CORRECTIONAL MANAGED HEALTH CARE COMMITTEE

June 7, 2012

Chairperson: Margarita de la Garza-Grahm, M.D.

CMHCC Members Present: Cynthia Jumper, M.D., Lannette Linthicum, M.D., Harold Berenzweig, M.D.

CMHCC Members Absent: Ben G. Raimer, M.D., Billy Millwee

Partner Agency Staff Present: Denise DeShields, M.D., Texas Tech University Health Sciences Center; Ron Steffa, Robert Williams, M.D., Kathryn Buskirk, George Crippen, RN, Texas Department of Criminal Justice; Anthony Williams, Stephen Smock, Kelley Coates, Gary Eubank, Dr Owen Murray, UTMB; Allen Hightower, Stephanie Harris, Lynn Webb, CMHCC Staff.

Others Present:

Location: Frontiers of Flight Museum, 6911 Lemmon Ave., Room #1, Dallas, Texas

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I. Call to Order **- Margarita de la Garza-Grahm**	Dr. de la Garza-Grahm called the CMHCC meeting to order at 9:20 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 **- Margarita de la Garza-Grahm**	Dr. de la Garza-Grahm thanked everyone for being in attendance and asked everyone to introduce themselves for the record. I wanted to point out Dr. Harold Berenzweig who is the newest member appointed by the Governor.		
III. Approval of Excused Absence **- Margarita de la Garza-Grahm**	Dr. Linthicum and Billy Millwee were absent from our March 19th meeting. Dr. de la Garza-Grahm stated next on the agenda is the approval of the Minutes from the meeting held on March 19, 2012: TDCJ Health Services Monitoring Report; both UTMB and TTUHSC Medical Director's Report; and the Summary of Joint Committee Activities. She then asked the members if they had any specific consent items(s) to pull out for separate discussion.	Dr. Jumper noted that on page 64 the TTUHSC Medical Director's Report it should be the 2nd Qtr and not the 1st Qtr.	Dr. Linthicum moved to approve the excused absences and Dr. Jumper seconded the motion.

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IV. Approval of Consent Items **- Margarita de la Garza-Grahm**	Hearing no further comments, Dr. de la Garza-Grahm stated that she would now entertain a motion on approving the consent items.	Dr. Williams also noted that on page 76 that Dr. Glenda Adams was chair of the Joint Mortality and Morbidity committee and Dr. Williams was co-chair.	Both corrections were so noted and would be corrected. Dr. Linthicum moved to approve the consent items as presented at Tab A of the agenda booklet. Dr. Cynthia Jumper seconded the motion. The motion passed by unanimous vote.
V. Executive Director's Report **- Allen Hightower**	Dr. de la Garza-Grahm then called on Mr. Hightower to provide the Executive Director's report. I won't take up any more time than I have to. Everybody has taken the opportunity to review the Sunset Recommendations to the Legislature. I testified Tuesday before the Sunset Commission after visiting with the universities in regard to their response o tome of the changes that were made to include the makeup of the committee the universities will visit with the Legislature and the Sunset Commission as their universities wish to do. I made the comment before the House Committee that we had not had a formal board meeting since the final document had come out and therefore the committee had not been able to take a side by side by side stances on these issues but the committee and its staff are more than willing to assist the universities or to transport to the Sunset Commission wishes of the universities in regard to any of the issues in the Sunset Recommendation. What I call the interval part which is a big move, which makes the CMHCC an Advisory Committee to the TDCJ Board in name does caveat the ability of the committee that being us, being you board members to write, approve, alter the offender health care plan and adopt that plan without taking it to the TDCJ board for approval. Also, the committee should provide expertise and develop any associated policies and procedures to further		

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V. Executive Director's Report	implement the plans, directives and allow the committee to continue to keep its sub-committees with the universities in place for those purposes. The one thing that I talked about probably the only thing I talked about in that committee was to challenge the, not that someone in my position would challenges the Legislature I don't mean it to come out that way. The issue of the litigation shield that this committee has provided and done an excellent job of providing for the State of Texas in regard to what we always talk about in a friendly conversation with TDCJ is that we don't allow correctional people to make medical decisions and medical people to make correctional decisions often we have bad outcome of those issues. And I brought that to the attention of the members of the commission which I had already talked to about. I have met with the Attorney Generals trial lawyers to the extent I have asked the members of the Sunset Committee which is Rep. Bonham from Angleton who is the Chair, Dr. Nichols Vice-Chair to please, please, please sit down and have a long serious conversation with the AG lawyers in regard to the structural change that has been made does it weaken the states position in federal court against litigation before they move forward with combining what they recommended in this document. As I said, all of us have read it their changes to the committee talk about not talk about it gives TDCJ more authority and more leeway to do more contracting with different vendors. I did write as a response to the fiscal implications of the Sunset Commission and in good faith they had just taken 1st Qtr and 2nd Qtr and multiplied it by two and came up with the cost of the committee. For your information we did not request since Mr. McNutt retired in August and since we did not know whether or not we were going to do the study that the legislature had asked us to do. We had asked for a certain amount of money in our budget along with enough monies for the same budget that we ask for with fewer duties. As your staff we saw in May that we had enough money in our account not to request a 4th Qtr payment from TDCJ. Therefore it reduced the estimated savings that the commission made from $556,000 to somewhere around $330 to $340 thousand is the actual cost to the general revenue for this committee to exist and		

