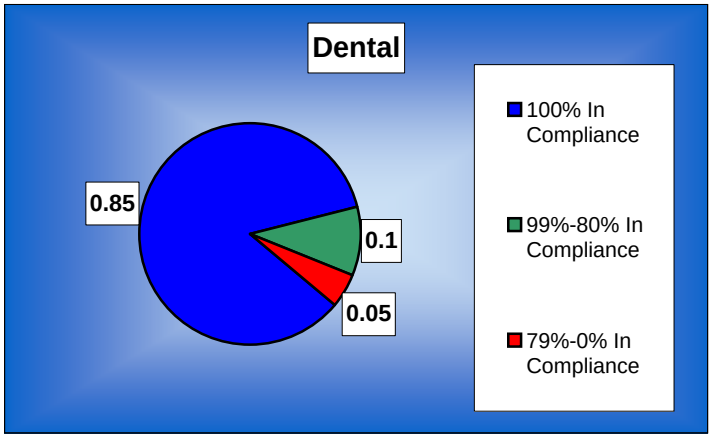
Quarterly Reports for
Compliance Rate By Operational Categories
Billy Moore Facility
March 5, 2009

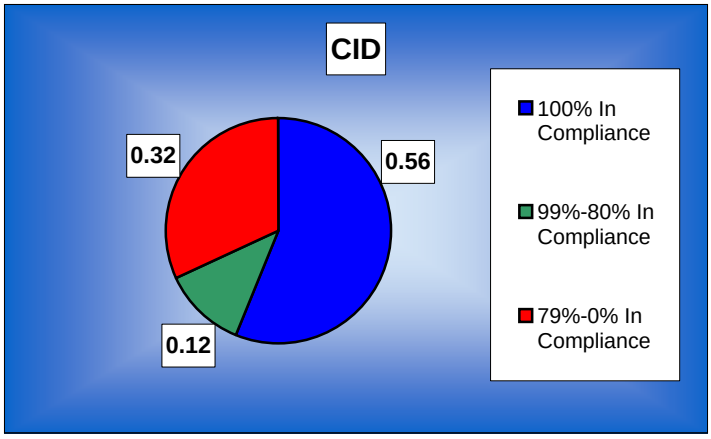












PATIENT LIAISON AND STEP II GRIEVANCE STATISTICS
QUALITY OF CARE/PERSONNEL REFERRALS AND ACTION REQUESTS

STEP II GRIEVANCE PROGRAM (GRV)									
FY2009	Total # of **GRV** Correspondence Received Each Month	Total # of Action Requests (Quality of Care, Personnel, and Process Issues)	% of Action Requests from Total # of **GRV** Correspondence	Total # of Action Requests Referred to **UTMB-CMHC**		Total # of Action Requests Referred to **TTUHSC-CMHC**		Total # of Action Requests Referred to **PRIVATE FACILITIES**	
					% of Total Action Requests Referred		% of Total Action Requests Referred		% of Total Action Requests Referred
March	537	126	23.46%	94	17.50%	30	5.59%	2	0.37%
April	504	116	23.02%	83	16.47%	25	4.96%	8	1.59%
May	513	124	24.17%	99	19.30%	24	4.68%	1	0.19%
Totals:	**1554**	**366**	**23.55%**	**276**	**17.76%**	**79**	**5.08%**	**11**	**0.71%**

PATIENT LIAISON PROGRAM (PLP)									
FY2009	Total # of **PLP** Correspondence Received Each Month	Total # of Action Requests (Quality of Care, Personnel, and Process Issues)	% of Action Requests from Total # of **PLP** Correspondence	Total # of Action Requests Referred to **UTMB-CMHC**		Total # of Action Requests Referred to **TTUHSC-CMHC**		Total # of Action Requests Referred to **PRIVATE FACILITIES**	
					% of Total Action Requests Referred		% of Total Action Requests Referred		% of Total Action Requests Referred
March	520	69	13.27%	41	7.88%	28	5.38%	0	0.00%
April	434	46	10.60%	30	6.91%	16	3.69%	0	0.00%
May	438	49	11.19%	38	8.68%	11	2.51%	0	0.00%
Totals:	**1392**	**164**	**11.78%**	**109**	**7.83%**	**55**	**3.95%**	**0**	**0.00%**
GRAND TOTAL=	**2946**	**530**	**17.99%**						

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

Month: March 2009

Reportable Condition	Reports Received		Cases Confirmed	
	This Month	Same Month Last Year	Year to Date	Last Year to Date
Chlamydia	7	5	20	14
Gonorrhea	3	4	8	7
Syphilis	59	52	211	169
Hepatitis A	0	0	0	0
Hepatitis B, acute cases	0	1	0	2
Hepatitis C	247	261	855 (2)	996 (2)
HIV Screens (non-pre-release)	6,894	6,526	19,233	18,073
HIV Screens (pre-release)	3,820	3,685	10,500	9,398
HIV + pre-release tests	3	5	11	32
HIV Infections (total new)	60	55	140	197
AIDS	3	12	8	19
Methicillin-Resistant *Staph Aureus*	213	280	848	1073
Methicillin-Sensitive *Staph Aureus*	115	90	491	424
Occupational Exposures (TDCJ Staff)	12	13	23	39
Occupational Exposures (Medical Staff)	5	6	15	23
HIV CPX Initiation	4	7	11	16
Tuberculosis skin tests – intake (#positive)	118	166	697	789
Tuberculosis skin tests – annual (#positive)	38	31	157	105
Tuberculosis cases				
(1) Diagnosed during intake and attributed to county of origin	0	0	0	1
(2) Entered TDCJ on TB medications	1	0	2	0
(3) Diagnosed during incarceration in TDCJ	1	1	6	10
TB cases under management	19	21		
Peer Education Programs	0	1	108	98
Peer Education Educators	26	11	1147	753
Peer Education Participants	7334	3350	19078	10115
Sexual Assault In-Service (sessions/units)	0	0	1/1	3/2
Sexual Assault In-Service Participants	0	0	10	17
Alleged Assaults & Chart Reviews	55	43	153	130
BBE Labs (Offenders)	4	2	13	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.

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

Month: April 2009

Reportable Condition	Reports Received		Cases Confirmed	
	This Month	Same Month Last Year	Year to Date	Last Year to Date
Chlamydia	4	2	24	16
Gonorrhea	3	5	10	12
Syphilis	60	72	271	241
Hepatitis A	0	0	0	0
Hepatitis B (acute cases)	1	0	3	2
Hepatitis C	329 (0)	354 (0)	1184 (2)	1349 (2)
HIV Screens (non-pre-release)	9401	6871	28540	24865
HIV Screens (pre-release)	5147	3949	15647	13327
HIV + pre-release tests	4	3	14	20
HIV Infections (total new)	67	44	206	224
AIDS	29	7	34	28
Methicillin-Resistant *Staph Aureus*	239	328	992	1510
Methicillin-Sensitive *Staph Aureus*	114	152	527	622
Occupational Exposures (TDCJ Staff)	3	20	26	67
Occupational Exposures (Medical Staff)	6	7	21	30
HIV CPX Initiation	0	4	9	21
Tuberculosis skin tests – intake (#positive)	247	190	1168	1130
Tuberculosis skin tests – annual (#positive)	68	48	236	164
Tuberculosis cases				
(1) Diagnosed during intake and attributed to county of origin	0	0	0	1
(2) Entered TDCJ on TB medications	0	2	2	2
(3) Diagnosed during incarceration in TDCJ	3	0	9	10
TB cases under management	16	22		
Peer Education Programs	0	2	108	100
Peer Education Educators	44	26	1191	779
Peer Education Participants	7012	5114	26021	16178
Sexual Assault In-Service (sessions/units)	3/2	0	4/3	3/2
Sexual Assault In-Service Participants	22	0	32	17
Alleged Assaults & Chart Reviews	53	59	206	189
BBE Labs (Offenders)	2	3	15	8

NOTE: 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: May 2009

Reportable Condition	Reports Received		Cases Confirmed	
	This Month	Same Month Last Year	Year to Date	Last Year to Date
Chlamydia	3	3	27	19
Gonorrhea	1	5	11	17
Syphilis	49	57	320	298
Hepatitis A	0	0	0	0
Hepatitis B (acute cases)	1	1	4	3
Hepatitis C	256	403	1440	1751
HIV Screens (non-pre-release)	7392	6928	36093	32127
HIV Screens (pre-release)	3482	3900	19129	17227
HIV + pre-release tests	2	5	12	41
HIV Infections (total new)	41	72	247	296
AIDS	16	28	82	56
Methicillin-Resistant *Staph Aureus*	173	340	1226	1865
Methicillin-Sensitive *Staph Aureus*	78	138	670	773
Occupational Exposures (TDCJ Staff)	3	12	29	69
Occupational Exposures (Medical Staff)	3	9	24	38
HIV CPX Initiation	1	5	10	26
Tuberculosis skin tests – intake (#positive)	387	296	1661	1555
Tuberculosis skin tests – annual (#positive)	35	51	279	234
Tuberculosis cases				
(1) Diagnosed during intake and attributed to county of origin	0	3	0	4
(2) Entered TDCJ on TB medications	0	2	2	4
(3) Diagnosed during incarceration in TDCJ	2	3	11	13
TB cases under management	18	27		
Peer Education Programs	0	1	108	101
Peer Education Educators	96	10	1287	789
Peer Education Participants	6816	4498	32837	20674
Sexual Assault In-Service (sessions/units)	0	5/7	4/3	8/9
Sexual Assault In-Service Participants	0	48	32	65
Alleged Assaults & Chart Reviews	55	47	261	236
BBE Labs (Offenders)	7	4	22	12

NOTE: 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.

Health Services Liaison Utilization Review Audit
3rd Quarter FY-2009
(March, April, and May)

During the third quarter of FY-2009 ten percent of the combined UTMB and TTUHSC hospital and infirmary discharges were audited. A total of 93 hospital discharges and 58 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[3] (Cases with deficiencies)
March	2 (33%)	0	4 (66%)
April	3 (50%)	1 (16%)	1 (16%)
May	5 (93%)	0	3 (50%)

UTMB Hospital Discharges

Month	Unstable Discharges [1] (Cases with deficiencies)	Readmissions [2] (Cases with deficiencies)	Lack Documentation[3] (Cases with deficiencies)
March	17 (51%)	11 (33%)	15 (45%)
April	5 (36%)	2 (14%)	11 (58%)
May	17 (60%)	1 (3%)	8 (29%)

TOTAL: Combined Hospital Discharges (Texas Tech and UTMB)

Month	**Unstable Discharges [1]** (Cases with deficiencies)	**Readmissions [2]** (Cases with deficiencies)	**Lack Documentation**[3] (Cases with deficiencies)
March	19 (49%)	11 (28%)	19 (49%)
April	8 (40%)	3 (15%)	12 (60%)
May	22 (65%)	1 (2%)	11 (32%)

Texas Tech Infirmary Discharges

Month	Unstable Discharges [1] (Cases with deficiencies)	Readmissions [2] (Cases with deficiencies)	Lack Documentation[3] (Cases with deficiencies)
March	5 (63%)	1 (18%)	3 (43%)
April	5 (64%)	0	4 (50%)
May	12 (100%)	0	6 (50%)

UTMB Infirmary Discharges

Month	Unstable Discharges [1] (Cases with deficiencies)	Readmissions [2] (Cases with deficiencies)	Lack Documentation[3] (Cases with deficiencies)
March	6 (46%)	1 (18%)	1 (7%)
April	5 (64%)	0	4 (50%)
May	8 (92%)	0	2 (22%)

TOTAL: Combined Infirmary Discharges (Texas Tech and UTMB)

Month	**Unstable Discharges [1]** (Cases with deficiencies)	**Readmissions [2]** (Cases with deficiencies)	**Lack Documentation**[3] (Cases with deficiencies)
March	11 (52%)	2 (10%)	4 (19%)
April	10 (67%)	0	5 (33%)
May	20 (95%)	0	8 (38%)

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 (Audit question A).

[2] Discharged patient offenders required emergency acute care or readmission to tertiary level care within a 7 day period (Audit questions B and D).

[3] The discharge summary was not available in the offender's medical record within 24 hours of arriving at the unit (Audit question E).

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

March	Numbered Pro tal Numb tal Numb			Total Number of New Equipment
	ventory F f Deletion f Transfe			
Huntsville	52	0	1	3
Bradshaw	26	0	0	0
Billy Moore	9	0	0	0
Coffield	60	0	1	3

April	Numbered Pro tal Numb tal Numb			Total Number of New Equipment
	ventory F f Deletion f Transfe			
Eastham	40	1	1	2
Hightower	31	0	2	1
Henley	23	0	2	2
Goodman	15	0	1	2

May	Numbered Pro tal Numb tal Numb			Total Number of New Equipment
	ventory F f Deletion f Transfe			
Dawson	40	0	5	7
Estes	16	0	1	1
Estelle	205	0	5	0

CAPITAL ASSETS AUDIT
THIRD QUARTER, FISCAL YEAR 2009

Audit Tools	March	April	May	Total
Total number of units audited	4	4	3	11
Total numbered property	147	109	261	517
Total number out of compliance	0	0	0	0
Total % out of compliance	0.00%	0.00%	0.00%	0.00%

Executive Services
Active Monthly Medical Research Projects
Health Services Division

FY-2009 Third Quarterly Report: March, April, and May

Project Number: 408-RM03

Researcher: Ned Snyder
IRB Number: 02-377
IRB Expiration Date: 30-Jun-09
Research Began: 03-Jun-03

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

Data Collection Began: 01-Jul-03

Data Collection End: 03-Jul-08

Proponent:
University of Texas Medical Branch at Galveston

Projected Completion Date: 31-Jul-08

Project Status:
Data Analysis

Progress Report Due: 17-Jan-09

Units: Hospital Galveston

Project Number: 433-RM04

Researcher: Ned Snyder
IRB Number: 03-357
IRB Expiration Date: 30-Jun-09
Research Began: 19-Mar-04

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

Data Collection Began: 22-Mar-04

Data Collection End: 31-Jul-08

Proponent:
University of Texas - Galveston

Projected Completion Date: 31-Jul-08

Project Status:
Data Collection

Progress Report Due: 12-Feb-08

Units: UTMB

Project Number: 450-RM04

Researcher: Everett Lehman
IRB Number: 04.DSHP FS.02XP
IRB Expiration Date: 14-Jul-08
Research Began: 30-Sep-04

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

Data Collection Began: 16-Nov-04

Data Collection End: 30-Nov-04

Proponent:
Centers for Disease Control and Prevention/Nat'l Institute for

Projected Completion Date: 30-Jun-09

Project Status:
Manuscript Being Reviewed

Progress Report Due: 17-Oct-09

Units: ;Stingfellow

Project Number: 475-RM05

Researcher: Robert Morgan
IRB Number: L05-077
IRB Expiration Date: 27-Feb-09
Research Began: 01-Aug-05

Title of Research:
Tailoring Services for Mentally Ill Offenders

Data Collection Began: 20-Jan-06

Data Collection End: 31-Jul-07

Proponent:
Texas Tech University

Projected Completion Date: 01-Jan-08

Project Status:
Data Collection

Progress Report Due:
24-Sep-08

Units: Gatesville, Montford

Project Number: 490-RM06

Researcher: Sharon Melville
IRB Number: Exempt
IRB Expiration Date: 18-Apr-06
Research Began: 24-Apr-06

Title of Research:
Medical Monitoring Project (MMP)

Data Collection Began: 24-Apr-06

Data Collection End: 30-Apr-10

Proponent:
Texas Department of State Health Services; US Center for Disease

Projected Completion Date: 30-Apr-10

Project Status:
Data Collection

Progress Report Due:
22-Apr-08

Units: System-wide

Project Number: 503-RM06

Researcher: William O'Brien
IRB Number: 06-189
IRB Expiration Date: 30-Apr-08
Research Began: 02-Aug-06

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 pariticipated in a DUET trial (TMC125-C206 or TMC125-C216)

Data Collection Began: 26-Oct-06

Data Collection End: 31-Oct-08

Proponent:
UTMB

Projected Completion Date:

Project Status:
Data Collection

Progress Report Due:
16-Jul-07

Units: UTMB

Project Number: 513-MR07

Researcher: H. Morgan Scott
IRB Number: Exempt
IRB Expiration Date: N/A
Research Began: 21-Nov-06

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: 21-Nov-06

Data Collection End: 31-Aug-07

Proponent:
Department of Veterinary Integrative Biosciences, College of Veterinary

Projected Completion Date: 31-Aug-08

Project Status:
Manuscripts Reviewed; Continued Data Analysis

Progress Report Due: 22-Dec-09

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: Jacques Baillargeon
IRB Number: 06-249
IRB Expiration Date: 30-Jun-09
Research Began: 27-Oct-07

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

Data Collection Began: 05-Mar-07

Data Collection End: 05-Mar-07

Proponent:
UTMB

Projected Completion Date: 31-Dec-09

Project Status:
Manuscripts Being Reviewed

Progress Report Due: 06-Sep-09

Units: Data Collection

Project Number: 527-MR07

Researcher: Ned Snyder
IRB Number: 05-277
IRB Expiration Date: 30-Jun-08
Research Began: 12-Apr-07

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

Data Collection Began: 12-Mar-07

Data Collection End: 31-Jul-08

Proponent:
UTMB

Projected Completion Date: 31-Jul-09

Project Status:
Data Collection

Progress Report Due: 17-Jan-09

Units: UTMB

Project Number: 568-RM08

Researcher:
Julito Uy

IRB Number:
L08-184

IRB Expiration Date:
26-Aug-09

Research Began:
19-Nov-08

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

Data Collection Began:
19-Nov-08

Data Collection End:

Proponent:
Texas Tech University

Projected Completion Date:
30-May-09

Project Status:
Data Collection

Progress Report Due:
14-Nov-09

Units: Clements

Executive Services
Pending Monthly Medical Research Projects
Health Services Division

FY-2009 Third Quarterly Report: March, April, and May

Project Number: **584-RM09**

Researcher:
Sreeram Parupudi

IRB Number:
Exempt

Application Received:
Thursday, April 30, 2009

Title of Research:
Case Report: Endoscopic Removal of Long Rigid Foreign Bodies from Duodenum

Completed Application:
Sunday, May 17, 2009

Peer Panel Schedule:
Thursday, May 28, 2009

Proponent:
Texas Tech University

Panel Recommendations:
Pending

Project Status:
Pending OGC & HSD Review

Detail:
Case Report: Endoscopic Removal of Long Rigid Foreign Bodies from Duodenum

TDCJ HEALTH SERVICES
ADMINISTRATIVE SEGREGATION MENTAL HEALTH AUDITS
THIRD QUARTER FY 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
CLEMENTS (ECB)	3/11&12/09	100%	100%	2	9	435	206/136	5/6
FORMBY (SJ)	3/12/09	33%	100%	1	2	21	12/9	1/3
McCONNELL	3/18&19/09	100%	100%	2	8	466	69/188	6/6
FERGUSON	3/25/09	100%	100%	2	1	378	22/182	3/6
WYNNE	4/2/09	100%	100%	1	4	295	29/134	3/6
CONNALLY	4/8&9/09	100%	100%	1	9	468	102/153	5/6
MOUNTAIN VIEW	4/23/09	100%	100%	0	0	28	9/19	2/4
COFFIELD	4/27&28/09	100%	100%	0	9	638	79/237	4/8
LEWIS (ECB)	5/6&7/09	100%	50%	1	8	435	62/189	4/6
POLUNSKY	5/13,14,15/09	83%	100%	0	8	412	65/164	4/6
MURRAY	5/21/09	100%	N/A	1	7	42	12/30	2/5
HUGHES	5/27&28/09	100%	100%	2	10	459	90/239	5/6
TOTAL		1,116	1,050	13	75	4,077	757/1,680	44/68
AVERAGE		93.0%	95.5%	1.08	6.25	339.8	63.1/140	3.67/5.67

Consent Item 3(a)

University Medical Director's Report

The University of Texas Medical Branch

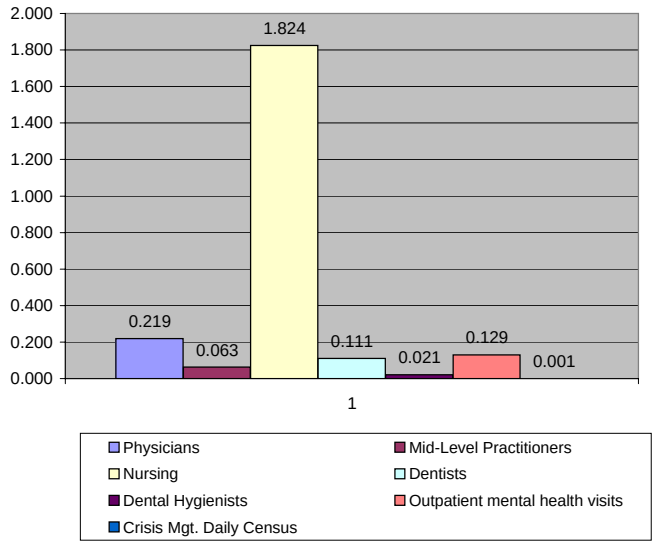
Correctional Health Care
MEDICAL DIRECTOR'S REPORT

THIRD QUARTER
FY 2009

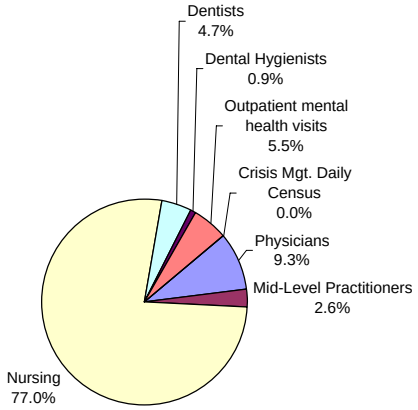
Medical Director's Report:

	March		April		May		Qtly Average	
Average Population	**119,714**		**119,926**		**119,747**		**119,796**	
	Number	**Rate Per Offender**	**Number**	**Rate Per Offender**	**Number**	**Rate Per Offender**	**Number**	**Rate Per Offender**
Medical encounters								
Physicians	25,908	0.216	26,313	0.219	26,660	0.223	**26,294**	**0.219**
Mid-Level Practitioners	11,474	0.096	5,676	0.047	5,338	0.045	**7,496**	**0.063**
Nursing	216,966	1.812	220,047	1.835	218,646	1.826	**218,553**	**1.824**
Sub-total	**254,348**	**2.125**	**252,036**	**2.102**	**250,644**	**2.093**	**252,343**	**2.106**
Dental encounters								
Dentists	13,867	0.116	13,589	0.113	12,542	0.105	**13,333**	**0.111**
Dental Hygienists	2,649	0.022	2,716	0.023	2,313	0.019	**2,559**	**0.021**
Sub-total	**16,516**	**0.138**	**16,305**	**0.136**	**14,855**	**0.124**	**15,892**	**0.133**
Mental health encounters								
Outpatient mental health visits	15,171	0.127	15,680	0.131	15,682	0.131	**15,511**	**0.129**
Crisis Mgt. Daily Census	65	0.001	72	0.001	77	0.001	**71**	**0.001**
Sub-total	**15,236**	**0.127**	**15,752**	**0.131**	**15,759**	**0.132**	**15,582**	**0.130**
Total encounters	**286,100**	**2.390**	**284,093**	**2.369**	**281,258**	**2.349**	**283,817**	**2.369**

Encounters as Rate Per Offender Per Month



Encounters by Type

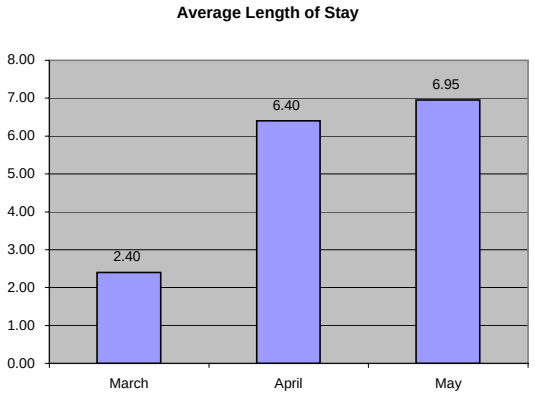


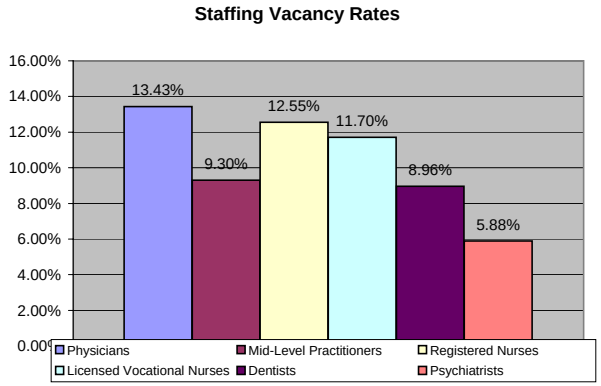
Medical Director's Report (Page 2):

	March	April	May	Qtly Average
Medical Inpatient Facilities				
Average Daily Census	63.00	70.00	81.00	**71.33**
Number of Admissions	261.00	327.00	359.00	**315.67**
Average Length of Stay	2.40	6.40	6.95	**5.25**
Number of Clinic Visits	*	*	*	**#VALUE!**
Mental Health Inpatient Facilities				
Average Daily Census	1,022.68	1,014.36	1,001.26	**1,012.77**
PAMIO/MROP Census	702.22	701.13	701.48	**701.61**
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	58.00	9.00	67.00	13.43%
Mid-Level Practitioners	117.00	12.00	129.00	9.30%
Registered Nurses	453.00	65.00	518.00	12.55%
Licensed Vocational Nurses	566.00	75.00	641.00	11.70%
Dentists	61.00	6.00	67.00	8.96%
Psychiatrists	16.00	1.00	17.00	5.88%





Consent Item 3(b)

University Medical Director's Report

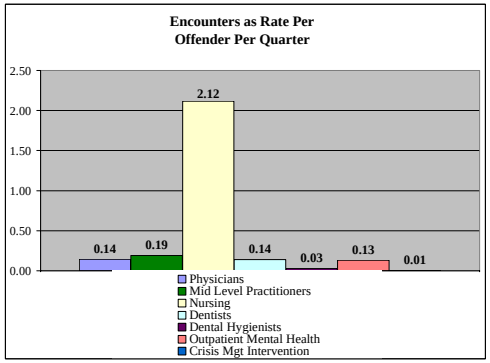
Texas Tech University
Health Sciences Center

Correctional Managed Health Care
MEDICAL DIRECTOR'S REPORT

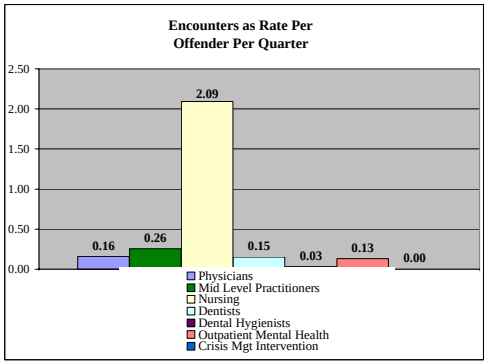
THIRD QUARTER
FY 2009

Medical Director's Report:

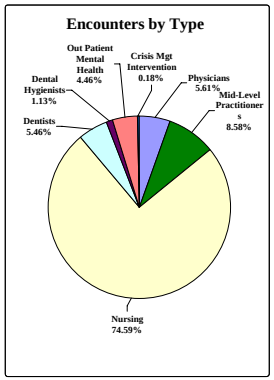
	March		April		May		Quarterly Average	
Average Population	30,538.19		30,605.76		30,661.08		30,601.68	
Medical Encounters	Number	Rate Per Offender	Number	Rate Per Offender	Number	Rate Per Offender	Number	Rate Per Offender
Physicians	5,075	0.166	4,737	0.155	4,902	0.160	4,905	0.160
Mid-Level Practitioners	8,540	0.280	7,925	0.259	7,029	0.229	7,831	0.256
Nursing	64,217	2.103	61,340	2.004	66,582	2.172	64,046	2.093
Sub-Total	**77,832**	**2.549**	**74,002**	**2.418**	**78,513**	**2.561**	**76,782**	**2.509**
Dental Encounters								
Dentists	4,373	0.143	4,636	0.151	4,775	0.156	4,595	0.150
Dental Hygienists	878	0.029	1,082	0.035	1,078	0.035	1,013	0.033
Sub-Total	**5,251**	**0.172**	**5,718**	**0.187**	**5,853**	**0.191**	**5,607**	**0.183**
Mental Health Encounters								
Outpatient Mental Health Visits	3,775	0.124	4,018	0.131	4,445	0.145	4,079	0.133
Crisis Mgt. Interventions	64	0.002	43	0.001	44	0.001	50	0.002
Sub-Total	**3,839**	**0.126**	**4,061**	**0.133**	**4,489**	**0.146**	**4,130**	**0.135**
Total Encounters	**86,922**	**2.846**	**83,781**	**2.737**	**88,855**	**2.898**	**86,519**	**2.827**



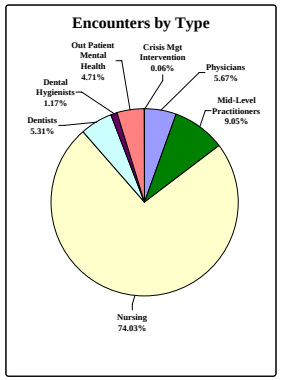
2nd Quarter 2009



3rd Quarter 2009



2nd Quarter 2009

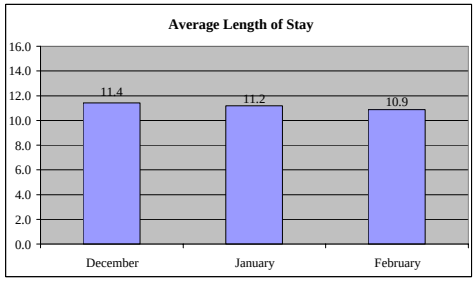


3rd Quarter 2009

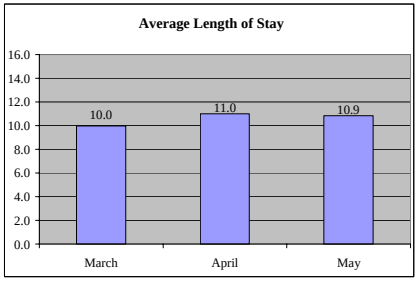
Medical Director's Report (page 2):

	March	April	May	Quarterly Average
Medical Inpatient Facilities				
Average Daily Census	117.35	113.1	112.77	**114.41**
Number of Admissions	242	233	249	**241.33**
Average Length of Stay	9.96	10.99	10.85	**10.60**
Number of Clinic Visits	734	781	713	**742.67**
Mental Health Inpatient Facilities				
Average Daily Census	478	461	452	**463.67**
PAMIO/MROP Census	414	414	412	**413.33**
Specialty Referrals Completed	904	945	927	**925.33**
Telemedicine Consults	347	291	326	**321.33**

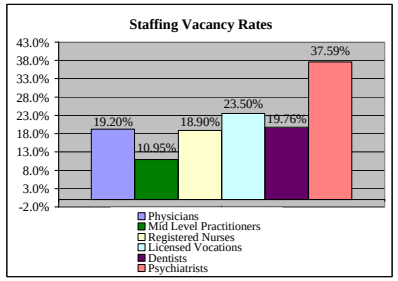
	Average This Quarter			Percent
Health Care Staffing	Filled	Vacant	Total	Vacant
Physicians	21.1	3.67	24.77	14.82%
Mid-Level Practitioners	28.22	2.91	31.13	9.35%
Registered Nurses	145.27	31.34	176.61	17.75%
Licensed Vocational Nurses	268.62	81.44	350.06	23.26%
Dentists	16.48	3.23	19.71	16.39%
Psychiatrists	6.56	4.08	10.64	38.35%



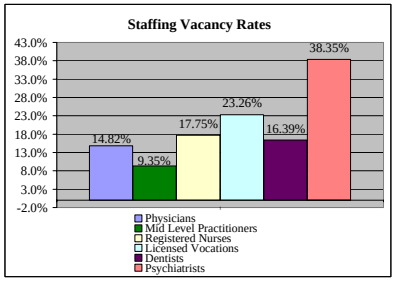
2nd Quarter 2009



3rd Quarter 2009



2nd Quarter 2009



3rd Quarter 2009

Consent Item 4

Summary of CMHCC Joint Committee / Work Groups

Correctional Managed Health Care
Joint Committee/Work Group Activity Summary
for September 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: August 13, 2009

Key Activities:

(1) Approved Minutes

(2) Reports from Champions/Discipline Directors – Dental Services / Medical Staff / Mental Health Services / Nursing Services / OPS Data

(3) Report on ATC Methodology Audit

(4) FY 2009 SLC Indicators:
- Infection Control
- Mental Health PULHES
- Monitoring CD4 Viral Load Analysis

(5) Monthly Grievance Exception Report

(6) New SLC Quality of Care Indicator data:
- Dental – Periodontal / Comprehensive Treatment Plan
- Refusal of Treatment
- No Shows
- Length of Stay
- Urgent Care
- Mammograms
- Coumadin

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

(8) Discussed issues related to SAFE Prisons Program

(9) Heard an update on Nursing Work Group

(10) Hand Washing Audit

(11) FLC

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: July 9, 2009

Key Activities:

(1) Reviewed revisions to policy A-08.10 Referral to the Program for the Aggressive Mentally Ill Offenders (PAMIO)
(2) Approved revisions to policy E-37.1 Daily Triaging of Health Complaints
(3) Reviewed revisions to policy E-44.2 Examination of Offenders by Private Practitioners

(4) Reviewed revisions to policy F-49.1 Personal Hygiene
(5) Approved new policy on Wheelchair Repair and Maintenance
(6) Approved revisions to policy E-42.3 Transportation of Infirmary and Assisted Living Patients
(7) Approved revisions to policy G-55.1 Pregnant Offenders
(8) Approved revisions to policy H-60.1 Health Records –Organization and Maintenance
(9) Approved revisions to policy H-60.1 Attachment C
(10) Approved revisions to policy G-55.1 Special Needs Offenders
(11) Approved revisions to policy B114.4 Prevention of Hepatitis B Virus Infection in TDCJ Facilities
(12) Approved revisions to policy E-43.2 Drug Therapy Management by Pharmacist
(13) Approved Minutes from the April 9, 2009 Policy and Procedures 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: July 9, 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:

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

(3) Quarterly Medical Error Reports (Third Quarter, March – May, 2009)

(4) Action Request (Old Business)

- Clarification of Medical Administration During Computer Breakdown (Down-time)
- Anemia Management in Pre-Dialysis Patients
- Documentation of Hepatitis A Vaccine
- Bipolar Depression Pathway Update
-

(5) Action Requests (New Business):

- Convert Clopidogrel (Plavix®) to a Prior Authorization Agent
- Select New Pharmacy and Therapeutics Chair
- Allow Refills on Enteral Nutrition
- Increase Refills Allowed on NSAIDs
- Midlevel Prescribing of Controlled Substances
- Add Restrictions for Benadryl Prescribing
- Update Seizure Guideline to Include How to Taper Seizure Medications
- Update Pharmacy Warehouse M-List

(6) Category Review:

- Analgesics
- Electrolytes

(7) Discussion on Propylthiouracil and Liver Toxicity

(8) Reviewed Policy and Procedures Revisions:

- P&P 55-10
- P&P 55-15
- P&P 55-20
- P&P 60-05
- P&P 60-10
- P&P 65-05
- P&P 65-10
- P&P 70-05
- P&P 70-10
- P&P 75-05
- P&P 75-15
- P&P75-20

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: August 13, 2009

Key Activities:

(1) Discussion on Respiratory Protection Proposed B-14.30

(2) Discussion on Varicella Vaccine and HIV Patients

(3) Discussion on Swine Flu

(4) Discussion on Screening Offenders on Chain Buses

(5) Reviewed the following policies:
- Policy B-14.03. Employee TB Testing
- Policy B-14.11 Through B14.13
- Policy B-14.14 – Prevention of Hepatitis B Virus (HBV) Infection in TDCJ Facilities
- Policy14.16 – Staph Aureus & Methicillin-Resistant Staph Aureus (MRSA)
- Policy 14.17 Through B14.18
- Policy 14.19 – Disease Reporting

Joint Dental Work Group

Chair: Dr. Brian Tucker

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

Meeting Date: May 20, 2009

Key Activities:

(1) Report from the Dental Utilization Quality Review Committee
(2) Report from the TDCJ Health Services Director / Eastern Sector Dental Services / Northern Dental Director / Southern Dental Director
(3) Approval of Minutes, Division and Department Directors / District Director Meeting
(4) Report from the Formulary Committee
(5) Report from the Dental Hygiene Manager
(6) Specialty Coordinators:

- Periodontics
- Endodontics
- Prosthodontics

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: March, 2009 (review of 40 cases), April, 2009 (review of 36 cases) and May, 2009 (review of 40 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: August 12, 2009

Key Activities:

(1) Discussion and review on ER Record

(2) Discussion and review of Protocols
(3) Heard Report JACHO / NCCHC Mental Health Facilities Issues
(4) Reviewed and discussed National Patient Safety Standards / Root Cause Analysis
(5) Discussion and review of Clinical Ladder / PBDS System
(6) Discussion and review of Delivery Models / Outpatient
(7) Discussion and review of Serious Incident Reviews / Peer Review Report

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: August 25, 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:

This report gives a listing and a brief description of each bill or rider that affects CMHCC. Many of the Appropriation Riders are not new but a carry-over from previous sessions. However, of significance are two (2) new ones, Rider 82, Managed Health Care Staff Loan Repayment and Rider 83, Appropriation Transfers Between Fiscal Years.

Also of significant importance was Section 16(a) of HB 4586 that requires TDCJ and CMHCC to identify and evaluate mechanisms to lower the cost of or increase the quality of care in health or pharmacy services and submit a report to the Legislative Budget Board and the Governor's Office no later than May 1, 2010.

FY 2010-2011 CMHCC Contracts:

Contract discussions continue for FY 2010 and 2011. A contract extension is being processed on the FY 2008-2009 contract to cover the month of September, 2009.

ARH:tb

Updates on 81st Legislative Session

September 8, 2009

SB 1 (Appropriations Bill)	Distribution of funds in FY 2010-2011 provided in the base appropriations for correctional health care contained in Strategies C.1.7 and C.1.8 of the TDCJ Appropriations. C.1.7 Psychiatric Care: FY 2010: $46.5M FY 2011: $51.3M C.1.8 Managed Health Care: FY 2010: $419.8M FY 2011: $416.9M
SB 1 (Rider 41)	Managed Health Care Reporting Requirements: Required to submit to the Legislative Budget Board and Governor a report detailing: a. correctional managed health care actual and projected expenditures for on-site, off-site, and pharmaceutical costs; b. health care cost for inmates over age 55 including utilization data; c. other health care information determined by the Office of the Governor and LBB; and d. all monies held in reserve during quarterly reporting period.
SB 1 (Rider 42)	Managed Health Care Operational Shortfalls: Provides authority for the transfer of up to $5M additional funding from TDCJ to the correctional health care program to address operational shortfalls.
SB 1 (Rider 72)	Marlin Correctional Mental Health Facility: Provides that $4,843,986 is available in Strategy C.1.7, psychiatric care to provide mental health care in FY 2011.
SB 1 (Rider 82)	Managed Health Care Staff Loan Repayment: From the amounts appropriated in Strategy C.1.7 Psychiatric Care and Strategy C.1.8 Managed Health Care, the CMHCC may use not more than a total of $500,000 for fiscal year 2010 and $500,000 for fiscal year 2011 for loan repayment assistance for medical and mental health care staff in accordance with guidelines outlined by the committee. Not later than December 1, 2011, the committee shall submit to the Legislative Budget Board and the Governor's Office a report detailing the use and disposition of those funds.