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V. Executive Director's Report (Cont'd)	for this committee to continue its work. Madam Chairman I'm willing to answer any questions that anyone might have in regard to the Sunset Commissions request or the Legislative Response. I didn't intend to go any deeper into this unless the membership wanted to at this meeting. Mr. Hightower added that he had not talked to Dr. Nichols since the final report came out, but he has talked to Rep. Bonnen.	Dr. de la Garza-Grahm asked what their feelings up to this point were. Mr. Hightower responded with, I think their feeling are that this is an issue that they have not really gotten into before and as I said, I have talked to Sen. Whitmire and Rep. Dutton. I served with all three of the others. Sen. Nichols came along after I did and Sen. Whitmire was there during all the reform and during all of the majority of the Ruiz lawsuit. I have read the California lawsuit and there a many similarities in California being put in receivership in their health care delivery and what Texas was placed in their receivership for its medical issues. I wanted to remind the committee with this committees support would like to continue to talk with the members of the Legislature in making sure in the attempt to save $340 or $350 thousand dollars a year we don't create more liability at the federal court level for the State of Texas. The shield that was put in place by the initiation of this committee along with saving the state money and along with providing the constitution in the level of health care. That shield has worked well for the whole tenure of this committee, the shield is for the Board of Criminal Justice, it's not just necessarily its more easy to testify about treatments, inmate health services plan when it comes from a physician dominated license practitioner recommendation before	

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V. Executive Director's Report (Cont'd)		federal court than from people that are not that don't have that expertise. And my long time interest in this is that and I even said this even though I have been voted off the island and if this is best for the State of Texas that this change be made it would be my request that you would at length talk to not only the Attorney General but more specially to the trial lawyers that have to try these cases in court to make sure that a movement to save $340 thousand dollars does not put the State of Texas in more litigation situation. Dr. de la Garza-Grahm asked if he had an idea when we were going to hear from them. Mr. Hightower responded that it would be a long drawn out process. They have at least 20 other state agencies that are under Sunset now. The work now is for universities, the committee and TDCJ to work with the Legislature and Legislative leadership because the Sunset Commission now has made their recommendations in the form of a bill. The Legislature will take that bill just like they would any other bill and work its way thru the House, it has to work its way thru the Senate it has to be signed or not signed by the Governor for a period of time to go into law. This will be a long drawn out process before it is	
VI. Performance and Financial Status Report - **Lynn Webb**	Dr. de la Garza-Grahm thanked Mr. Hightower for the report and asked if there were any questions. Mr. Webb will now present the financial report. Mr. Webb began with as kind of a follow-up to Mr. Hightower I thought I would go ahead to let the committee know also when Sunset was visiting with us and when they had come out with their recommendation they had sat down with us in our area. I actually indicated to them as far as my rule, I was very comfortable with the idea since TDCJ right now receives all the legislative funding and because it's all in one pile.		

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VI. Performance and Financial Status Report (Cont'd)	It makes sense to get some economies to scale. TDCJ has a very large auditing division which can handle the auditing functions which I essentially do and also they have a very sophisticated roll up in tracking their financials as which I think they get some economies to scale on that. Then as far as the statistical data and all the other data that we track. I indicated to them that I will be willing to help transition very smoothly this process into TDCJ. This financial summary report will cover all data for the 2nd Quarter FY 2012 ending February 29, 2012. This report is found in your packet at Tab C. Population Indicators on pages 90 and 91 as represented on (Table 2 and page 90), the average daily offender population has increased slightly to 152,924 for the Second Quarter Fiscal Year 2012. Through this same quarter a year ago (FY 2011), the daily population was 152,655, an increase of 269 or (0.17%). Consistent with trends over 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 offender population to 13,534 as of 2nd Quarter FY 2012. This is an increase of 961 or about 7.6% from 12,573 as compared to this same second quarter a year ago. Hospital Inpatient Census is a new statistical indicator established to reflect the health care dollars spent in the C.1.8 Strategy "Hospital and Clinic Costs". The hospital inpatient average daily census (ADC) served through the second quarter of FY 2012 was 204 inmates for both the Texas Tech and UTMB Sectors. Outpatient Clinic and ER Visits is another new statistical indicator established to reflect the health care dollars spent in the C.1.8 Strategy "Hospital and Clinic Costs". The medical outpatient clinic and ER visits served through the second quarter of FY 2012 was 3,252 for both the Texas Tech and UTMB Sectors.		

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VI. Performance and Financial Status Report (Cont'd)	The overall HIV+ population has remained relatively stable throughout the last few years at 2,319 through 2nd Quarter FY 2012 (or about 1.52% of the population served). The two mental health caseload measures have remained relatively stable: 1). The average number of psychiatric inpatients within the system was 1,817 through the Second Quarter of FY 2012. This inpatient caseload is limited by the number of available inpatient beds in the system. 2). Through the Second Quarter of FY 2012, the average number of mental health outpatient visits was 18,136 representing 11.9% of the service population. Health Care Costs (Table 3 and page 92, 93 and 94) Overall health costs through the Second Quarter of FY 2012 totaled $244.3M. On a combined basis, this expense amount is more than overall revenues earned by the university providers by approximately $7.5M. UTMB's total revenue through the second quarter was $188.1M; expenditures totaled $196.3M, resulting in a net shortfall of $8.2M. Texas Tech's total revenue through the second quarter was $48.7M; expenditures totaled $48.0M, resulting in a net gain of $722K. Examining the healthcare costs in further detail on (Table 4 of page 95) indicates that of the $244.3M in expenses reported through the Second Quarter of FY 2012: Onsite services comprised $111.4M, or about 45.6% of expenses: Pharmacy services totaled $27.1M, about 11.1% of total expenses: Offsite services accounted for $78.6M or 32.1% of total expenses: Mental health services totaled $20.4M or 8.4% of the total costs: and Indirect support expenses accounted for $6.8M, about 2.8% of the total costs.		