SB 1 (Rider 83)	Managed Care Appropriation Transfer Between Fiscal Years: States that the CMHCC may transfer appropriations with prior approval from the Governor's Office and the Legislative Budget Board, in an amount not to exceed $20M for FY 2011 to FY 2010 if correctional managed health and psychiatric care populations exceed performance measure targets; if expenditures for correctional managed health and psychiatric care exceed amounts appropriated for this purpose; and for any other emergency expenditure requirements including expenditures necessitated by public calamity.
HB 4586 (Section 16.a):	Appropriates $48,144,918 in supplemental funding for the correctional health care program.
HB 4586 (Section 16.b)	Out of the funds appropriated in Section 16.a, TDCJ and CMHCC shall identify and evaluate mechanisms to lower the cost of, or increase the quality of care in, health or pharmacy services and submit a report to the Legislative Budget Board and the Governor's Office no later than May 1, 2010.
HB 1959: (1st Called Session)	Relates that unless continued in existence as provided by Chapter 325, Government Code, the Texas Board of Criminal Justice and Texas Department of Criminal Justice are abolished September 1, 2013, rather than 2011.
HB 1510:	Relating to Sudden Infant Death Syndrome. Requires a hospital, birthing center, physician, nurse midwife, or midwife who provides prenatal care to pregnant women during gestation or at delivery to develop a resource pamphlet for parents of newborn children on sudden infant death syndrome.
SB 381:	Relating to the authority of physicians to delegate to certain pharmacists the implementation and modification of a patient's drug therapy.
HB 2585:	Relating to digital or electronic signatures and witness signatures on advanced directives. Requires providing for the use of digital / electronic signatures as substitute to manual signatures.
HB 4029:	Relating to release of certain health care information. Requires "health care information" defined to include payment information. Amendment excludes payment information when health care information is requested by patient or authorized representatives.

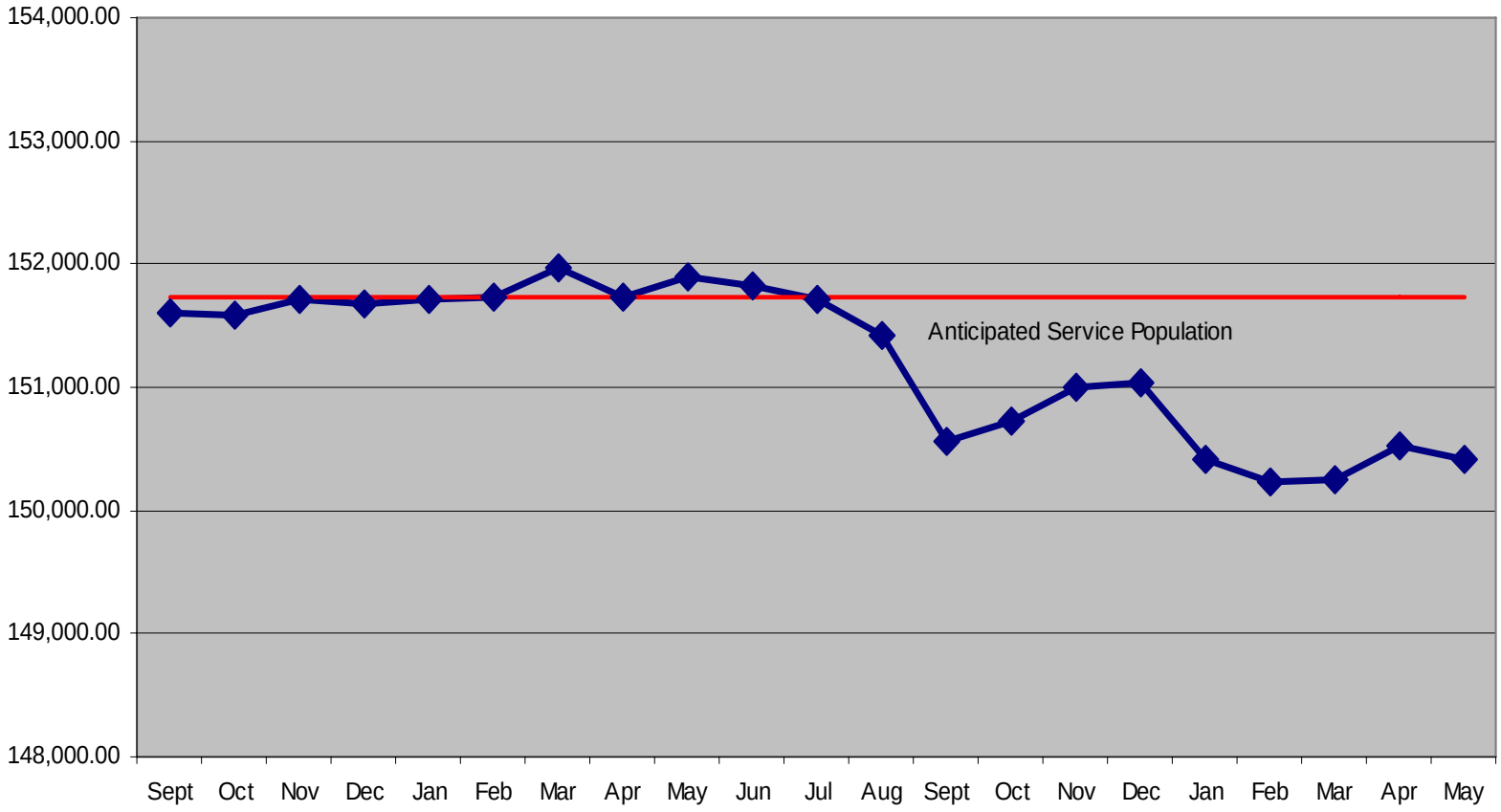
SB 532:	Relating to physician's delegation of prescriptive authority to physician assistant and advanced nurse practitioner.
SB 476:	Relating to staffing, overtime, and other employment protection for nurses. This Act requires the adoption, implementation, and enforcement of a written nurse staffing policy by the governing body of facilities defined as a "hospital".
HB 2027:	Relating to adoption of the Revised Uniform Anatomical Gift Act.
SB 203:	Relating to health care associated infection and preventable adverse events in certain health care facilities.
SB 1409	Relating to the definition of first responder for purposes of the immunization registry.

Correctional Managed Health Care Committee

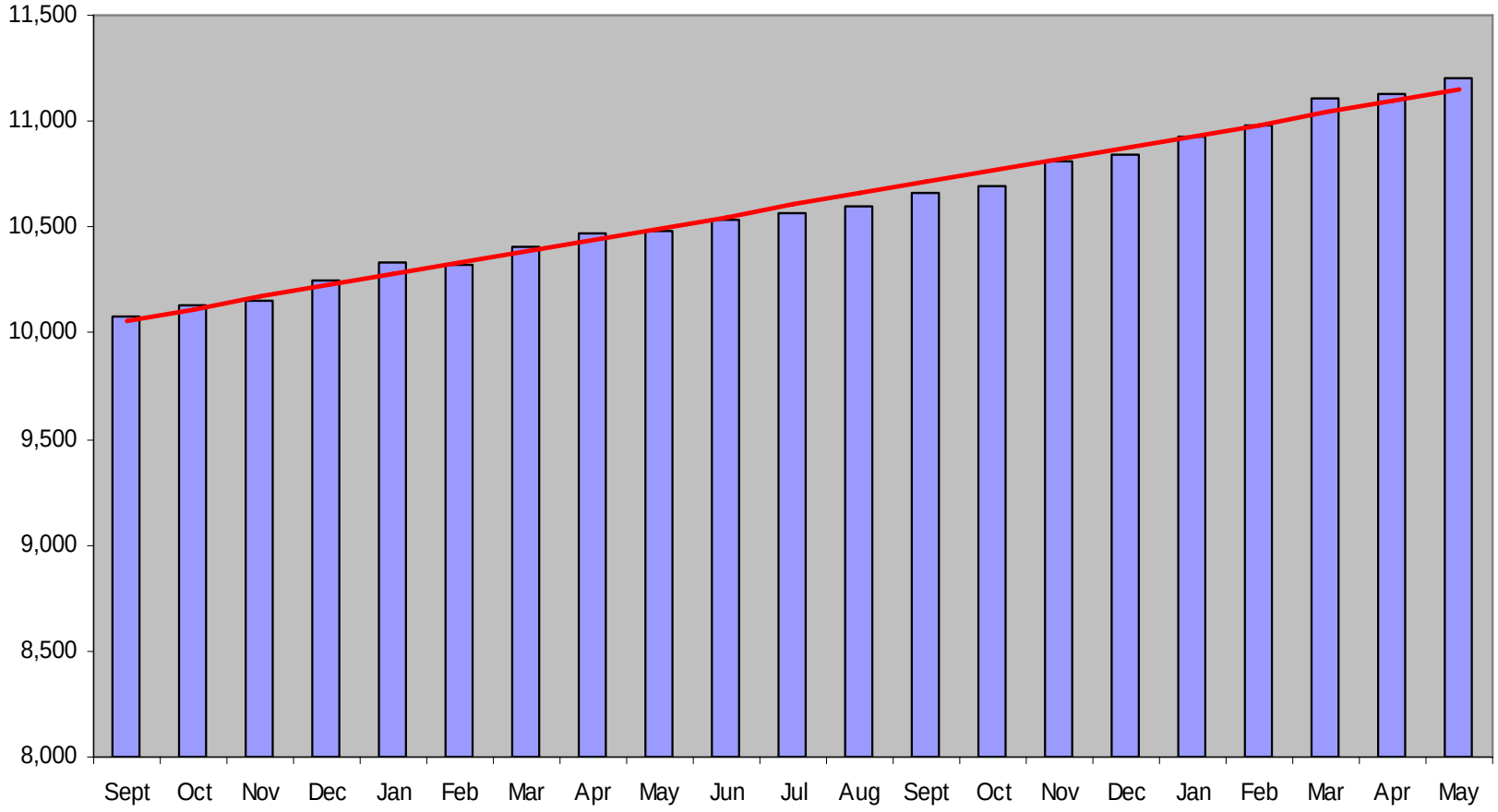
Key Statistics Dashboard

September 2009

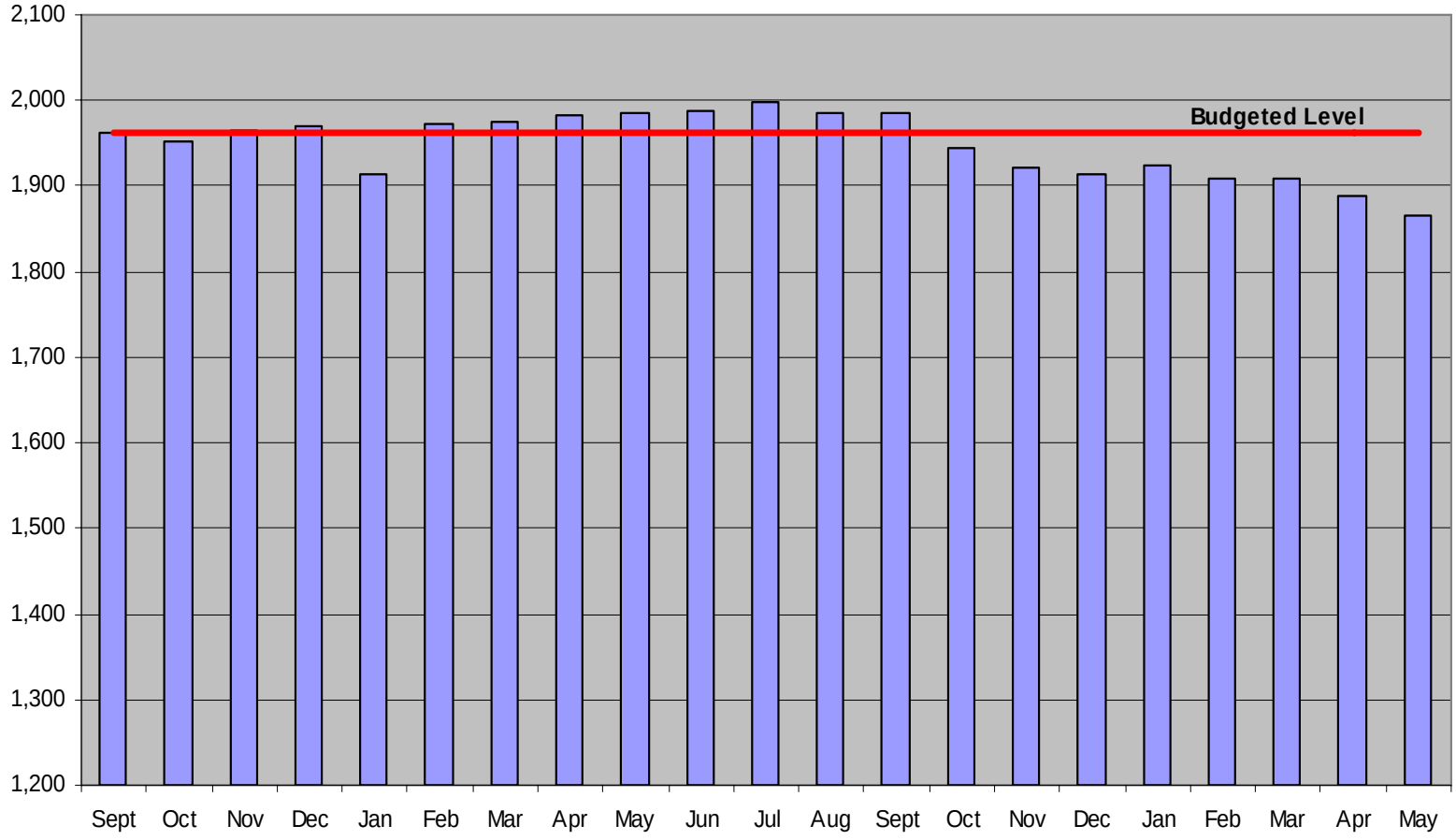
CMHC Service Population
FY 2008-2009 to Date



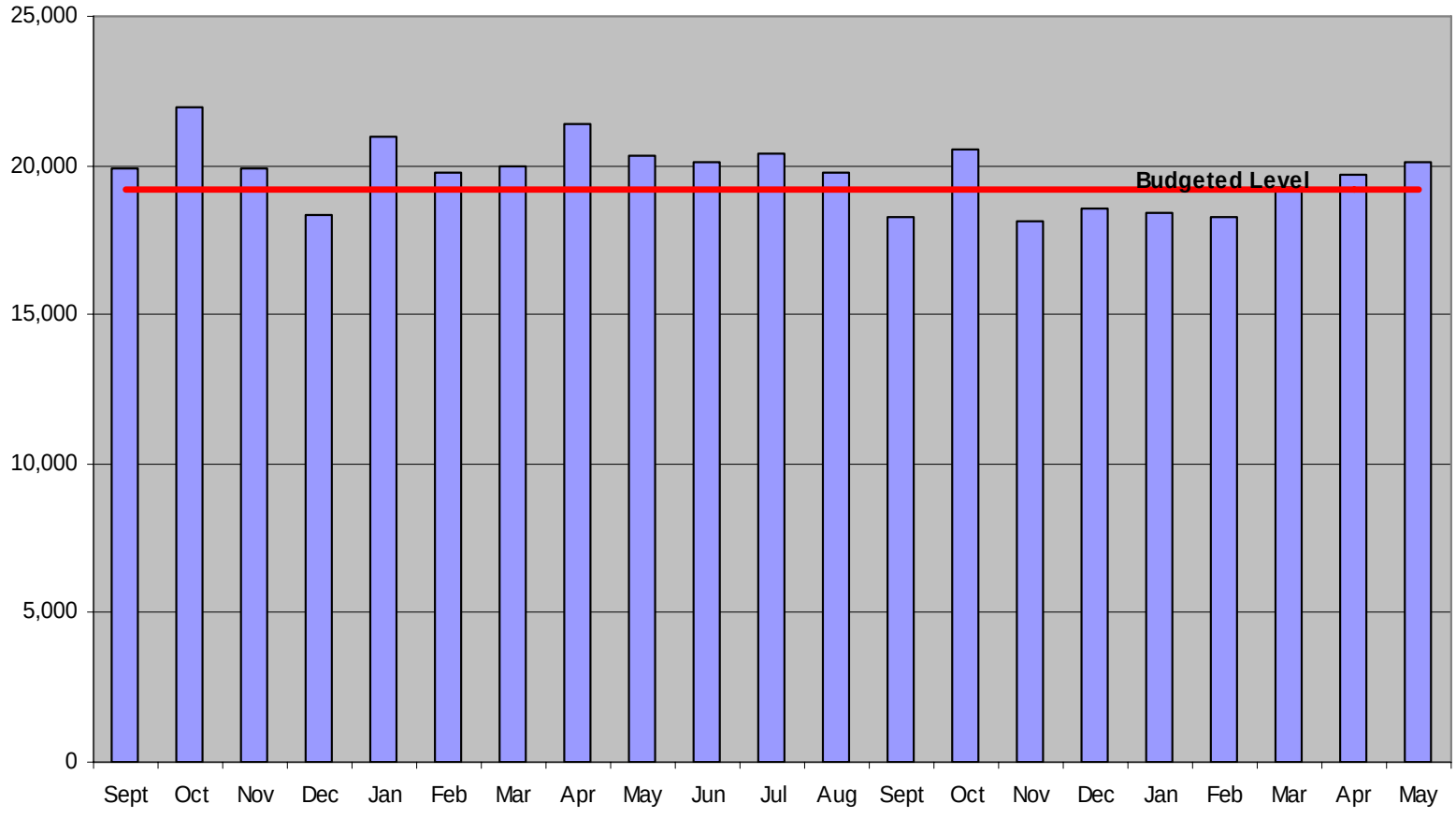
Offenders Age 55+
FY 2008-2009 to Date



Psychiatric Inpatient Census



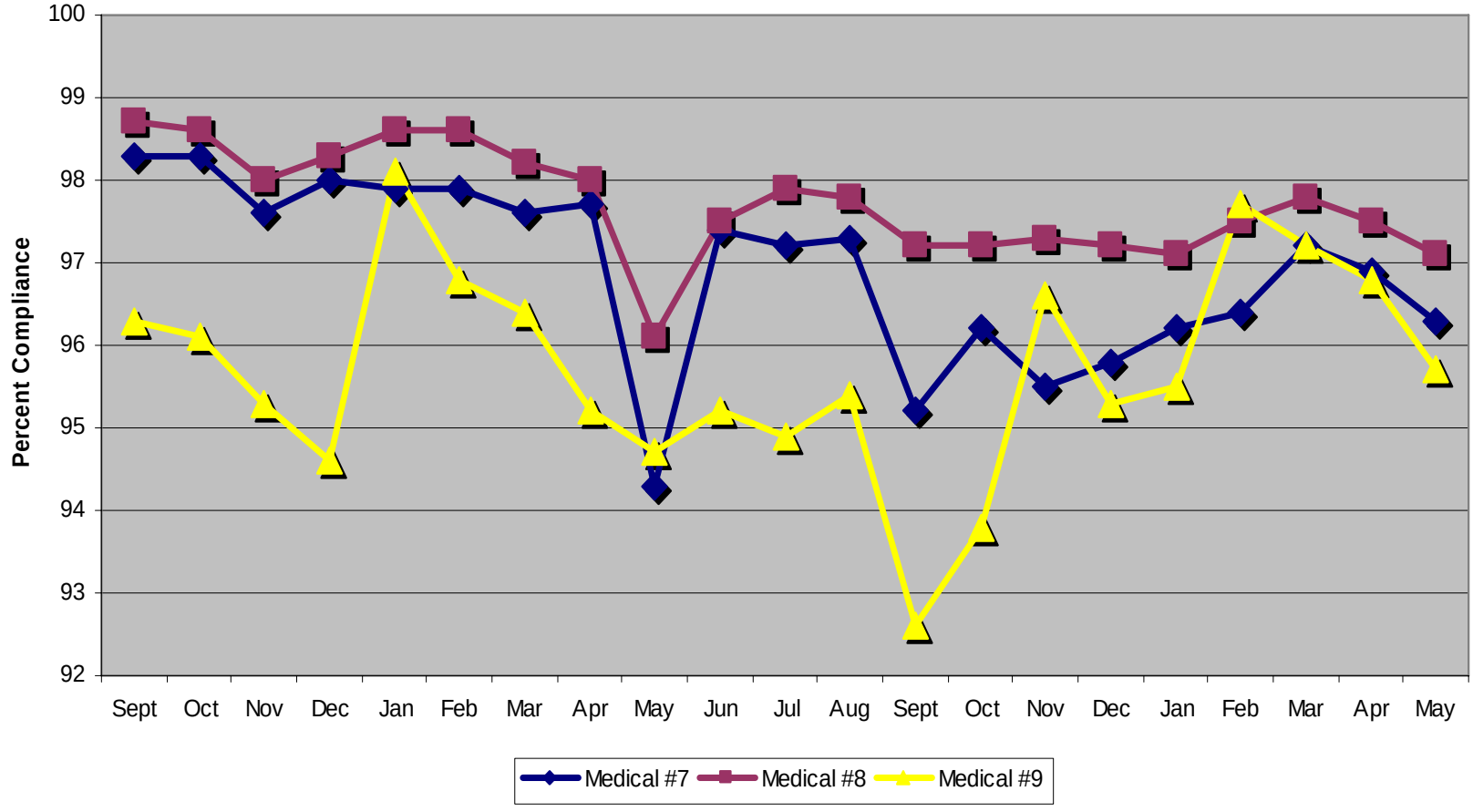
Psychiatric Outpatient Census



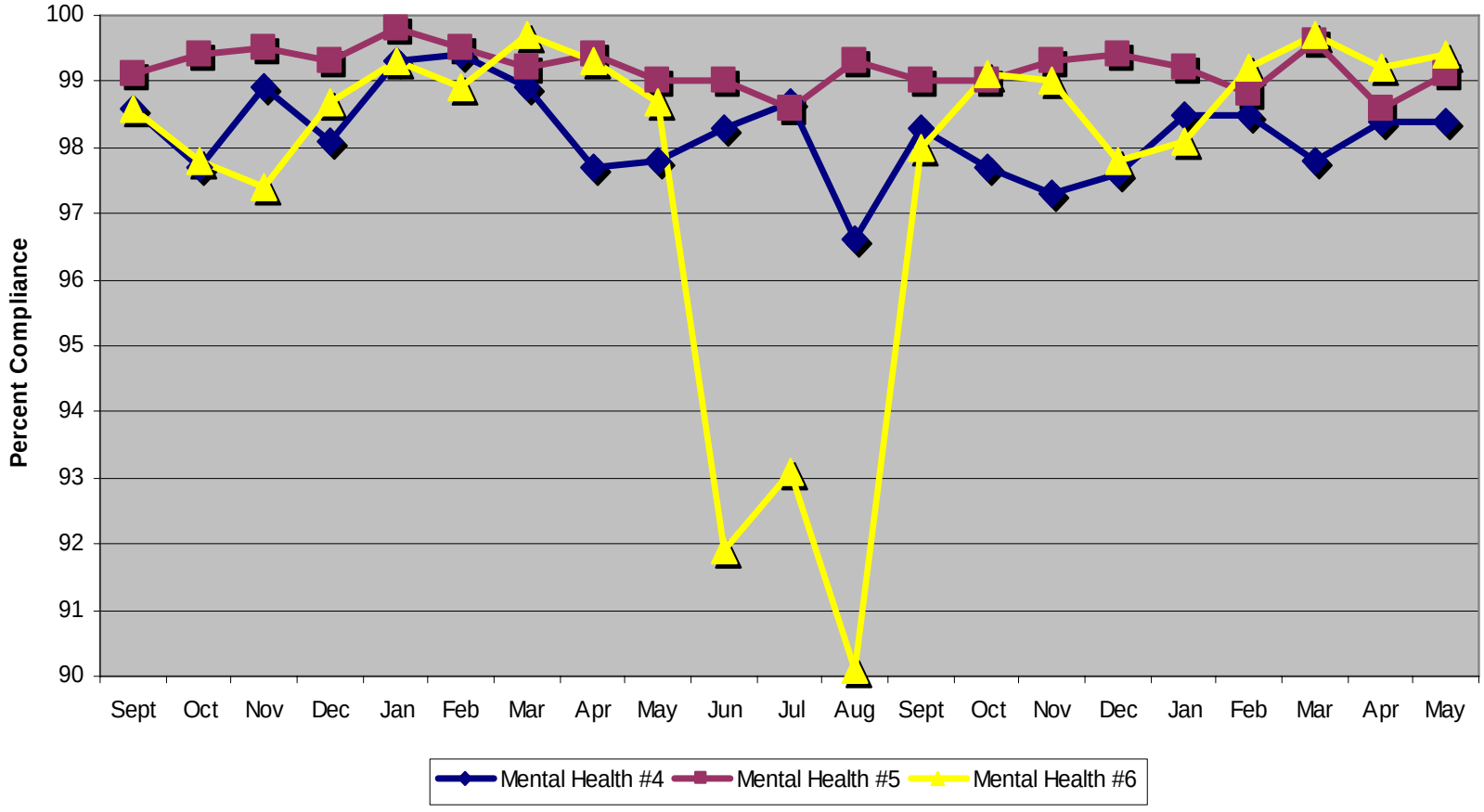
Access to Care Indicators

#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

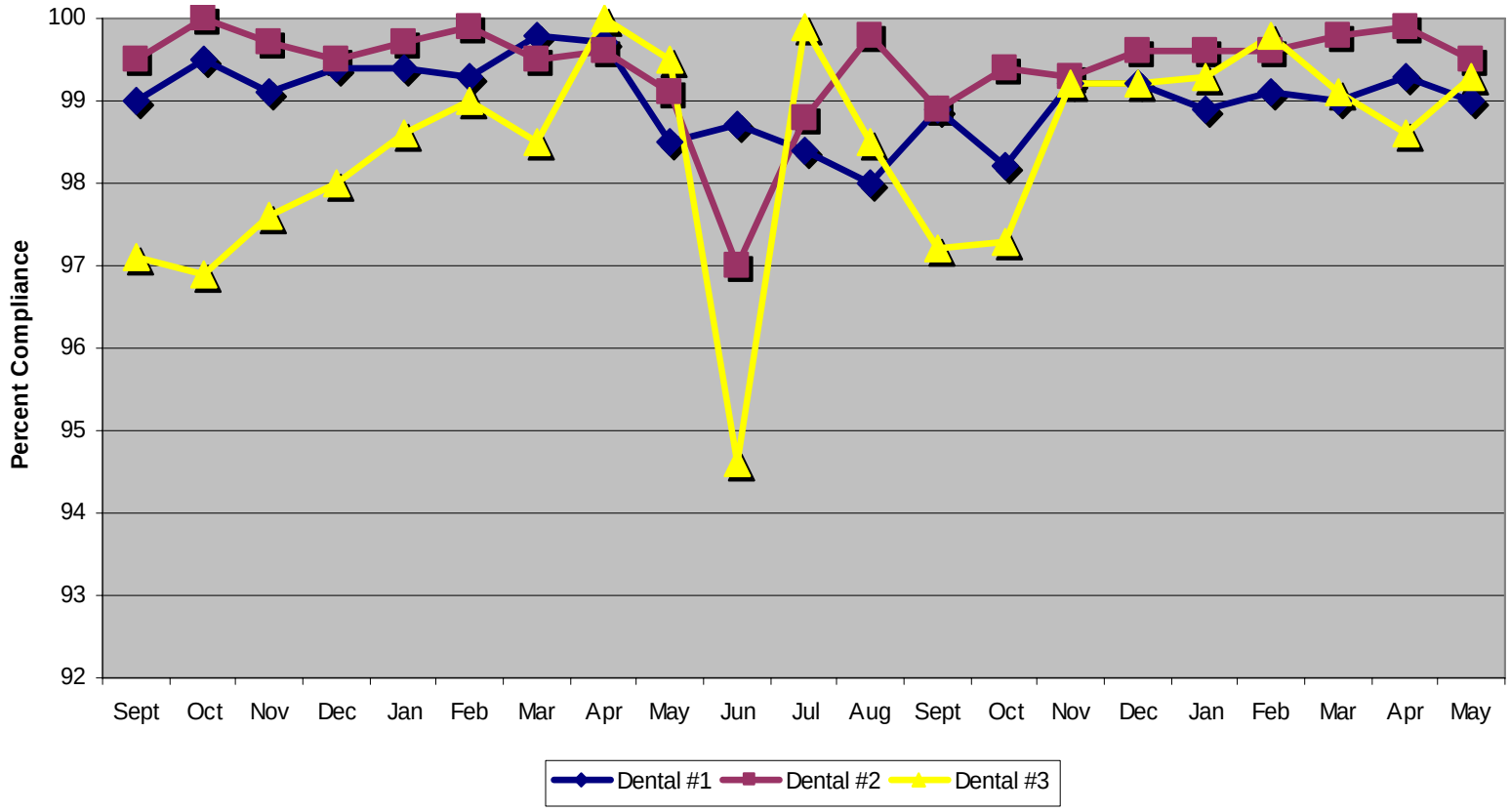
Medical Access to Care
Indicators FY 2008-2009 to Date



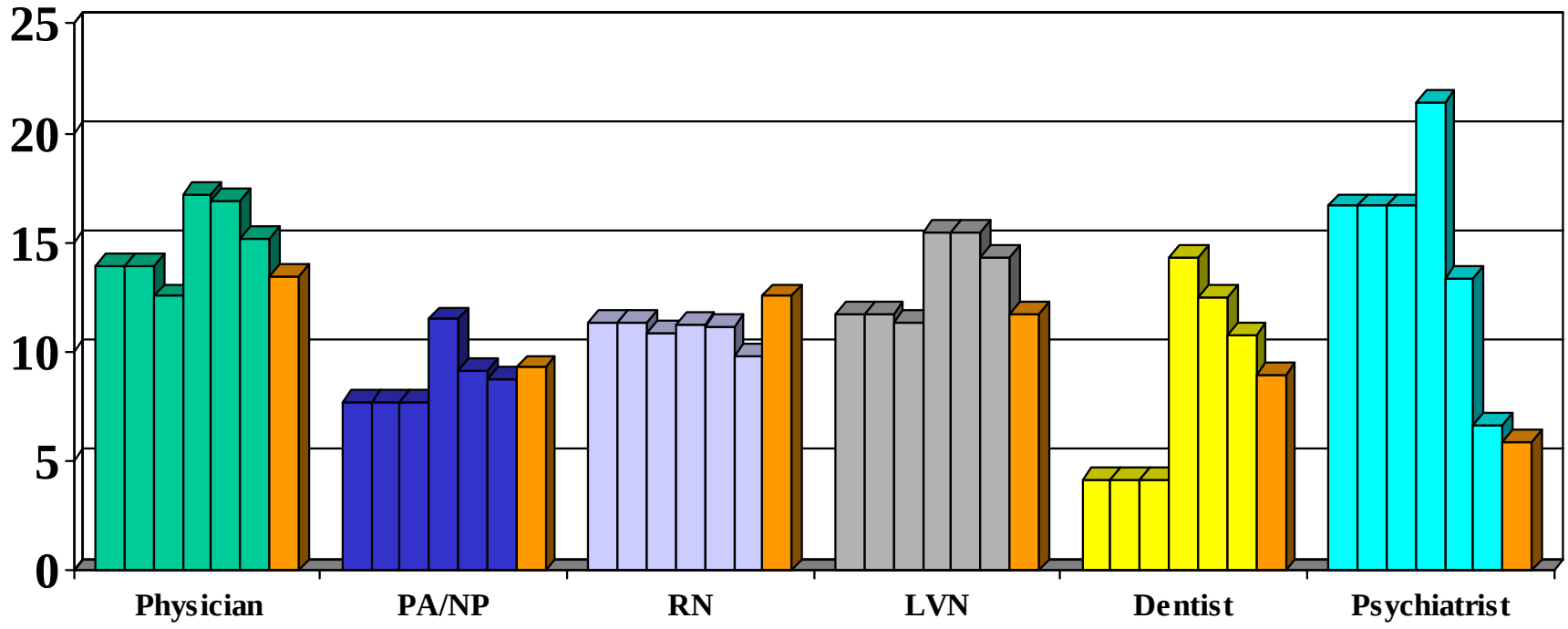
Mental Health Access to Care
Indicators FY 2008-2009 to Date



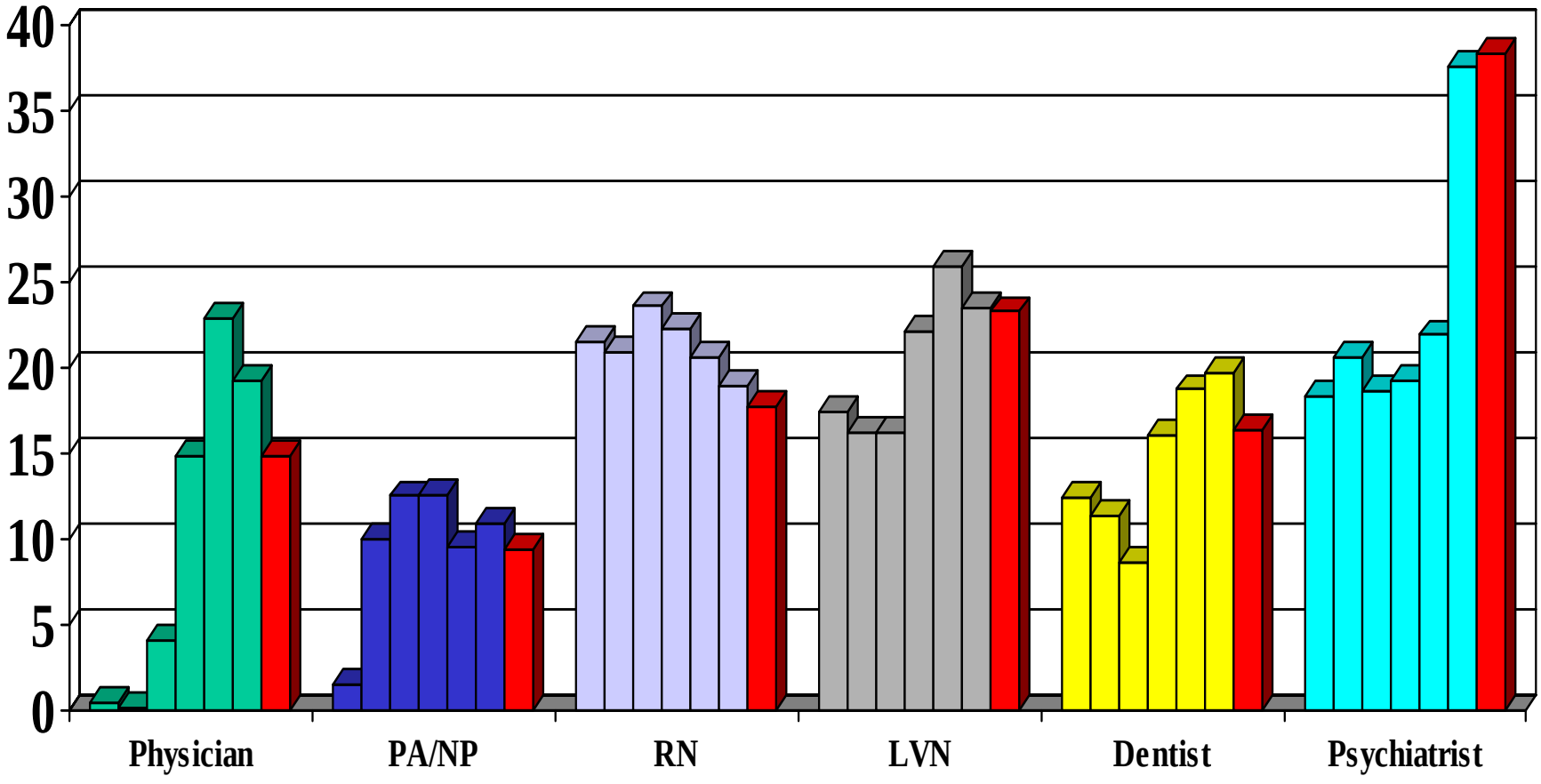
Dental Access to Care
Indicators FY 2008-2009 to Date



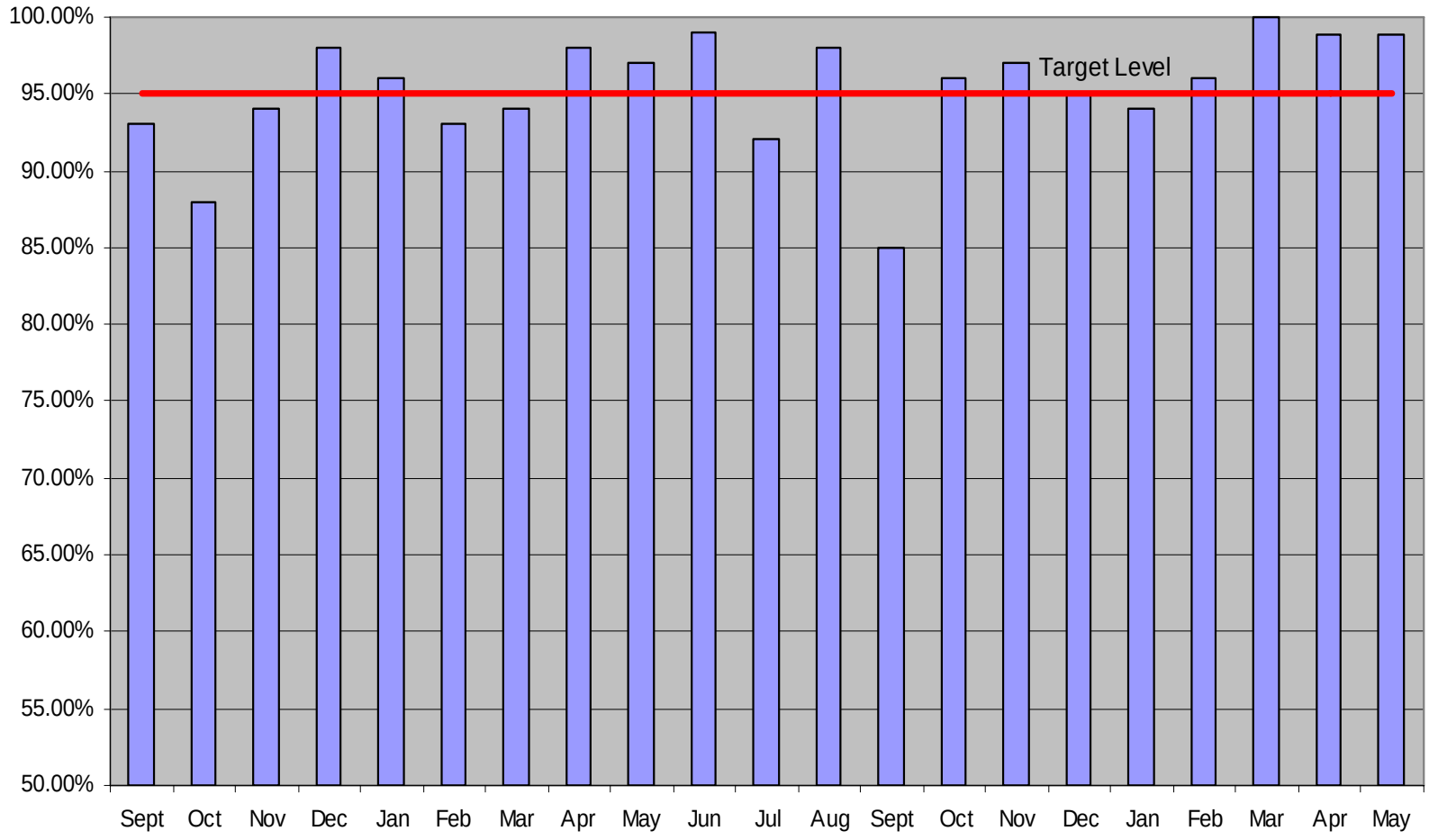
UTMB Vacancy Rates (%) by Quarter FY 2008 - FY 2009