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VI. Performance and Financial Status Report (Cont'd)	Table 5 and page 97 shows that the total cost per offender per day for all health care services statewide through the Second Quarter FY 2012, was $8.78, compared to $9.65 through the Second Quarter of the FY 2011. This is a reduction of 9.0% in costs year over year from the previous fiscal year. The average cost per offender per day for the last four fiscal years was $9.44. As a point of reference healthcare costs was $7.64 per day in FY03. This would equate to a 14.9% increase since FY03 or approximately 1.7% increase per year average, well below the national average. Aging Offenders Older offenders access the health care delivery system at a much higher acuity and frequency than younger offenders: Table 6 and page 98 shows that encounter data through the 2nd Quarter indicates that older offenders had a documented encounter with medical staff 1.2 times as often as younger offenders. Table 7 and page 99 indicates that hospital and outpatient clinic costs received to date this Fiscal Year for older offenders averaged approximately $1,802 per offender vs. $285 for younger offenders. Regarding hospitalization and specialty clinic costs shown in Chart 12, the older offenders were utilizing health care resources at a rate of 6.3 times higher than the younger offenders. While comprising only about 8.8% of the overall service population, older offenders account for 38.1% of the hospitalization and outpatient clinic costs received to date. Also, per Table 8 and page 100, older offenders are represented 4.8 times more often in the dialysis population than younger offenders. Dialysis costs continue to be significant, averaging about $20.2K per patient per year. Providing dialysis treatment for an average of 220 patients through the Second Quarter of FY 2012 cost $2.2M. On Drug Costs please note that Table 9 and page 101 shows that total drug costs through the 2nd Quarter FY		

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VI. Performance and Financial Status Report (Cont'd)	2012 totaled $21.3M. Of this, $9.9M (or under $1.7M per month) was for HIV medication costs, which was about 46.9% of the total drug cost. Psychiatric drugs costs were approximately $1.2M, or about 5.6% of overall drug costs. Hepatitis C drug costs were $1.6M and represented about 7.7% of the total drug cost. Reporting of Reserves: It is a legislative requirement that both UTMB and Texas Tech are required to report if they hold any monies in reserve for correctional managed health care. UTMB reports that they hold 6.2 Million Dollars in such reserves which is left over from FY 2011 SAR, and report a total operating loss of $8.2M through the end of the 2nd Quarter of Fiscal Year 2012. Texas Tech reports that they hold no such reserves and report a total operating gain of $721,986 through the 2nd Quarter FY 2012. A summary analysis of the ending balances of revenue and payments through February 29th FY 2012, on (Table 10 and page 102) for all CMHCC accounts are included in this report. The summary indicates that the net unencumbered balance on all CMHCC accounts on February 29, 2012 is $105,303.10. This excess amount is due to the un-filled position of Assistant Executive Director when Mr. David McNutt when he retired. On financial monitoring detailed transaction level data from both providers is being tested on a monthly basis to verify reasonableness, accuracy, and compliance with policies and procedures. The testing of detail transactions performed on TTUHSC's financial information for December 2011 through February 2012 found all tested transactions to be verified with appropriate backup documentation. The testing of detail transactions performed on UTMB's financial information for December 2011 through		

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VI. Performance and Financial Status Report (cont'd)	February 2012 found all tested transactions to be verified with appropriate back-up documentation, except for two transactions with no back-up in January 2012 and one transaction in February 2012 with no back-up documentation. That concludes my report Dr. de la Garza-Grahm. Dr. de la Garza-Grahm asked if there were any questions for Mr. Webb.	Dr. Deshields had a question about page 85, under aging offenders, second bullet point where it says encounter data through the second quarter of FY2012 indicates that offenders aged 55 and over had a documented encounter with medical staff a little more than one time as often as those under age 55. Is that correct? Mr. Webb I'm glad you brought that to our attention because typically I've reported that previously in the range of about 5 and that is a perfect kind of segway into some changes it was determined. Mr. Alderman apparently they were tracking TTUHSC in with the UTMB data and so for quite a few years that has been an incorrect number. Dr. Linthicum asked how they were able to track Texas Tech encounter data. Mr. Webb apparently they have a program and looked at it closely enough. Dr. Linthicum said thru the EMR? Dr. Murray added that it all centralizes in that EMR. Mr. Webb added it pulled the data and so now I have to report it, obviously it's something that is a cliché and I report numbers I'm given. Sorry they have been incorrect for quite a while. Dr. Linthicum added some of the reduction is probably due to the health services fee because we have seen reductions across the board and that was implemented in September.	