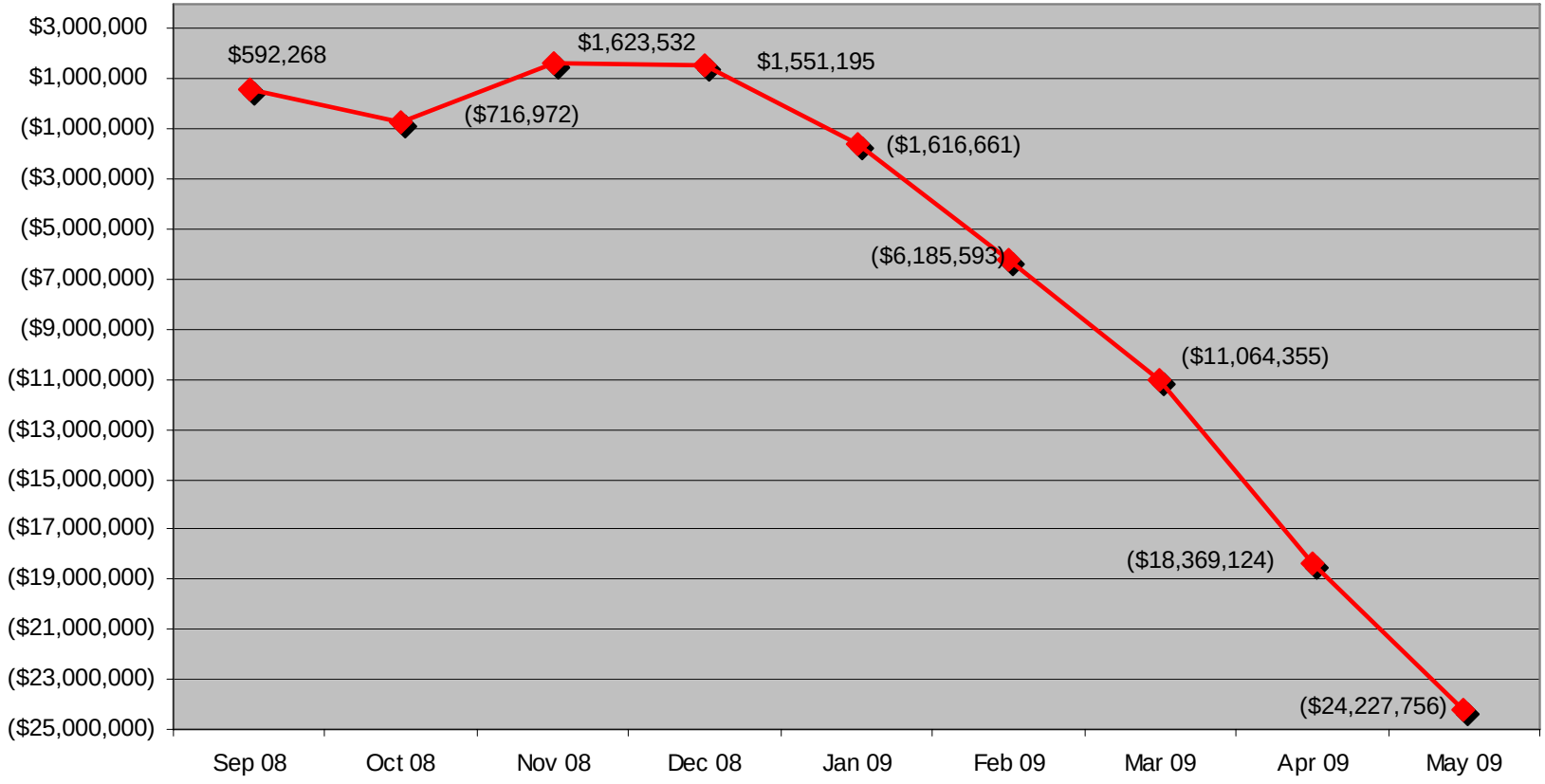
TTUHSC Vacancy Rates (%) by Quarter FY 2008 - FY 2009



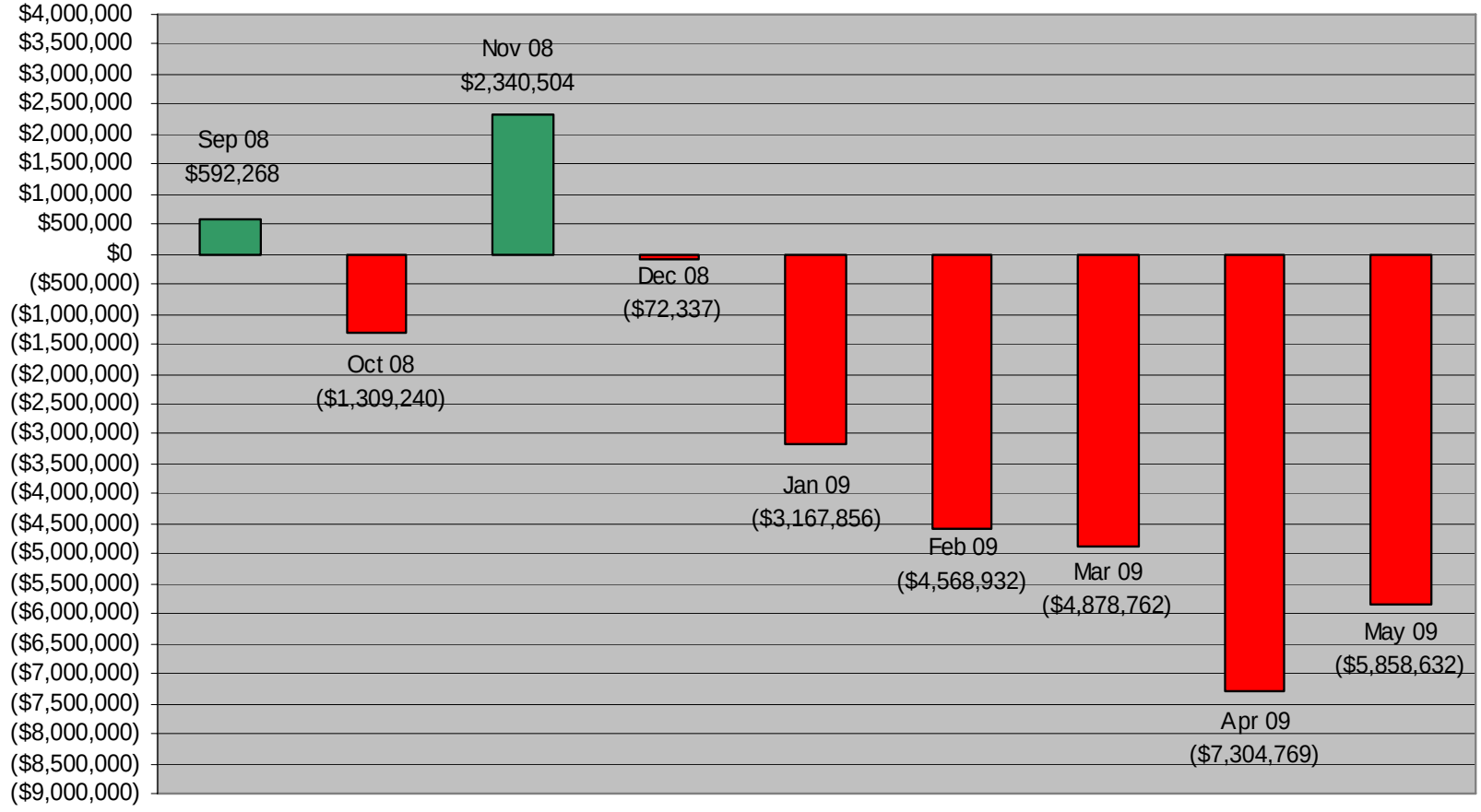
Percent of Timely MRIS Summaries FY 2008-2009



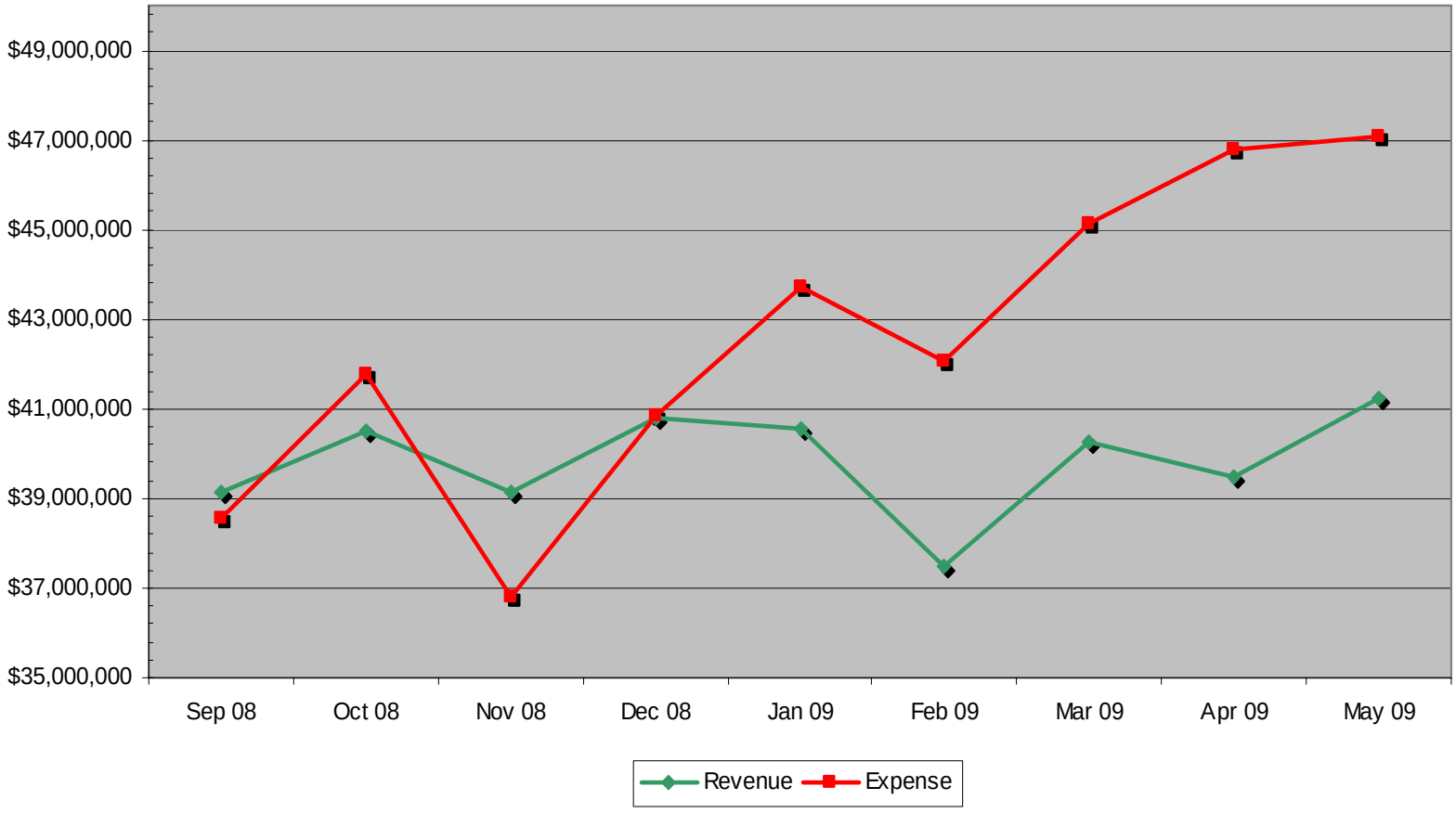
Statewide Cumulative Loss/Gain
FY 2009



Statewide Loss/Gain by Month
FY 2009



Statewide Revenue v. Expenses by Month
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	09/1/07	1 Part time position remaining
Nurse II	TDCJ	03/05/09	Posted 3/5/09; Reposted 5/15/09 (no qualified applicants)
Nurse II	TDCJ	06/05/09	Posting 5/20/09; Employee found other employment
LVN III	TDCJ	05/15/09	Posting 5/20/09; Employee found other employment
Correctional Physician	TTUHSC	08/2007	Enhanced Advertisement and Recruitment Through Newly Contracted Agencies

Title of Position	CMHCC Partner Agency	Vacant Since (mm/yyyy)	Actions Taken to Fill Position
PAMIO Medical Director	TTUHSC	02/2009	Enhanced Advertisement and Recruitment through Newly Contracted Agencies (Position filled and the new person will start on September 2009)
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 (PA / FNP) Practitioners	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

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.

HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION

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. (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 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.

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 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
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 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.
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 Correctional Managed Health Care Clinical Virology Department (CMHCCV). Offenders should be encouraged to cooperate with the CMHCCV Continuity of Care worker, and to consider contacting community based organizations in their community prior to release.
B. CMHCCV shall inform the Texas Correctional Office of Offenders with Mental or Medical Impairment (TCOOMMI) of each individualized discharge plan, including the name of the AIDS service organization (ASO) to which the offender was referred, contact information for the ASO and date of the offender's appointment with the ASO.
C. 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.
D. Unit medical staff shall assist the offender in filling out the Texas HIV Medication Program application and shall send the completed form to CMHCCV. CMHCCV will review the application and submit the completed application, with the offender's projected release date to the Department of State Health Services HIV Medication program.

XIV. EDUCATION AND TRAINING OF STAFF AND INMATES:

Refer to TDCJ Administrative Directive 6.60, Section XI.

CMHC Policy B-14.11 HIV

Showing July Changes

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.

HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION

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. (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 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.

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 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
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.

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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.

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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.

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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.

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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

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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

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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 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.
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 Correctional Managed Health Care Clinical Virology Department (CMHCCV). Offenders should be encouraged to cooperate with the CMHCCV Continuity of Care worker, and to consider contacting community based organizations in their community prior to release.

B. CMHCCV shall inform the Texas Correctional Office of Offenders with Mental or Medical Impairment (TCOOMMI) of each individualized discharge plan, including the name of the AIDS service organization (ASO) to which the offender was referred, contact information for the ASO and date of the offender's appointment with the ASO.

C. 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.

D. Unit medical staff shall assist the offender in filling out the Texas HIV Medication Program application and shall send the completed form to CMHCCV. CMHCCV will review the application and submit the completed application, with the offender's projected release date, to the Department of State Health Services HIV Medication program.

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XIV. EDUCATION AND TRAINING OF STAFF AND INMATES:

Refer to TDCJ Administrative Directive 6.60, Section XI.

TEXAS DEPARTMENT OF CRIMINAL JUSTICE

HEALTH SERVICES DIVISION MEDICAL DIRECTOR'S REPORT

Third 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 third quarter of FY-2009 (March, April, and May), 11 Operational Review Audits were conducted at the following facilities: Bradshaw, Coffield, Dawson State Jail, Eastham, Estelle, Estes, Goodman, Henley, Hightower, Huntsville, and B. Moore. The nine items most frequently out of compliance follow:

1. Item 5.04(3) requires that the facility's self-reported Access to Care accurately reflect data. 11 of the 11 facilities were not in compliance with this requirement. The 11 facilities out of compliance were: Bradshaw, Coffield, Dawson State Jail, Eastham, Estelle, Estes, Goodman, Henley, Hightower, Huntsville, and B. Moore. Corrective actions were requested from the 11 facilities. The corrective action plans for the Bradshaw, Eastham, Goodman, Huntsville, and B. Moore Units have been accepted and the audit process for these units is closed. Six facility audits remain open at this time. The action plans of the following facilities have been submitted with TDCJ Health Services approval pending as of the date of this report: Coffield, Dawson State Jail, Estelle, Estes, Henley, and Hightower.

2. Item 5.11 requires Emergency Room forms (HSM-16) be filled out completely and legibly, to include assessment, intervention, medications administered, disposition, and appropriate signatures or co-signatures. 11 of the 11 facilities were not in compliance with this requirement. The 11 facilities out of compliance were: Bradshaw, Coffield, Dawson State Jail, Eastham, Estelle, Estes, Goodman, Henley, Hightower, Huntsville, and B. Moore. Corrective actions were requested from the 11 facilities. The corrective action plans for the Bradshaw, Eastham, Goodman, Huntsville, and B. Moore Units have been accepted and the audit process for these units is closed. Six facility audits remain open at this time. The action plans of the following facilities have been submitted with TDCJ Health Services approval pending as of the date of this report: Coffield, Dawson State Jail, Estelle, Estes, Henley, and Hightower.

3. Item 5.10 requires the medical records of offenders receiving initial therapeutic diets in excess of seven days, reflect that nutritional counseling has been provided within 30 days. 10 of the 11 facilities were not in compliance with this requirement. The 10 facilities out of compliance were: Coffield, Dawson State Jail, Eastham, Estelle, Estes, Goodman, Henley, Hightower, Huntsville, and B. Moore. Corrective actions were requested from the 10 facilities. The corrective action plans for the Eastham, Goodman, Huntsville, and B. Moore Facilities have been accepted and the audit process for these units is closed. Six facility audits remain open at this time. The action plans of the following facilities have been submitted with TDCJ Health Services approval pending as of the date of this report: Coffield, Dawson State Jail, Estelle, Estes, Henley, and Hightower.

4. Item 5.19 requires the medical provider document on the HSM-4 **(**Report of Physical Exam) physical exams annually on male offenders sixty (60) years of age or older, to include digital rectal exam and fecal occult blood testing. 10 of the 11 facilities were not in compliance with this requirement. The 10 facilities out of compliance were: Bradshaw, Coffield, Dawson State Jail, Eastham, Estelle, Estes, Goodman, Hightower, Huntsville, and B. Moore. Corrective actions were requested from the ten facilities. The corrective action plans for the Bradshaw, Eastham, Goodman, Huntsville, and B. Moore Units have been accepted and the audit process for these units is closed. Five facility audits remain open at this time. The action plans of the following facilities have been submitted with TDCJ Health Services approval pending as of the date of this report: Coffield, Dawson State Jail, Estelle, Estes, and Hightower.

Operational Review Audit (ORA) Cont'd.

5. Item 5.04(2) requires that the facility's self-reported Access to Care data accurately reflect documentation regarding the timely provider assessment of patients who have submitted a sick call request. Nine of the 11 facilities were not in compliance with this requirement. The nine facilities out of compliance were: Bradshaw, Coffield, Estelle, Estes, Goodman, Henley, Hightower, Huntsville, and B. Moore. Corrective actions were requested from the nine facilities. The corrective action plans for the Bradshaw, Goodman, Huntsville, and B. Moore Units have been accepted and the audit process for these units is closed. Five facility audits remain open at this time. The action plans of the following facilities have been submitted with TDCJ Health Services approval pending as of the date of this report: Coffield, Estelle, Estes, Henley, and Hightower.

6. Item 5.14 requires that a dated and signed Certification and Record of Segregation Visits form have an attached current housing roster. Nine of the 11 facilities were not in compliance with this requirement. The nine facilities out of compliance were: Bradshaw, Coffield, Dawson State Jail, Estelle, Estes, Goodman, Henley, Hightower, and B. Moore. Corrective actions were requested from the nine facilities. The corrective action plans for the Bradshaw, Goodman, and B. Moore Units have been accepted and the audit process for these units is closed. Six facility audits remain open at this time. The action plans of the following facilities have been submitted with TDCJ Health Services approval pending as of the date of this report: Coffield, Dawson State Jail, Estelle, Estes, Henley, and Hightower.

7. Item 5.16 requires nursing staff documentation to reflect on the Nursing Incoming Chain Review (HSN-1) that a review was conducted within 12 hours of the offender's arrival at the facility for housing assignments, work assignments, work restrictions, disciplinary restrictions, mental health restrictions, prescribed medications, and treatments. Nine of the 11 facilities were not in compliance with this requirement. The nine facilities out of compliance were: Bradshaw, Coffield, Dawson State Jail, Eastham, Estelle, Henley, Hightower, Huntsville, and B. Moore. Corrective actions were requested from the nine facilities. The corrective action plans for the Bradshaw, Eastham, Huntsville, and B. Moore Units have been accepted and the audit process for these units is closed. Five facility audits remain open at this time. The action plans of the following facilities have been submitted with TDCJ Health Services approval pending as of the date of this report: Coffield, Dawson State Jail, Estelle, Henley, and Hightower.

8. Item 5.17 requires offenders with chronic illnesses have a documented Individual Treatment Plan, which includes instructions about diet, exercise, medications, frequency of diagnostic testing, and follow-up evaluations (as applicable). Nine of the 11 facilities were not in compliance with this requirement. The nine facilities out of compliance were: Bradshaw, Coffield, Dawson State Jail, Eastham, Estelle, Estes, Goodman, Hightower, and B. Moore. Corrective actions were requested from the nine facilities. The corrective action plans for the Bradshaw, Eastham, Goodman, and B. Moore Units have been accepted and the audit process for these units is closed. Five facility audits remain open at this time. The action plans of the following facilities have been submitted with TDCJ Health Services approval pending as of the date of this report: Coffield, Dawson State Jail, Estelle, Estes, and Hightower.