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VII. Medical Director's Updates **- Critical Vacancies** - **Lannette Linthicum, M.D. (TDCJ)**	Dr. de la Garza-Grahm then called upon Dr. Linthicum to report TDCJ's critical vacancies. Dr. Linthicum began with that TDCJ had three vacancies, Chief Public Health Officer, which is a Physicians position and has been vacant for some time and what we have done to litigate that is we placed a Registered Nurse in charge of that department who has a background in infection control and we are were using one of our physicians who is also a infectious disease specialist for the clinical consultation in that office until such time that we are able to recruit and obtain a public health officer. Our Director of the Office of Mental Health Monitoring & Liaison, Dr. Montrose who is a PHD, Psychologist retired last month, and we have another position in that office which is an Associate Psychologist. We are taking the opportunity with these vacancies to look at the entire office and maybe do some reengineering. Dr. de la Garza-Grahm asked if there were any questions and then called on Dr. Murray to present UTMB's position vacancies. Dr. Murray began with actually our mix is about two to one mid level providers. We struggle in both categories right now just because we have had no opportunities to expand current salaries with what we can offer. At least on our list again we have the general vacancies and mid level psychiatrists. The one specific vacancy I've spoke about before is our Clinical Director Virology that is Dr. Kahn to start June 25, she will be full time we will have her up to meet the health services staff and Dr. Linthicum to be indoctrinated into the system and we're very happy to have her. She's from Cook County and she will actually work out very very well.	Dr. de la Garza-Grahm added that looking back at the personnel, could we look at the physician assistants to place in some of these slots. Dr. Linthicum answered these positions that I have are all administrative. I know both universities on the unit use employee mid providers, physician assistants and advanced nurse practitioners.	
- **Owen Murray, D.O. (UTMB)**			

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VII. Medical Director's Updates - Critical Vacancies		Dr. Linthicum responded with Cook County, Illinois. Dr. Murray said yes. Dr. Linthicum added Cook County Jail, so she has correctional experience. Dr. Murray added that he really didn't know, but I think she trained at the county and that's the extent but typically most county residents have jail experience anyway. More on the professional side.	
- **Denise DeShields, M.D. (TTUHSC)**	Dr. DeShields began with Texas Tech again we are reporting the PAMIO Medical Director vacancy which has been prolonged for the last three years. We are still continuing to canvas several search engines. We have been approaching some psychiatric geo med programs see if we can encourage someone to apply for this position. In the meantime we have been utilizing locum to cover that vacancy when that is available and also increased telemedicine coverage. We have recently met with the Department of Psychiatry at Tech to provide some additional telemedicine and they unfortunately however are two psychiatrists down themselves and won't be able to probably help us until the end of 2012. We also have had one psychiatry vacancy at the Allred Unit which we are currently in the process of recruiting as well. And those are all our critical vacancies we have at Texas Tech.		
VIII. Medical Director's Updates (Cont'd.)	Dr. de la Garza-Grahm thanked Dr. DeShields and then called on Dr. Linthicum for the TDCJ Health Services Medical Directors' Review.		
- **Lannette Linthicum, M.D. (TDCJ)**	Dr. Linthicum began with report on page 105 under Tab E of the agenda packet. During the 2nd quarter of FY 2012, Dr. Linthicum reported that eight operational review audits were conducted at the Beto, Dawson State Jail, Dominquez State Jail, East Texas Treatment, Estelle, Ney State Jail, Stiles, and Torres. Also during the 2nd quarter at the second bullet with 13 ORA's were closed for the following facilities: Daniel, Dominquez, Ellis, Formby State jail, Glossbrenner, McConnell, Montford,		
- **Operational Review Audit**			

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VIII. Medical Director's Updates (Cont'd.)	Murray, Ramsey, Rudd, Smith, Stringfellow, and Wheeler. The 10 most found items out of compliance during those eight ORA's conducted being interpreter services for monolingual Spanish-speaking offenders, and all eight facilities were not in compliance with this requirement. The next area were the Hemoccult cards were collected offenders 40 years of age or greater, Within 60 days of their annual date of incarceration. This is a preventive measure that we do to monitor for fecal cult blood for colon cancer.	Dr. de la Garza-Grahm asked at what age. Dr. Linthicum responded from offenders 40 years of age or greater. We use the United States Public Health Services guide line that they publish annually. Dr. de la Garza-Grahm said we don't do that in the private sector. Dr. Linthicum answered that it's really an issue for us of doing colonoscopies or us doing fecal cult blood, and due to our fiscal conditions, this is a less costly mechanism for us to do. The United States Public Health Services Agency publishes guidelines all these preventive measures. All these things we do in terms of prevention are patterned after their guidelines. So again and for the benefit of Dr. Berenzweig, we underwent some reductions and now our funding across all those strategies, unit, hospital, pharmacy strategies. As a result of the funding reductions, we were forced to do a reduction in force of lying off a lot of key health care staff last FY2011 in July it happen. And then we have had previous reduction in force in July of 2010. And then in 2003 we lost over 500 FTE's, so if you look at it in total we've lost more than a 1,000 FTE's out of our health care operations over the unit levels. I think it's starting to show up as we are having some significant struggles in trying to in this	

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VIII. Medical Director's Updates (Cont'd.)	Dr. Linthicum continued with number three having to do with Hepatitis C. We have two policies that the committee is iatrical in deciding how we treat. One is Hepatitis C and the other one is HIV. Those policies are brought before the committee for approval and adoption. There are joint working groups that work on these policies under the committee's umbrella and the chairman is involved in appointing the members of those committees. In item 5.250 our current Hepatitis C policy we require an initial evaluation of offenders be completed by a provider either a physician or mid-level provider and we unfortunately on this round of audits I see that this was occurring and again I relate a lot of this back to the reduction in force. Item 6.360 is that those people who are when the decision is made for treatment for Hepatitis C it requires the provider to document if treatment for Hepatitis C is determined not to be implicated. So once they have been diagnosed they are not ready for treatment and they have to document it in their electronic medical record why. And again we didn't see adequate compliance on that.	compliance monitoring trying to stay in compliant with our policies and procedures. And all of our facilities are accredited by the American Correctional Association. There are two national organizations that are correctional health care facilities one is the American Correctional Association, the other is the National Commission for Correctional Health Care and both organizations follow the national standards. At one time we were accredited by the National Commission for Correctional Health Care and when TDCJ moved to accredit the entire unit then the health care portion of accreditation had to be done by the American Correctional Association. So all of these questions that are listed here are part of the operational review and they correlate back to a standard of ACA.	

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VIII. Medical Director's Updates (Cont'd.)	Getting back to item 5.210 our preventive annual physical exam for offenders 50 years of age or greater again to be documented in the electronic medical record within 30 days of their annual date of incarceration. Seven of the eight facilities were not in compliance. Next item 6.350 again deals with Hepatitis C Virus infected patients with AST Platelet Ratio Index (APRI) index which is a laboratory test and if the score greater than 0.42 or with abnormal liver function either the Prothrombin Time, Total Bilirubin, or Albumin and they do not have a documented contraindication for antiviral therapy they are suppose to be referred to a specialist at that point so that their treatment plans can be developed. Only Seven of the eight facilities were not in compliance. Item 6.380 deals with the pheumococcal vaccine are offered to offenders with certain chronic diseases and conditions, and all offenders 65 of age or older. Seven of the eight facilities were not in compliance. Item 6.450 is follow-up monitoring of serologies for Syphilis. Seven of the eight facilities were not in compliance in terms of their monitoring and follow up of treatment of Syphilis. Item 5.090 requires that nursing staff make daily rounds on offenders who are in segregation those are offenders who are locked down 23 out of 24 hours and that get one hour out for recreation. If they are in disciplinary segregation or solitary they do not get that one hr. The ACA standard which is a mandatory standard requires that look at these offenders everyday and make sure that they are doing ok in this environment and be documented on Flow Sheet (HSN-46). Six of the eight facilities were not in compliance. Item 5.150 requires all intra within the TDCJ system medical transfers that are coming back to a facility either from a free world hospital, free world diagnostic procedure or physician visit or whatever but when they come back a physicians or mid-level providers review		

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VIII. Medical Director's Updates (Cont'd.)	and sign the Nursing Incoming Chair Review (HSN-1) within 48 hours for returning offenders who had changes in medication orders, treatment plan, housing assignments or disciplinary restrictions and this is a continuity of care measure. Six of the eight facilities were not in compliance. So overall in terms of the compliance monitoring I think what we're seeing is that the units are struggling due to the sequential reductions of forces. They are many, many task to be done and what they are trying to do is focus on the resources they have in providing direct care. I'm hopeful that a lot of this care is being done but not being documented as well as it has in the past because of the fact that a lot of the support staff were taken out of the units. For example, nurses instead of just doing nursing now are doing all the support functions and nursing together. We lost our assistant unit health administrators, our medication aides, our patient care technicians and all of these allie health care staff that supported the daily operations at the unit level was lost thru the reductions in forces and budgetary problems that we face. So you have clinical staff now instead of being totally devoted to direct care, they are having to divide that function and I think if comes down to it a nurse will deliver rather than worry about catching up with the paper work later. We got a lot of our colleagues here, our nursing director for UTMB, that Dr. Berenzweig needs to be introduced to, Owen will you introduce your staff. Steve Smock, UTMB, Associate VP for Outpatient Services Gary Eubank, UTMB, Chief Nursing Officer Kelley Coates, UTMB, Director of Clinical Support Services Anthony Williams, UTMB, Associate VP for Inpatient Services Dr. Robert Williams, TDCJ, Deputy Director for Health Services George Crippen, RN, TDCJ, Chief Nursing Officer Dr. Kathryn Buskirk, TDCJ, Director of Quality Monitoring & Compliance Ron Steffa, TDCJ, Deputy Chief Financial Officer		