9. Item 6.36 requires that the influenza vaccine be offered annually to the following offenders: Certain chronic disease offenders e.g., heart disease, moderate to severe asthma (i.e. history of hospitalization, emergency treatment for asthma, or chronic medication for asthma), COPD, diabetes, all offenders with immunocompromising diseases (i.e. HIV infection, most cancers, end-stage renal disease, sickle cell disease, etc.). All offenders 55 years of age and older, pregnant

Operational Review Audit (ORA) Cont'd.

females after first trimester, and document the influenza vaccinations on the Abstract of Immunization **(**HSM-2). If vaccinations are refused, there must be a signed Refusal of Treatment Form (HSM-82). Nine of the 11 facilities were not in compliance with this requirement. The nine facilities out of compliance were: Coffield, Dawson State Jail, Eastham, Estelle, Estes, Goodman, Henley, Hightower, and B. Moore. Corrective actions were requested from the nine facilities. The corrective action plans for the Eastham, Goodman, and B. Moore Units have been accepted and the audit process for these units is closed. Six facility audits remain open at this time. The action plans of the following facilities have been submitted with TDCJ Health Services approval pending as of the date of this report: Coffield, Dawson State Jail, Estelle, Estes, Henley, and Hightower.

Grievances and Patient Liaison Correspondence

During the third quarter of FY-2009 (March, April, and May), the Patient Liaison Program and the Step II Grievance Program received 2,946 correspondences. The Patient Liaison Program had 1,392 and Step II Grievance had 1,554. Of the total number of correspondence received, 530 (17.99 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 was 8.3 percent. Performance measure expectation is 6.0 percent or less (Article IX, C-2, Correctional Managed Health Care contract).

Quality Improvement (QI) Access to Care Audits

During the third quarter of FY-2009 (March, April, and May), 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 111 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 11 units during the third 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 concluded the 11 units 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 third quarter of FY-2009:

- 168 cases of suspected syphilis were reported in the third quarter FY-2009, compared to 181 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.

Office of Preventive Medicine (Cont'd.)

- 625 Methicillin-Resistant Staphylococcus Aureus (MRSA) cases were reported in this quarter, compared to 948 during the same quarter of FY-2008. There has been a gradual decrease since the beginning of FY-2008 in the incidence of MRSA cases, while the incidence of Methicillin-Sensitive Staphylococcus Aureus (MSSA) has remained relatively stable.

- There was an average of 18 Tuberculosis (TB) cases under management per month during the third quarter FY-2009, compared to an average of 23 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 third quarter FY-2009, three training sessions were held, attended by two facilities, and 22 medical staff were trained. This position also audits the documentation and services provided by medical personnel for each sexual assault reported. There have been 163 chart reviews performed for the third quarter FY-2009. Five deficiencies were found not compliant with policy. One corrective action from the Byrd Unit remains open at this time. One of the corrective actions remains open, from the Byrd Unit, at this time. 13 baseline labs were drawn on exposed victims.

- Currently, Peer Education Programs are available at 109 of the 112 facilities housing Correctional Institution Division (CID) offenders. The three units that do not have Peer Education Programs are Bradshaw, Kyle, and San Saba Facilities. During the third quarter FY-2009, 21,162 offenders attended classes presented by peer educators. This is a 61 percent increase from the 12,962 attendees in the third quarter FY-2008.

Mortality and Morbidity

There were 116 deaths reviewed by the Mortality and Morbidity Committee during the months of March, April, and May 2009. Of those 116 deaths, 14 were referred to peer review committees and one was referred to utilization review.

A referral to a peer review committee does not necessarily indicate that substandard care was provided. It is a request for the Correctional Managed Health Care provider to review the case through their respective quality assurance process. Referrals may also be made to address systemic issues to improve the delivery of health care.

Peer Review Committee	**Number of Cases Referred**
Provider & Nursing Peer Review	4
Nursing Peer Review	5
Provider Peer Review	5
Total	**14**

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 third quarter of FY-2009.

Mental Health Services Monitoring & Liaison (Cont'd.)

- Liaison with County Jails identified the immediate mental health needs of 55 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 (MH/MR) history was reviewed for 20,038 offenders brought into TDCJ CID/SJ (State Jail). Intake facilities were provided with critical mental health data, not otherwise available, for 2,246 offenders.

- 3,198 Texas Uniform Health Status Update forms were reviewed which identified 901 deficiencies (primarily incomplete data).

- 436 offenders with high risk factors (very young, old, or long sentences) transferring into the Correctional Institutional Division were interviewed and resulted in 12 referrals.

- 38 offenders were screened for TDCJ Boot Camp. All were found appropriate.

- 21 Administrative Segregation facilities were audited. 4,147 offenders were observed, 2,504 of them interviewed and 13 were referred to the university providers for further evaluation. Access to Care (ATC) 4, timely triage and ATC 5, documentation of Sick Call Requests, met or exceeded 80 percent compliance for 17 facilities. There were two units not within compliance of processing Sick Call Request. The Sanchez Facility had 66 percent compliance and the Formby Facility, had 33 percent compliance. Two units, the Powledge and Dawson Facilities had no mental health Sick Call Requests. ATC 6, referral from triage, compliance was 100 percent except for two facilities. The Sanchez and Lewis Units each had a compliance of 50 percent. The Powledge, Dawson, and Murray Units had no referrals from triage.

Clinical Administration

During the third quarter of FY-2009 ten percent of the combined UTMB and TTUHSC hospital and infirmary discharges were audited. A total of 93 hospital discharges and 58 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[3] (Cases with deficiencies)
March	2 (33%)	0	4 (66%)
April	3 (50%)	1 (16%)	1 (16%)
May	5 (93%)	0	3 (50%)

UTMB Hospital Discharges

Month	Unstable Discharges [1] (Cases with deficiencies)	Readmissions [2] (Cases with deficiencies)	Lack Documentation[3] (Cases with deficiencies)
March	17 (51%)	11 (33%)	15 (45%)
April	5 (36%)	2 (14%)	11 (58%)
May	17 (60%)	1 (3%)	8 (29%)

TOTAL: Combined Hospital Discharges (Texas Tech and UTMB)

Month	**Unstable Discharges** [1] (Cases with deficiencies)	**Readmissions** [2] (Cases with deficiencies)	**Lack Documentation**[3] (Cases with deficiencies)
March	19 (49%)	11 (28%)	19 (49%)
April	8 (40%)	3 (15%)	12 (60%)
May	22 (65%)	1 (2%)	11 (32%)

Clinical Administration (Cont'd.)

Texas Tech Infirmary Discharges

Month	Unstable Discharges [1] (Cases with deficiencies)	Readmissions [2] (Cases with deficiencies)	Lack Documentation[3] (Cases with deficiencies)
March	5 (63%)	1 (18%)	3 (43%)
April	5 (64%)	0	4 (50%)
May	12 (100%)	0	6 (50%)

UTMB Infirmary Discharges

Month	Unstable Discharges [1] (Cases with deficiencies)	Readmissions [2] (Cases with deficiencies)	Lack Documentation[3] (Cases with deficiencies)
March	6 (46%)	1 (18%)	1 (7%)
April	5 (64%)	0	4 (50%)
May	8 (92%)	0	2 (22%)

TOTAL: Combined Infirmary Discharges (Texas Tech and UTMB)

Month	**Unstable Discharges** [1] (Cases with deficiencies)	**Readmissions** [2] (Cases with deficiencies)	**Lack Documentation**[3] (Cases with deficiencies)
March	11 (52%)	2 (10%)	4 (19%)
April	10 (67%)	0	5 (33%)
May	20 (95%)	0	8 (38%)

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 (Audit question A).

[2] Discharged patient offenders required emergency acute care or readmission to tertiary level care within a 7 day period (Audit questions B and D).

[3] The discharge summary was not available in the offender's medical record within 24 hours of arriving at the unit (Audit question E).

Accreditation

The American Correctional Association (ACA) Panel of Commissioners met at the Correctional Accreditation Managers Association (CAMA) Conference in Saratoga Springs, New York on April 3 and April 4, 2009. The ACA Panel awarded three facilities initial accreditation: Coffield, Mountain View, and Carole Young. In addition, six facilities received reaccreditation and they are Leblanc, Lopez, Sayle, Segovia, Telford, and Terrell.

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 Institutions Division (CID) Active Monthly Research Projects – 39,
- CID Pending Monthly Research Projects – 5,
- Health Services Division Active Monthly Medical Research Projects – 13, and
- Health Services Division Pending Medical Research Projects – 1.

TCOOMMI

Medically Recommended Intensive Supervision (MRIS)

Update

MRIS Data Comparison
(by fiscal year)

FY 08

MRIS Referrals – 1319

- **Prison**

Presented to BPP – 415

Total Decision FY08 – 411

- Deny Consideration* - 311 (76%)
- Approved – 90 (22%)
- Denied – 10 (2%)

FY 09 to date

MRIS Referrals – 1060

- **Prison**

Presented to BPP – 303

Total Decision FY09 to date – 299

- Deny Consideration* - 249 (83%)
- Approved – 43 (15%)
- Denied – 7 (2%)

---

* Considered a threat to public safety and no further consideration given

BPP – Texas Board of Pardons and Paroles

MRIS Data Comparison
(by fiscal year)

FY 08

- **State Jail**

Presented to Judge – 25

Total Decision FY08 – 19

- Approved – 13 (68%)
- Denied – 6 (32%)

FY 09 to date

- **State Jail**

Presented to Judge – 21

Total Decision FY09 to date – 17

- Approved – 14 (82%)
- Denied – 3 (18%)

Note: For both Prison and State Jail, the difference in numbers presented and voted may be due to deaths after presentation and prior to vote or to cases presented during the previous fiscal year (i.e., presented August 30 and voted September 5)

TEXAS TECH UNIVERSITY SYSTEM™
Office of Audit Services

Texas Tech University Health Sciences Center

Report on Correctional Managed Health Care

July 20, 2009
Project #2009028

Box 41104 | Lubbock, Texas 79409-1104 | T 806.742.3220 | F 806.742.3219

TEXAS TECH UNIVERSITY SYSTEM™
Office of Audit Services

July 20, 2009

Mr. Larry Elkins
Executive Director, Correctional Managed Health Care
Texas Tech University Health Sciences Center

Dear Mr. Elkins:

We have completed our audit of Correctional Managed Health Care. This engagement was performed to satisfy the annual audit requirement of the Correctional Managed Health Care Committee (CMHCC) Agreement and was included in our annual plan for the year ending August 31, 2009. The audit was conducted in accordance with generally accepted government auditing standards and in conformance with the International Standards for the Professional Practice of Internal Auditing (Standards). The objective of this audit was to evaluate Correctional Managed Health Care's capital asset inventory system controls, reporting, and compliance with the Capital Assets section of the CMHCC Agreement.

Correctional Managed Health Care is in compliance with the requirements outlined in the Capital Assets section of the CMHCC Agreement. However, to further enhance the inventory process, we recommend management implement a process for the Material Control Manager to spot-check inventory at the unit level on an ongoing, sample basis.

Management concurs with the recommendation made in this report and will implement a spot-checking process at the unit level by the Material Control Manager. Management's complete response is included in this report. Management is responsible for implementing the course of action outlined in the response.

Our Standards require that we monitor audit issues to ensure that management action plans have been effectively implemented. Based on your estimated implementation dates, we will contact you to schedule the follow-up procedures. Our follow-up procedures may consist of reviewing compliance-related policies, procedures, or other materials developed while implementing the plan. In addition, we may perform limited procedures to ensure the plan is working as intended.

Our recommendations are provided to assist the management of Texas Tech University Health Sciences Center in enhancing its operations and managing its risks. We appreciate the courtesies and considerations extended to us during our engagement. If you have any questions or if we can be of further assistance, please do not hesitate to contact our office.

Sincerely,

Kimberly F. Turner, CPA
Chief Audit Executive

Box 41104 | Lubbock, Texas 79409-1104 | T 806.742.3220 | F 806.742.3219

REPORT

BACKGROUND AND OBJECTIVE

The Texas Correctional Managed Health Care program represents a legislatively established partnership between the Texas Department of Criminal Justice (TDCJ), Texas Tech University Health Sciences Center (TTUHSC), and the University of Texas Medical Branch at Galveston (UTMB). The partnership is governed by the Correctional Managed Health Care Committee (CMHCC) and is responsible for providing comprehensive health care services to offenders incarcerated in Texas state prisons. TTUHSC provides health care services to offenders housed in the TDCJ correctional facilities in West Texas.

As part of the CMHCC Agreement with TTUHSC, Correctional Managed Health Care at TTUHSC is required to maintain an inventory system of all capital assets used in the correctional facilities. The CMHCC Agreement also requires TTUHSC to prepare monthly reports of any capital asset changes (e.g., purchases, transfers, disposals) as well as an annual inventory report to be submitted to TDCJ.

The objective of this audit was to evaluate Correctional Managed Health Care's capital asset inventory system controls, reporting, and compliance with the capital assets section of the CMHCC Agreement.

To accomplish the objectives, the audit team conducted interviews to determine the controls in place to ensure proper procurement, tagging, and tracking of capital assets. Members of the audit team also travelled to the Montford Regional Medical Facility, Montford Psychiatric Facility, Neil Unit, Clemens Unit, Tulia Unit, Formby Unit, and Wheeler Unit to verify the existence and proper location of a sample of 187 capital assets. This sample accounted for approximately forty percent of the total capital assets at these selected units. Lastly, the audit team reviewed the Fiscal Year 2008 Annual Inventory Report and Fiscal Year-to-Date 2009 Monthly Inventory Change Reports submitted to TDCJ to ensure reports were timely.

CONCLUSION AND RECOMMENDATION

Correctional Managed Health Care is in compliance with the requirements outlined in the Capital Assets section of the CMHCC Agreement. Correctional Managed Health Care and the Material Control Manager have implemented a process for the procurement, tagging, and tracking of capital assets. Lastly, required reports to TDCJ were submitted timely.

Based on our testing, the location of five capital assets was not accurately reflected on the inventory reports; however, appropriate documentation was maintained to confirm the correct location, and the Material Control Manager corrected the inventory. The annual physical inventory is decentralized and delegated to a property manager at each unit to conduct the physical inventory. After physical inventories are completed for all units, the Material Control Manager prepares the required reports to TDCJ. It appears the decentralized annual physical inventory process performed by the units could be the cause of the noted discrepancies because the Material Control Manager does not physically perform the inventory at the unit level. The Material Control Manager relies on a property manager at each unit to perform the physical inventory.

To further enhance the inventory process, we recommend management implement a process for the Material Control Manager to spot-check inventory at the unit level on an ongoing, sample basis. By implementing a spot-checking procedure, the Material Control Manager would be able to identify inventory discrepancies in a timelier manner without

having to rely solely on the information provided by the unit property managers on the annual physical inventory.

SYNOPSIS OF MANAGEMENT'S RESPONSE

Management concurs with the recommendation made in this report and will implement a spot-checking process at the unit level by the Material Control Manager. Management's complete response is included in this report beginning on page 3.

SCOPE

This audit was conducted in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. Additionally, this audit was performed in conformance with The Institute of Internal Auditors' International Standards for the Professional Practice of Internal Auditing (Standards). Our audit scope was based on the following Standard:

2130.A1- The internal audit activity must evaluate the adequacy and effectiveness of controls in responding to risks within the organization's governance, operations, and information systems regarding the:

- Reliability and integrity of financial and operational information;
- Effectiveness and efficiency of operations;
- Safeguarding of assets; and
- Compliance with laws, regulations, and contracts.

REPORT DISTRIBUTION

Audit Committee, Texas Tech Board of Regents
Mr. Kent Hance
Mr. Jim Brunjes
Dr. John E. Opperman
Dr. John C. Baldwin
Mr. Elmo Cavin
Dr. Cynthia Jumper
Dr. Denise DeShields
Mr. Jerry Hoover
Mr. Jeff Hough
Mr. David McNutt

MANAGEMENT'S ACTION PLAN

TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER™

July 16, 2009

Kimberly F. Turner, CPA
Chief Audit Executive
Office of Audit Services
Texas Tech University System

Dear Ms. Turner:

Thank you for accepting my suggestion of devoting the 200 hours of audit services for this fiscal year to evaluating Correctional Managed Health Care's capital asset inventory system controls, reporting, and compliance with the Capital Assets sections of the CMHCC Agreement.

In this regard, I wish to extend special thanks to Ms. Teresa Jack, Mr. Brian Uline and Ms. Elizabeth Stuart for their time and efforts in completing this audit.

On behalf of TTUHSC Correctional Managed Health Care, your recommendation is accepted and our plan of action follows:

The Material Control Manager will personally "spot-check" inventory at the unit level as shown in the schedule below:

Monthly Visits:

Montford Psych
Montford RMF
Montford Trusty Camp

Quarterly Visits:

Allred GP
Allred ECB
Clements GP
Clements ECB
Middleton
Robertson
Smith GP
Smith ECB

TEXAS TECH UNIVERSITY
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Semi-Annual Visits:

Baten
Dalhart
Daniel
Formby
Ft. Stockton
Havins
Jordan
Lynaugh
Neal
PAMIO
Roach
Roach Boot/Work Camp
Rudd
San Angelo Work Camp
Sanchez
Sayle
Tulia
Wallace
Ware
Wheeler

Sincerely,

Larry Elkins
Executive Director
Correctional Managed Health Care
Texas Tech University Health Sciences Center

Correctional Managed Health Care
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Correctional Managed Health Care

Quarterly Report
FY 2009 Third Quarter

September 2008 – May 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 third 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 third quarter of this fiscal year, the correctional health care program has slightly declined in the overall offender population served. The average daily population served through the third quarter of FY 2009 was 150,572. Through this same quarter a year ago (FY 2008), the average daily population was 151,736, a decrease of 1,164 (0.77%). While overall growth has declined, 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 third quarter of FY 2009, the average number of older offenders in the service population was 10,929. Through this same quarter a year ago (FY 2008), the average number of offenders age 55 and over was 10,291. This represents an increase of 638 or about 6.2% 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 2,473 (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 1,918 through the third quarter of FY 2009, as compared to 1,964 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 third quarter of FY 2009, the average number of mental health outpatients was 19,030 representing 12.6% of the service population.

Health Care Costs

- Overall health costs through the third quarter of FY 2009 totaled $382.7M. This amount exceeded overall revenues earned by the university providers by $24.2M or 6.7%.
  - UTMB's total revenue through the quarter was $284.1M. Their expenditures totaled $307.0M, resulting in a net loss of $22.9M. On a per offender per day basis, UTMB earned $8.68 in revenue and expended $9.37 resulting in a shortfall of $0.69 per offender per day.
  - TTUHSC's total revenue through the third quarter was $74.4M. Expenditures totaled $75.7M, resulting in a net loss of $1.3M. On a per offender per day basis, TTUHSC earned $8.91 in revenue, but expended $9.06 resulting in a shortfall of $0.15 per offender per day, rounded to the nearest penny.

- Examining the health care costs in further detail indicates that of the $382.7M in expenses reported through the third quarter of the year:
  - Onsite services (those medical services provided at the prison units) comprised $183.6M representing about 48.0% of the total health care expenses:
    - Of this amount, 80.3% was for salaries and benefits and 19.7% for operating costs.
  - Pharmacy services totaled $37.8M representing approximately 9.9% of the total expenses:
    - Of this amount 17.5% was for related salaries and benefits, 3.8% for operating costs and 78.7% for drug purchases.
  - Offsite services (services including hospitalization and specialty clinic care) accounted for $116.1M or 30.3% of total expenses:
    - Of this amount 53.2% was for estimated university provider hospital, physician and professional services; and 46.8% for Freeworld (non-university) hospital, specialty and emergency care.
  - Mental health services totaled $34.7M or 9.1% of the total costs:
    - Of this amount, 97.0% was for mental health staff salaries and benefits, with the remaining 3.0% for operating costs.
  - Indirect support expenses accounted for $10.5M and represented 2.7% of the total costs.

- The total cost per offender per day for all health care services statewide through the third quarter of FY 2009 was $9.31. 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 $9.37. 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 $9.06, 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 third quarter of FY 2009 indicates that offenders aged 55 and over had a documented encounter with medical staff almost 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 $2,871 per offender. The same calculation for offenders under age 55 totaled about $463. 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 7.3% 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 more than four times more often in the dialysis population than younger offenders. Dialysis costs continue to be significant, averaging about $21K per patient per year. Providing medically necessary dialysis treatment for an average of 188 patients through the third quarter of FY2009 cost $3.0M.