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VIII. Medical Director's Updates (Cont'd.) **- Capital Assets Monitoring**	Dr. Linthicum continued that the Capital Assets Monitoring ….	Dr. Berenzweiz asked if he could interrupt since you have given him some administrative information I have a couple of questions. So we went back three years or so for the last two RIFs and the compliance report was significantly different. Dr. Linthicum responded that yes it was a lot better. Dr. Berenzweig added the other question which I guess would be premature since the compliance has just taken a nose dive. Have you seen any changes in the medical condition of the inmates now? The inferences that's being done and not documented. That is just a concern of mine certainly with the infectious diseases that in fact the state would have shot it self in the foot and the cost would go up because the infectious diseases either progressed untreated now that we have treatments to keep from spreading in the inmate population. Dr. Linthicum added that our TB case rates were on the rise. In fact the Department of State Health Services has gotten intrically involved in our units and the TB Elimination Division. I will let Dr. Williams tell you about a strand of TB that is only in the State of Texas that they sort of localized to our prison system. Dr. Williams began with this is identified as a specific genie type to date within the United States that exists only in Texas. There are 26 cases, 25 of those 26 cases have a history of incarceration, and 21 of the 26 cases have a history of incarceration within TDCJ. There were not all diagnosed in TDCJ and we do not know for sure where they were exposed. The one key component of this information that is	

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VIII. Medical Director's Updates (Cont'd.)		missing at this time is that from the sources that they were not from TDCJ but were from Fort Bend and Harris Counties. So we are talking about a specific area within Texas. And then our offenders once they are in the system they may be at any different units, but the country south of the United States are not doing genie typing. So right now that genotype only exists in Texas and more predominately in Harris county and then commuting into our system. I really suspect that when we have more genia typing information ultimately it's going to lead from south of the border. Because we don't have that information right now, we are setting up to conduct a field investigation and where we can get a little more detail in trying to figure out what the relationships and where people were exposed. Our initial data we had two to three cases at the same unit, so you think there must be a link. But if you look at temp they were not at the unit at the same time. It's separated by even periods of years. So there was no obvious link, now we are going into a little more detail and trying to see if there are any links. The really confusing thing is within the United States 25 out of 26 have some link to incarceration. Dr. Linthicum added that the United States for Disease Control are involved and want to get involved and we need to let Dr. DeShields and UTMB know of this. Further discussions between, Dr. Linthicum, Dr. de la Garza-Grahm, and Mr. Hightower. Dr. Linthicum also added and informed Dr. Berenzweig that several years ago we did a seroprevalence study with our State Health Department with DISHES and we found that 30% of the incoming offender population had Hep C positive. So our total population is	

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VIII. Medical Director's Updates (Cont'd.)		around is 156,000 so we have a lot of Hep C on hand. In fact when you look at our Mortality data second behind chronical vascular related deaths is cancer. And the largest numbers of cancer related deaths are now hepatocellular carcinoma. Probably greater than 90% of offender population has substance abuse history, so a lot intravenous abuse is contributing factors.	
- Grievances and Patient Liaison	Dr. Linthicum continued with her report in stating that she has in her office an office called the Office of Professional Standards and there are two programs in that office they have Offender Grievance Program and Patient Liaison. The Patient Liaison Program really functions like an ombudsmen for health care we take third party complaints from anybody about health care. Inmate families, legislators, governor's office, federal officials, lawyers, representatives, senators, just anybody can write into that program if they have a complaint and of course we get the necessary information and answer their complaints. So during the second quarter of FY2012, the Patient Liaison Program and the Step II grievance Program together received 3,963 correspondences. The Patient Liaison Program received 1,882 correspondences and Step II Grievance program received 2,081 grievances. As a result of us investigating there were 263 Action Requests generated. UTMB and Texas Tech combined had a sustained percentage of offender grievances that was at 6%. Performance expectation is 6% and for UTMB separate their percentage was 1.07 and Texas Tech was 3%.	Dr. Berenzweig thanked Dr. Linthicum. Sorry for the interruption.	
- Quality Improvement (QI) Access to Care Audits	We also have under the umbrella of the committee the Quality Improvement and the Quality Management Program. It is organized into a central System Leadership Council and at the unit level we have the Facility Leadership Councils. Within my office are auditors that go out and verify sick call requests, which		

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VIII. Medical Director's Updates (Cont'd.)	is a mechanism for us to ensure access to care? In the Correctional Managed Health Care Statue 501.150 specifies what responsibilities are the departments and what the responsibilities are the university providers. TDCJ is the department and we're responsible for ensuring access to care, conducting operational review audits, investigating medical grievances, and monitoring quality of care. So one of the ways that we ensure access to care is thru this sick call verification audit. Units that have scored 80 percent or above in each discipline, which we look at medical, dental, mental health and nursing, we've agreed they will be audited one time per fiscal year. So our threshold is 80 percent. Those that have less than 80 percent in a discipline(s) or less than a two year history of scores will be audited quarterly. So during the second quarter they performed 44 audits on 44 facilities. At some units have multiple areas, they have a general population, then they have what we call Expansion Cell Block or high security which is where all the administrative segregation is and which we'll do a separate audit. So the result of that was a total of 279 indicators were reviewed at the 44 facilities and 21 of the indicators fell below the 80 percent compliance threshold representing seven percent. So then corrective action is requested from these facilities and that will be reported back. Dr. Buskirk who just introduced herself as our Director of Compliance and Quality Monitoring is an MD and she does all of the quality audits centrally utilizing the electronic medical records. And during this quarter she looked at how we're managing Hyperlipidemia across the system. She reviewed a total of 1,273 charts, 1,012 from the UTMB sector and 261 from TTUHSC sector. On page 109 is an outline of the questions used in the Hyperlipidemia audit, and the results and I won't take the time to go over all of that. But overall I think we did fairly well actually more than fairly well.		
- Office of Public Health	The Office of Public Health where we have a physician vacancy and we have an infectious disease doctor filling in. The Public Health program monitors		