Drug Costs

- Total drug costs through the third quarter of FY 2009 totaled $27.9M.
    - Pharmaceutical costs related to HIV care continue to be the largest single component of pharmacy expenses.
        - Through this quarter, $13.2M in costs (or over $1.4M per month) for HIV antiretroviral medication costs were experienced. This represents 47.2% of the total drug cost during this time period.
        - Expenses for psychiatric drugs are also being tracked, with approximately $897K being expended for psychiatric medications through the third quarter, representing 3.2% of the overall drug cost.
        - Another pharmacy indicator being tracked is the cost related to Hepatitis C therapies. These costs were $1.1M and represented about 3.9% 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 $22,904,077 through this quarter. TTUHSC reports that they hold no such reserves and report a total shortfall of $1,323,679.

- A summary analysis of the ending balances, revenue and payments through the third quarter for all CMHCC accounts is included in this report. That summary indicates that the net unencumbered balance on all CMHCC accounts on May 31, 2009 was $14,307.44. It should be noted that this balance is projected to decrease over the course of the fiscal year.

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 May 2009 is completed. The testing of detail transactions performed on TTUHSC's financial information for March through May 2009 resulted in no significant findings which need correction.

The testing of detail transactions performed on UTMB's financial information for May 2009 is pending requested information. The testing of detail transactions performed on UTMB's financial information for March through April 2009 resulted in one Non-allowable Business Expense finding which needed correction.

Concluding Notes

The combined operating loss for the university providers through the third quarter of FY 2009 is $24.2 M. 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

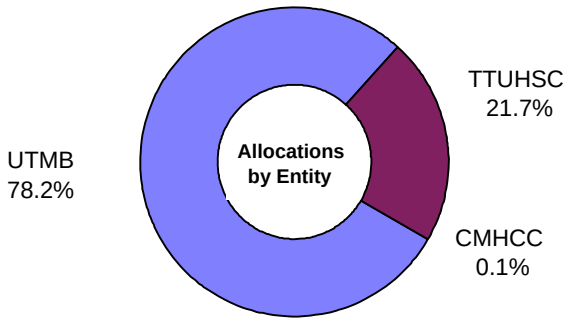


Table 2
FY 2009
Key Population Indicators
Correctional Health Care Program

Indicator	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-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	107,806	108,017	107,833	108,084
UTMB Private Prison Population*	11,882	11,897	11,894	11,880	11,873	11,894	11,908	11,909	11,914	11,895
UTMB Total Service Population	119,973	120,174	120,299	120,405	119,824	119,839	119,714	119,926	119,747	119,978
TTUHSC Total Service Population	30,590	30,644	30,695	30,638	30,583	30,386	30,538	30,606	30,661	30,593
CMHC Service Population Total	**150,563**	**150,818**	**150,994**	**151,043**	**150,406**	**150,225**	**150,252**	**150,531**	**150,409**	**150,572**
Population Age 55 and Over										
UTMB Service Population Average	8,728	8,769	8,868	8,899	8,993	9,046	9,176	9,189	9,247	8,991
TTUHSC Service Population Average	1,937	1,928	1,941	1,947	1,934	1,933	1,930	1,937	1,955	1,938
CMHC Service Population Average	**10,665**	**10,697**	**10,809**	**10,846**	**10,927**	**10,979**	**11,106**	**11,126**	**11,202**	**10,929**
HIV+ Population	**2,566**	**2,460**	**2,451**	**2,450**	**2,458**	**2,449**	**2,475**	**2,472**	**2,474**	**2,473**
Mental Health Inpatient Census										
UTMB Psychiatric Inpatient Average	1,045	1,014	1,014	1,023	1,034	1,016	1,023	1,014	1,001	1,020
TTUHSC Psychiatric Inpatient Average	941	930	907	890	891	892	885	875	864	897
CMHC Psychiatric Inpatient Average	**1,986**	**1,944**	**1,921**	**1,913**	**1,925**	**1,908**	**1,908**	**1,889**	**1,865**	**1,918**
Mental Health Outpatient Census										
UTMB Psychiatric Outpatient Average	13,919	16,222	14,456	14,657	15,100	14,521	15,171	15,680	15,682	15,045
TTUHSC Psychiatric Outpatient Average	4,356	4,294	3,645	3,926	3,313	3,775	4,091	4,018	4,445	3,985
CMHC Psychiatric Outpatient Average	**18,275**	**20,516**	**18,101**	**18,583**	**18,413**	**18,296**	**19,262**	**19,698**	**20,127**	**19,030**

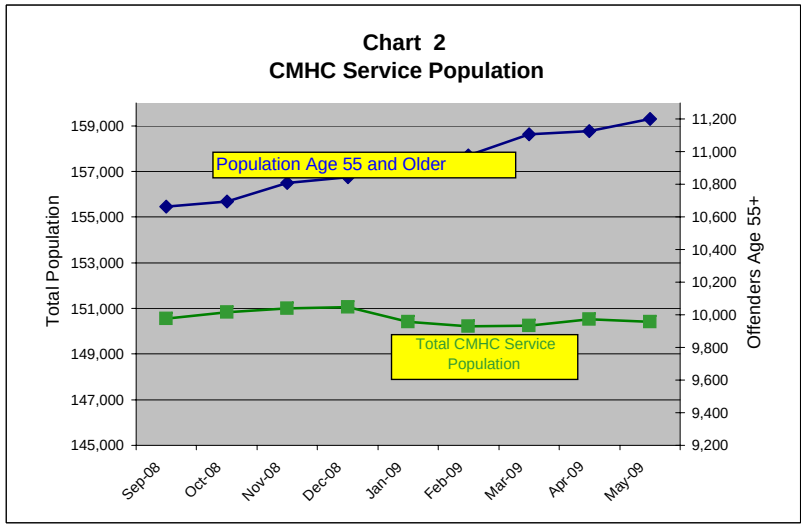


Chart 2
CMHC Service Population
Total Population
Offenders Age 55+
Population Age 55 and Older
Total CMHC Service Population
159,000
157,000
155,000
153,000
151,000
149,000
147,000
145,000
11,200
11,000
10,800
10,600
10,400
10,200
10,000
9,800
9,600
9,400
9,200
Sep-08
Oct-08
Nov-08
Dec-08
Jan-09
Feb-09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

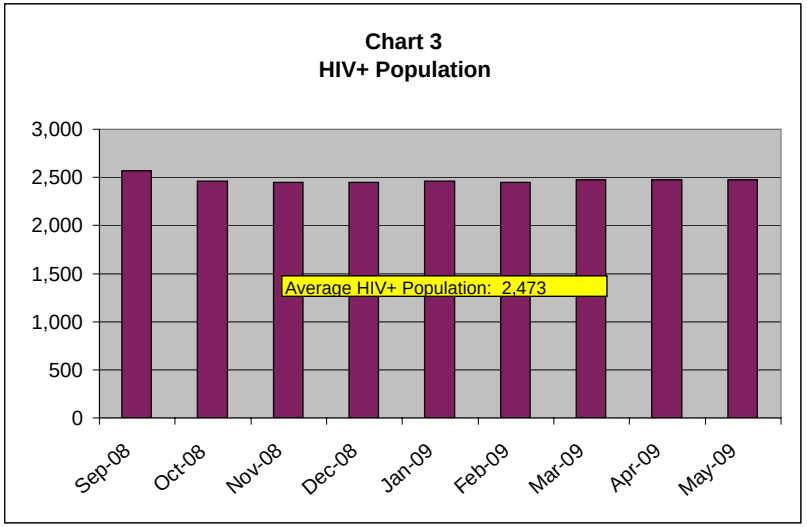


Chart 3
HIV+ Population
Average HIV+ Population: 2,473
3,000
2,500
2,000
1,500
1,000
500
0
Sep-08
Oct-08
Nov-08
Dec-08
Jan-09
Feb-09
Mar-09
Apr-09
May-09

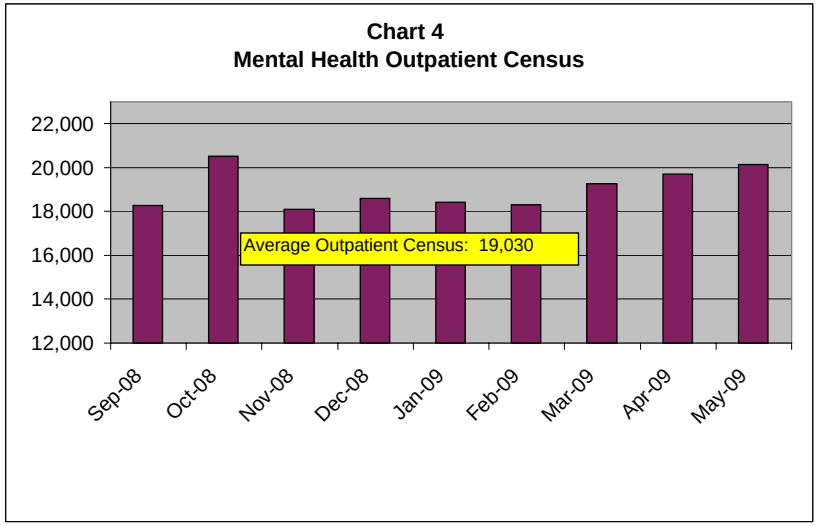


Chart 4
Mental Health Outpatient Census
Average Outpatient Census: 19,030
22,000
20,000
18,000
16,000
14,000
12,000
Sep-08
Oct-08
Nov-08
Dec-08
Jan-09
Feb-09
Mar-09
Apr-09
May-09

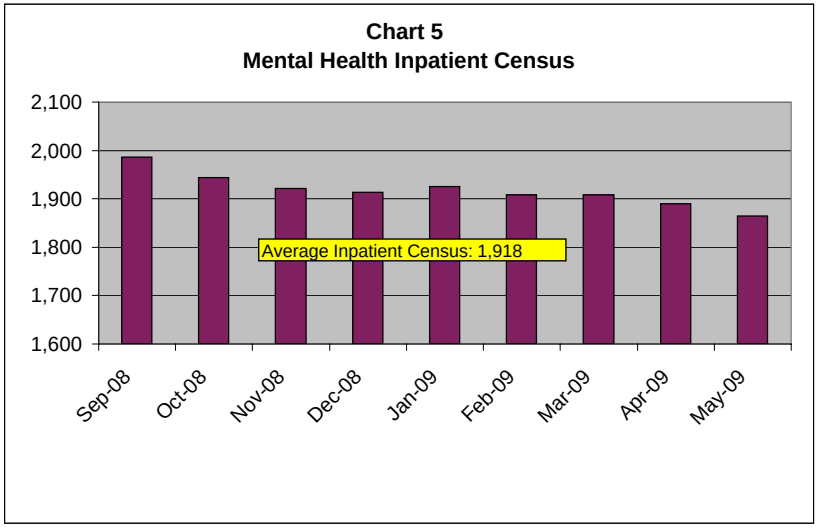


Chart 5
Mental Health Inpatient Census
Average Inpatient Census: 1,918
2,100
2,000
1,900
1,800
1,700
1,600
Sep-08
Oct-08
Nov-08
Dec-08
Jan-09
Feb-09
Mar-09
Apr-09
May-09

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

Days in Year: 273

	Medical Services Costs			Medical Cost Per Day Calculations		
	UTMB	**TTUHSC**	**TOTAL**	**UTMB**	**TTUHSC**	**TOTAL**
Population Served	**119,978**	**30,593**	**150,572**			
Revenue						
Capitation Payments	$227,342,373	$59,728,751	$287,071,124	$6.94	$7.15	$6.98
State Reimbursement Benefits	$31,189,992	$3,093,295	$34,283,287	$0.95	$0.37	$0.83
Non-Operating Revenue	$2,099,112	$1,438	$2,100,550	$0.06	$0.00	$0.05
Total Revenue	**$260,631,477**	**$62,823,484**	**$323,454,961**	**$7.96**	**$7.52**	**$7.87**
Expenses						
Onsite Services						
Salaries	$108,786,969	$9,258,787	$118,045,756	$3.32	$1.11	$2.87
Benefits	$27,104,259	$2,338,409	$29,442,668	$0.83	$0.28	$0.72
Operating (M&O)	$14,729,930	$1,232,304	$15,962,234	$0.45	$0.15	$0.39
Professional Services	$0	$1,955,031	$1,955,031	$0.00	$0.23	$0.05
Contracted Units/Services	$0	$16,301,408	$16,301,408	$0.00	$1.95	$0.40
Travel	$859,800	$86,500	$946,300	$0.03	$0.01	$0.02
Electronic Medicine	$0	$233,486	$233,486	$0.00	$0.03	$0.01
Capitalized Equipment	$328,000	$405,689	$733,689	$0.01	$0.05	$0.02
Subtotal Onsite Expenses	$151,808,958	$31,811,614	$183,620,572	$4.63	$3.81	$4.47
Pharmacy Services						
Salaries	$4,084,549	$1,294,471	$5,379,020	$0.12	$0.15	$0.13
Benefits	$1,201,615	$37,071	$1,238,686	$0.04	$0.00	$0.03
Operating (M&O)	$846,261	$562,728	$1,408,989	$0.03	$0.07	$0.03
Pharmaceutical Purchases	$24,844,364	$4,894,752	$29,739,116	$0.76	$0.59	$0.72
Professional Services	$0	$0	$0	$0.00	$0.00	$0.00
Travel	$30,103	$10,071	$40,174	$0.00	$0.00	$0.00
Subtotal Pharmacy Expenses	$31,006,892	$6,799,093	$37,805,985	$0.95	$0.81	$0.92
Offsite Services						
University Professional Services	$7,302,306	$698,297	$8,000,603	$0.22	$0.08	$0.19
Freeworld Provider Services	$43,051,618	$11,240,755	$54,292,373	$1.31	$1.35	$1.32
UTMB or TTUHSC Hospital Cost	$34,934,167	$9,086,586	$44,020,753	$1.07	$1.09	$1.07
Estimated IBNR	$9,064,992	$745,830	$9,810,822	$0.28	$0.09	$0.24
Subtotal Offsite Expenses	$94,353,083	$21,771,468	$116,124,551	$2.88	$2.61	$2.82
Indirect Expenses	$5,679,182	$3,725,115	$9,404,297	$0.17	$0.45	$0.23
Total Expenses	**$282,848,115**	**$64,107,290**	**$346,955,405**	**$8.64**	**$7.68**	**$8.44**
Operating Income (Loss)	**($22,216,638)**	**($1,283,806)**	**($23,500,444)**	**($0.68)**	**($0.15)**	**($0.57)**

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

Days in Year: 273

	Mental Health Services Costs			Mental Health Cost Per Day Calculations		
	UTMB	TTUHSC	TOTAL	UTMB	TTUHSC	TOTAL
Population Served	**119,978**	**30,593**	**150,572**			
Revenue						
Capitation Payments	$19,161,871	$9,564,900	$28,726,771	$0.59	$1.15	$0.70
State Reimbursement Benefits	$4,351,020	$1,992,649	$6,343,669	$0.13	$0.24	$0.15
Other Misc Revenue	($1,374)	$0	($1,374)	($0.00)	$0.00	($0.00)
Total Revenue	**$23,511,517**	**$11,557,549**	**$35,069,066**	**$0.72**	**$1.38**	**$0.85**
Expenses						
Mental Health Services						
Salaries	$18,632,444	$8,377,556	$27,010,000	$0.57	$1.00	$0.66
Benefits	$4,478,452	$2,173,416	$6,651,868	$0.14	$0.26	$0.16
Operating (M&O)	$384,983	$182,957	$567,940	$0.01	$0.02	$0.01
Professional Services	$0	$293,696	$293,696	$0.00	$0.04	$0.01
Contracted Units/Services	$0	$0	$0	$0.00	$0.00	$0.00
Travel	$160,277	$16,153	$176,430	$0.00	$0.00	$0.00
Electronic Medicine	$0	$0	$0	$0.00	$0.00	$0.00
Capitalized Equipment	$16,989	$0	$16,989	$0.00	$0.00	$0.00
Subtotal Mental Health Expenses	$23,673,145	$11,043,778	$34,716,923	$0.72	$1.32	$0.84
Indirect Expenses	$525,811	$553,644	$1,079,455	$0.02	$0.07	$0.03
Total Expenses	**$24,198,956**	**$11,597,422**	**$35,796,378**	**$0.74**	**$1.39**	**$0.87**
Operating Income (Loss)	**($687,439)**	**($39,873)**	**($727,312)**	**($0.02)**	**($0.00)**	**($0.02)**

All Health Care Summary

	All Health Care Services			Cost Per Offender Per Day		
	UTMB	TTUHSC	TOTAL	UTMB	TTUHSC	TOTAL
Medical Services	$260,631,477	$62,823,484	$323,454,961	$7.96	$7.52	$7.87
Mental Health Services	$23,511,517	$11,557,549	$35,069,066	$0.72	$1.38	$0.85
Total Revenue	**$284,142,994**	**$74,381,033**	**$358,524,027**	**$8.68**	**$8.91**	**$8.72**
Medical Services	$282,848,115	$64,107,290	$346,955,405	$8.64	$7.68	$8.44
Mental Health Services	$24,198,956	$11,597,422	$35,796,378	$0.74	$1.39	$0.87
Total Expenses	**$307,047,071**	**$75,704,712**	**$382,751,783**	**$9.37**	**$9.06**	**$9.31**
Operating Income (Loss)	**($22,904,077)**	**($1,323,679)**	**($24,227,756)**	**($0.69)**	**($0.15)**	**($0.59)**

Table 4
FY 2009 3rd Quarter
UTMB/TTUHSC EXPENSE SUMMARY

Category	Expense	Percent of Total
Onsite Services	**$183,620,572**	**47.97%**
Salaries	$118,045,756	
Benefits	$29,442,668	
Operating	$36,132,148	
Pharmacy Services	**$37,805,985**	**9.88%**
Salaries	$5,379,020	
Benefits	$1,238,686	
Operating	$1,449,163	
Drug Purchases	$29,739,116	
Offsite Services *	**$116,124,551**	**30.34%**
Univ. Professional Svcs.	$8,000,603	
Freeworld Provider Svcs.	$54,292,373	
Univ. Hospital Svcs.	$44,020,753	
Est. IBNR	$9,810,822	
Mental Health Services	**$34,716,923**	**9.07%**
Salaries	$27,010,000	
Benefits	$6,651,868	
Operating	$1,055,055	
Indirect Expense	**$10,483,752**	**2.74%**
*-Breakout of Expense Detail on Table 3		
Total Expenses	**$382,751,783**	**100.00%**

Chart 6: Total Health Care by Category

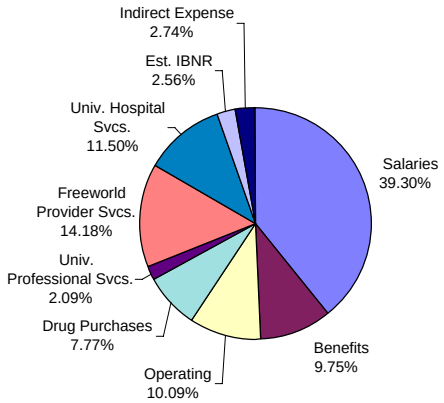


Chart 7: Onsite Services

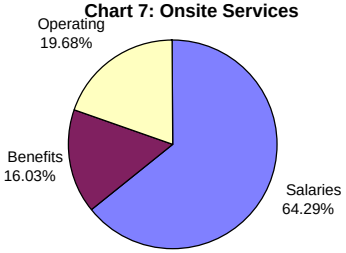


Chart 8: Pharmacy Services

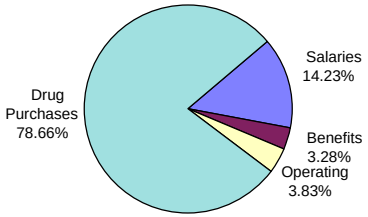


Chart 9: Offsite Services

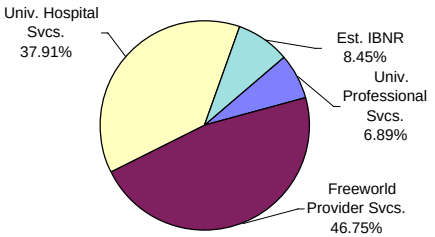


Chart 10: Mental Health Services

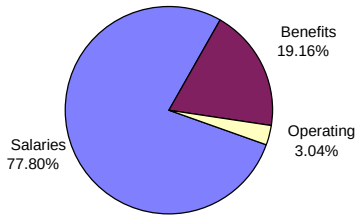


Table 5
Comparison of Total Health Care Costs

	FY 05	FY 06	FY 07	FY 08	4-Year Average	FYTD 09 1st Qtr	FYTD 09 2nd Qtr	FYTD 09 3rd Qtr
Population								
UTMB	119,322	119,835	120,235	120,648	120,010	120,117	120,070	119,978
TTUHSC	31,437	31,448	31,578	31,064	31,382	30,643	30,589	30,593
Total	150,759	151,283	151,813	151,712	151,392	150,760	150,659	150,572
Expenses								
UTMB	$330,672,773	$336,934,127	$342,859,796	$381,036,398	$347,875,774	92,490,864	193,410,886	$307,047,071
TTUHSC	$80,083,059	$83,467,550	$87,147,439	$96,482,145	$86,795,048	24,625,338	50,348,949	$75,704,712
Total	$410,755,832	$420,401,677	$430,007,235	$477,518,543	$434,670,822	117,116,202	243,759,835	$382,751,783
Cost/Day								
UTMB	$7.59	$7.70	$7.81	$8.63	$7.94	$8.46	$8.85	$9.37
TTUHSC	$6.98	$7.27	$7.56	$8.49	$7.58	$8.83	$9.04	$9.06
Total	**$7.46**	**$7.61**	**$7.76**	**$8.60**	**$7.86**	**$8.54**	**$8.89**	**$9.31**