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VIII. Medical Director's Updates (Cont'd.)	cases of infectious diseases in newly incarcerated offenders as well as new cases that occur in the on hand offenders within TDCJ population. The data is reported by the facilities for 11 infectious conditions including Syphilis, Hepatitis C Virus (HCV), Human Immunodeficiency Virus (HIV), and Tuberculosis (TB) as well as the data for occupational exposures to bloodborne pathogens. There were 657 cases of Hepatitis C identified for the Second Quarter FY2012, compared to 706 cases identified during the same quarter last year. The HIV tests were changed effective February 1, 2010. HIV tests are now to be classified as belonging to one of four categories: intake, offender-requested, provider-requested, or pre-release. HIV test became mandatory at intake in July 2007. However, offenders who are already known to be HIV positive are not required to be retested at intake. Instead, they are offered laboratory testing to assess the severity of their infections. HIV testing became mandatory for pre-release in September 2005 (HB43). During the Second Quarter FY2012, 21,075 offenders had intake tests, and 135 are newly identified as having HIV infections. During the Second Quarter FY2012, 17,702 offenders had pre-release tests; 4 were HIV positive. 15 new AIDS cases were identified during the Second Quarter FY2012. We had 195 cases of Syphilis reported during the quarter, 213 Methicillin-Resistant Staphylococcus Aureus cases, and 15 active Tuberculosis cases under management for the Second Quarter. Also we have in the Office of Public Health a SANE Registered Nurse (Sexual Assault Nurse Examiner). All correctional facilities in the United States (i.e., prisons, jails, juvenile and community corrections facilities) must comply with the Prison Rape Elimination Act (PREA). The United States Attorney General last month approved the standards that were promulgated by the PREA Commission and signed them into law. The American Correctional Association (ACA) will be addressing the PREA standards at the July Congress of Corrections Standards Committee in Denver. Correctional facilities that do not comply with these standards will lose all federal funding.		

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VIII. Medical Director's Updates (Cont'd.)	So we are going to have a lot of work to do. There a lot of medical and mental health standards that has been passed under this statue. So we'll be pairing behind what ACA adopts and we'll have to develop policies and procedures and monitoring mechanisms. Dr. Linthicum went on to add that we employee in TDCJ a SANE nurse. This position collaborates on the security side with the Safe Prisons Program and our nurses are actually trained and certified as a SANE nurse by the United States Attorney General's Office. And she reviews all allegations of sexual assaults. And in this second quarter she conducted 9 educational in-service programs that are held for 63 medical staff. In fact under the new standards all medical staff on every unit will have to be trained yearly on these standards. This position also audits all the documentation and services provided by medical staff for each sexual assault reported. There were 179 charts reviewed of alleged sexual assaults with one deficiency and a corrective action plan was requested. There were 31 bloodborne exposed victims and there were zero seroconversions as a result of sexual assault. We have a Peer Education program that has gotten national recognition. Many states have pattern behind our peer education program here in Texas. 98 of the 111 facilities have the Peer education program. During the second quarter health educators trained 212 offenders. This is an increase from the same quarter of FY2011. During the same quarter of this year, 16,813 offenders attended classes presented by peer educators. This is a slight decrease from last year.		
- Mortality and Morbidity	We have a Joint Mortality and Morbidity Committee under the umbrella of the Correctional Managed Health Care Committee there's several joint committees. One is the Mortality & Morbidity Committee, the Joint Pharmacy & Therapeutics Committee, the Joint Infection Control Committee and Joint Peer Review Committees all of these function under the umbrella of the CMHCC. The Mortality and Morbidity committee is composed of		

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VIII. Medical Director's Updates (Cont'd.)	physicians and doctors from UTMB, Texas Tech and from my staff TDCJ. They look at all the deaths during the quarter and there were 107 deaths reviewed and of those 87 deaths, 12 were referred to peer review committees as this chart on page 111 outlines.		
- **Mental Health Services Monitoring and Liaison**	The Office of Mental Health Services Monitoring and Liaison is our office that does primarily continuity of care for offenders coming into our system from the counties that have mental health illness history. As Lynn reported we have over 18,000 offenders on outpatient caseload, we have 2,000 inpatient psychiatric beds, we have 800 developmental disabled males, and 100 developmental disabled females mentally retarded. We have substance abuse felony punishment facilities where offenders are directly sentenced into these in-prison therapeutic communities by district judges and we have special needs ones where they are dual diagnose with mental health and substance abuse issues. So this office of mental health monitoring liaison they looked at 602 offenders that were identified as having a documented history of mental illness when they came to our facility. We also have a master's level psychologist and his job is to go to every administrative segregation unit because of the environment these offenders are on lock down 23 out of 24 hrs. particularly those with mental health histories. M&L monitors all offenders in Administrative Segregation facilities within the TDCJ Correctional Institution Division/State jails every six months. 4,857 offenders were observed, 2,474 of them were interviewed and six offenders were referred to the university providers for further evaluation. The four Substance Abuse Felony Punishment Facilities we look at the medications they come in on from the counties and make sure that those medications are continued for continuity of care. The district judges seem to be very concerned about the continuity of care of these offenders and so we have incorporated that into our monitoring. We also look at the use of enforce medications in our four psychiatric facilities when		