* 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

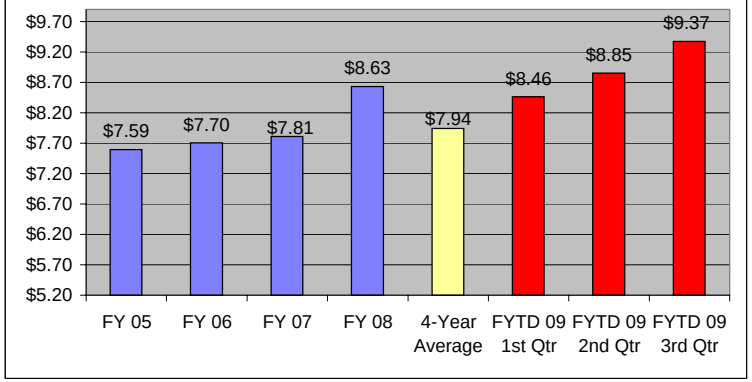


Chart 12: TTUHSC Cost Per Day

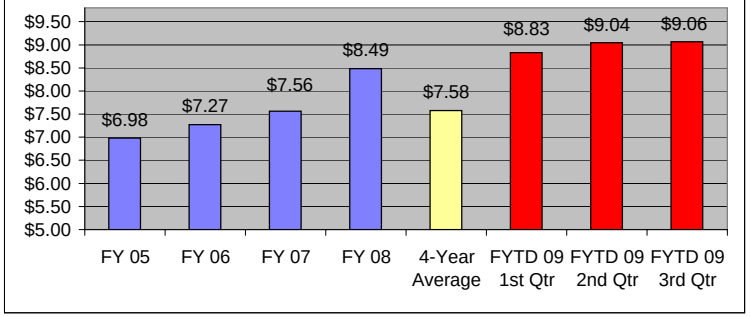


Chart 13: STATEWIDE Cost Per Day

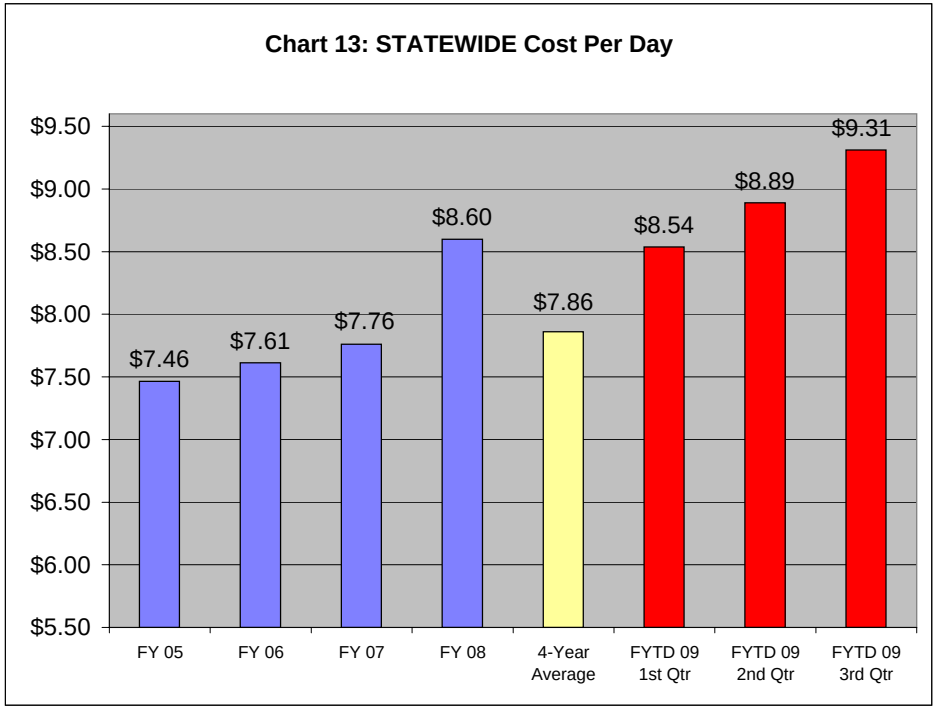


Table 6
Medical Encounter Statistics* by Age Grouping

9

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	29,127	127,514	156,641	8,728	111,245	119,973	3.34	1.15	1.31
Oct-08	37,749	163,976	201,725	8,769	111,405	120,174	4.30	1.47	1.68
Nov-08	35,008	148,192	183,200	8,868	111,431	120,299	3.95	1.33	1.52
Dec-08	37,661	161,650	199,311	8,899	111,506	120,405	4.23	1.45	1.66
Jan-09	38,665	167,016	205,681	8,993	110,831	119,824	4.30	1.51	1.72
Feb-09	36,383	159,997	196,380	9,046	110,793	119,839	4.02	1.44	1.64
Mar-09	38,812	170,108	208,920	9,176	110,538	119,714	4.23	1.54	1.75
Apr-09	38,452	173,180	211,632	9,189	110,737	119,926	4.18	1.56	1.76
May-09	36,296	166,852	203,148	9,247	110,500	119,747	3.93	1.51	1.70
Average	36,461	159,832	196,293	8,991	110,998	119,989	4.06	1.44	1.64

*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

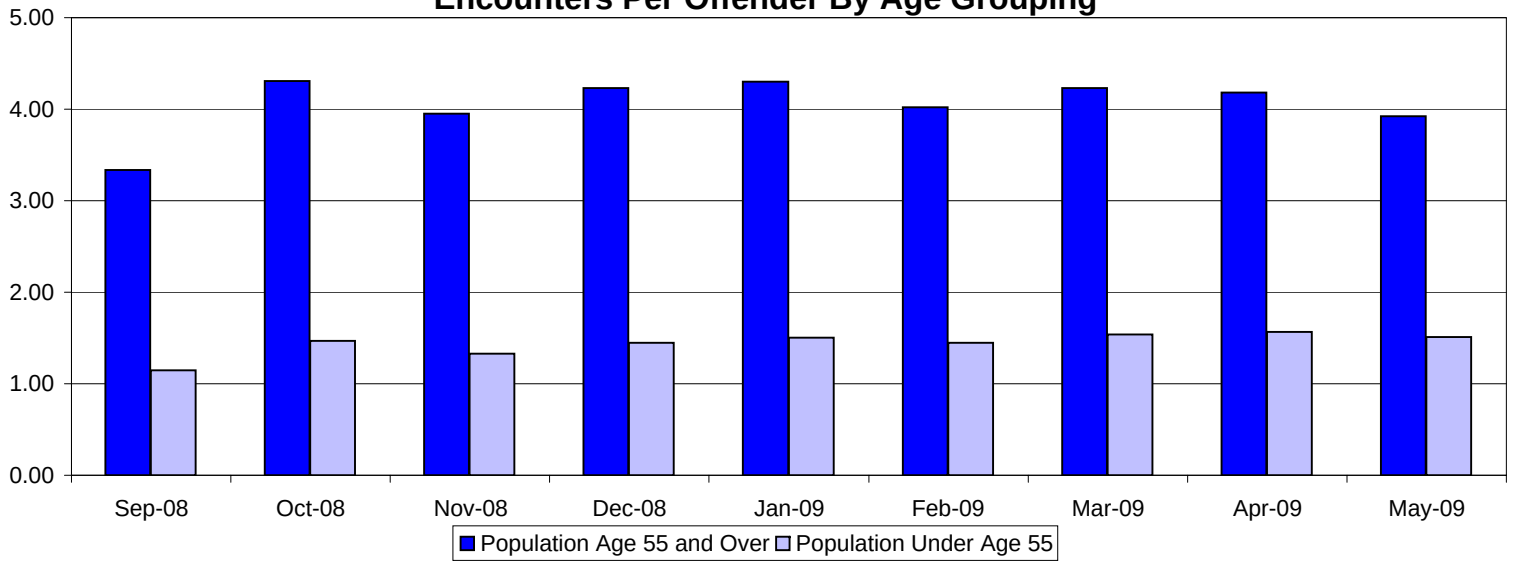


Table 7
FY 2009 3rd Quarter
Offsite Costs* To Date by Age Grouping

Age Grouping	Cost Data	Total Population	Total Cost Per Offender
Age 55 and Over	$31,380,949	10,929	$2,871.46
Under Age 55	$64,718,129	139,643	$463.45
Total	**$96,099,078**	**150,572**	**$638.23**

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

Chart 15
Hospital Costs to Date Per Offender
by Age Grouping

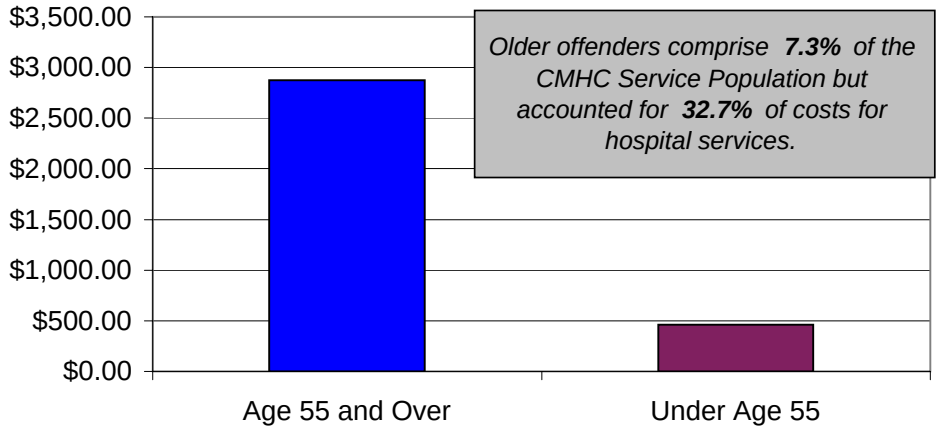
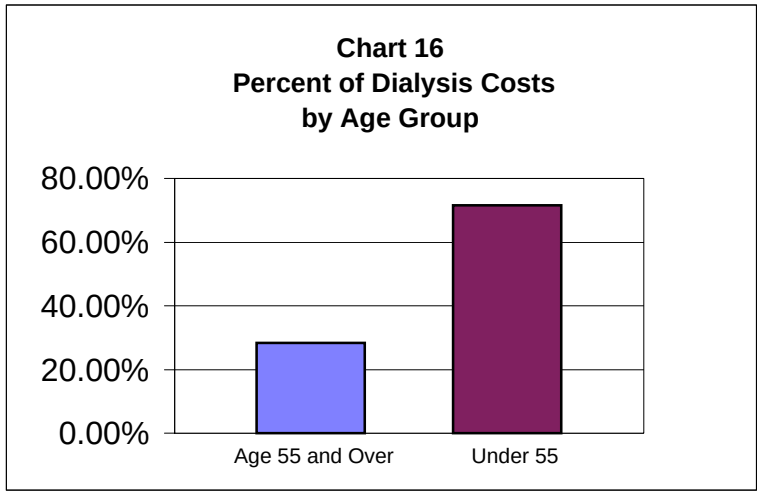


Table 8
Through FY 2009 3rd Quarter
Dialysis Costs by Age Grouping

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	$852,101	28.36%	10,929	7.26%	48	0.44%
Under Age 55	$2,152,997	71.64%	139,643	92.74%	140	0.10%
Total	**$3,005,098**	**100.00%**	**150,572**	**100.00%**	**188**	**0.12%**

Projected Avg Cost Per Dialysis Patient Per Year: $21,301



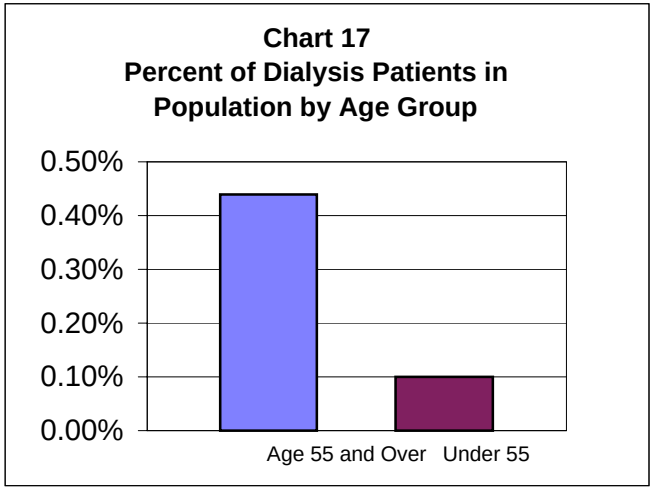


Table 9
Selected Drug Costs FY 2009

Category	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-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	$4,520,818	$2,314,038	$2,956,192	$27,974,899
HIV Medications										
HIV Drug Cost	$2,232,714	$1,326,580	$1,470,304	$1,700,599	$1,131,214	$1,220,780	$1,761,017	$1,128,059	$1,233,276	$13,204,542
HIV Percent of Cost	57.03%	47.32%	56.32%	40.85%	44.40%	56.92%	38.95%	48.75%	41.72%	47.20%
Psychiatric Medications										
Psych Drug Cost	$145,692	$12,015	$130,147	$86,408	$104,690	$88,198	$342,836	-$41,481	$28,804	$897,308
Psych Percent of Cost	3.72%	0.43%	4.99%	2.08%	4.11%	4.11%	7.58%	-1.79%	0.97%	3.21%
Hepatitis C Medications										
Hep C Drug Cost	$203,994	$53,482	$86,963	$106,573	$93,261	$78,899	$158,245	$130,485	$185,394	$1,097,295
Hep C Percent of Cost	5.21%	1.91%	3.33%	2.56%	3.66%	3.68%	3.50%	5.64%	6.27%	3.92%
All Other Drug Costs	$1,332,578	$1,411,382	$923,122	$2,269,048	$1,218,432	$756,778	$2,258,721	$1,096,975	$1,508,718	$12,775,754

Chart 18
Drug Costs by Selected Categories

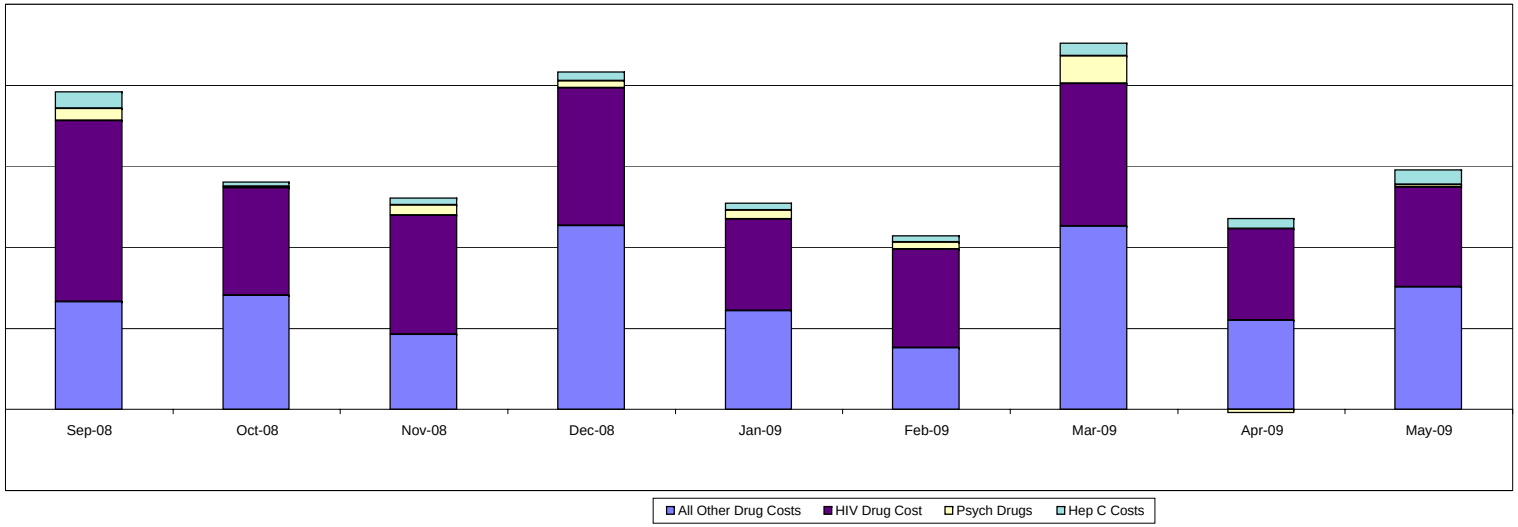


Table 10
Ending Balances 3rd Qtr FY 2009

	Beginning Balance September 1, 2008	Net Activity FY 2009	Ending Balance May 31, 2009
CMHCC Operating Funds	$31,702.52	$128,247.27	$159,949.79
CMHCC Medical Services	$46,317.13	$20,197,697.46	$20,244,014.59
CMHCC Mental Health	$7,512.29	$3,102,430.78	$3,109,943.07
Ending Balance All Funds	**$85,531.94**	**$23,428,375.51**	**$23,513,907.45**
4th QTR Advance Payments			
From TDCJ - Medical			($96,856,678.00)
From TDCJ - Mental Health			($9,567,080.00)
From TDCJ - CMHCC			($147,893.01)
To UTMB - Medical			$76,614,571.00
To UTMB - Mental Health			$6,457,480.00
Total Unencumbered Fund Balance			$14,307.44

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 Payment	$147,893.01
4th Qtr Advance Payment	$147,893.01
Interest Earned	$187.54
Subtotal Revenue	$586,937.54
Expenses	
Salary & Benefits	($358,985.07)
Operating Expenses	($68,002.68)
Subtotal Expenses	**($426,987.75)**
Net Activity thru this Qtr	**$128,247.27**
Total Fund Balance CMHCC Operating	**$159,949.79**
RECONCILIATION:	
Less: 4th Qtr Advance Payment from TDCJ	($147,893.01)
Total Unencumbered Fund Balance	$12,056.78

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 Payment from TDCJ	$96,856,678.00	$9,567,080.00
4th Qtr Advance Payment from TDCJ	$96,856,678.00	$9,567,080.00
Interest Earned	$1,907.59	$343.07
Revenue Received	**$384,270,248.59**	**$37,956,693.07**
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)
4th Qtr Advance Payment to UTMB	($76,614,571.00)	($6,457,480.00)
Subtotal UTMB Payments	**($303,959,985.00)**	**($25,619,350.00)**
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	**($364,026,233.00)**	**($34,846,750.00)**
Net ActivityThrough This Qtr	**$20,197,697.46**	**$3,102,430.78**
Total Fund Balance	**$20,244,014.59**	**$3,109,943.07**
RECONCILIATION:		
Less: 4th Qtr Advance Payment from TDCJ	($96,856,678.00)	($9,567,080.00)
Add: 4th Qtr Advance Payment to UTMB	$76,614,571.00	$6,457,480.00
Total Unencumbered Fund Balance	$1,907.59	$343.07