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VIII. Medical Director's Updates (Cont'd.)	medications when it is determined that they have to compell medications, we monitor that to make sure that all the policies and procedures are followed. The universities are doing very well with that and we had 100 percent compliance.		
- Clinical Administration	We have 24 intake facilities where offenders are coming into our system. Overall TDCJ has 111 institutions and 24 of them are intake facilities. And this is where our Mental Health Services Monitoring spends most of their time in looking at these intake facilities and ensuring that none of the mentally ill fall thru the cracks. And finally we have a program called BAMBI that is not in Health Services but is in the Rehabilitation Program Division. The BAMBI acronyms stand for Baby and Mother Bonding Initiative. These are for women that have had babies and can go out into the residential setting and have that bonding with their infant. UTMB has subcontracted with our division that's responsible for this program. Our role in Health Services is to make sure from a health care perspective that the women in this program are appropriate. So our mental health staff review them and make sure they do not have a history with child protective services and that they don't have any sort of access one or even access two personality that is going to endanger the babies or other people. So they interviewed 15 offenders and 12 of them were allowed to participate in the program in this quarter. Lastly I have an office called the Health Services Liaison office which is an office of all nurses. They are responsible for intake entities for TDCJ from all county jails, all offenders with special medical needs. If you can imagine the counties are wanting to get rid of these people first. Because they cost a lot of money, these are dialysis patients, patients that are in the hospital, stroke victims, etc. that are state prisoners or that they are going to be state prisoners. We can't take them until they are state ready but they are the first ones that the sheriff calls and say hey we need for you to take these people. So these nurses and the health services liaison coordinate the intake of all the special needs offenders into the system.		

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VIII. Medical Director's Updates (Cont'd.)	In addition to that they make all of the entrust system moves and within these there are 111 institutions that are moved for medical reasons. So if Dr. DeShields calls and says Dr. Linthicum I have in my sector a mentally retarded offender that somehow got into the Texas Tech sector where we don't provide those services, then my nurses will move him into the UTMB sector. Where we have the developmental and disabled program. If they need physical therapy, occupational therapy, brace and limb clinic or oral surgeons, any kind specialty services that we concentrate on certain units then the requests comes into our office for transfers. The monitoring functions that these nurses do is that they look at continuity of care from the level of free world hospitals back into our system and then from offenders from within our system to our infirmary beds back to the system and we are doing very well on that.		
- **Accreditation**	Accreditation is the last area if you look at page 114, and the following units were awarded ACA Re-Accreditation: Briscoe, Cole, Gist, Jester I, Jester III, LeBlanc, C. Moore, Polunsky, Smith, and Vance.		
- **Biomedical Research Projects**	On the Biomedical Research the summary lists the current and pending research projects as reported by the Texas Department of Criminal Justice Executive Services. Madam Chairman thank you for your indulgence. I just wanted to be able to give Dr. Berenzweig an overview of our programs since he was new. That ends my report.	Dr. de la Garza-Grahm noted that she was just going to go back to the Hemoccult testing and colonoscopies. The Gastroenterology Society decided to recognize the first colonospy at the	

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VIII. Medical Director's Updates (Cont'd.)	Dr. de la Garza-Grahm thanked Dr. Linthicum and called on Dr. DeShields for her report.	age of 50. I see a savings there. Dr. Linthicum noted they have recently put out some new guidelines and we are going to review them The United States Public Health Service. We are looking at a lot of things now with the reduction of forces that we may be changing.	
- **Denise DeShields, M.D. (TTUHSC)**	Dr. DeShields noted that the report she was going to give was short and really just stems from a lot of what Dr. Linthicum has already said. Our clinical volume as you recall in the beginning of FY12 there was a marked reduction in the volume of patients being seen. Presumably related to the initiation of the offender health care services fee the $100.00 co-pay as it is called. Over the course of these first two quarters however, we've started to see these encounters start to ramp up which is essentially what we anticipated when we had introduced the $3.00 copay some years ago and we saw the very same kind of phenomena. After about six months the volume pretty much returned to its previous level. So again these encounter numbers are a little bit misleading in that we really were able to manage the patient volume in the beginning of this fiscal year because the volume was so low. However, with the reduction of 77 actual FTE's and a functional reduction of about 176 FTE's including our vacant and frozen positions. We are really starting to see that the clinical volume is quickly outpacing our personnel resources. One of the largest areas of reduction to ensure workforce numbers is in the nursing discipline and that is from a particular interest because nursing is the portal of entry for these offenders to access health care. Some of the issues that we've seen are of course really impact access to care and they've been reflected in some of the declining compliances that we're seeing in our program mandates. The other issue that I think can't be ignored at this point is the employees salaries has been stagnant for the last three years. And this has been very difficult for us to recruit and then retain our employees particularly in light of the fact that they are now doing more with less. They are overwhelmed, there is evidence of staff burnout,		

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VIII. Medical Director's Updates (Cont'd.)	dissatisfaction and this will lead to further attrition of our workforce. So in short I believe that the return of the volume of patients to our previous FY12 levels is really taxing and already overburden system. We are starting to really witness the real impact of our reduced appropriations. I think that we really were not see this as readily in our first quarter as we have in our second quarter and Owen I'm sure you have mirrored that issue in UTMB as well.	Dr. de la Garza-Grahm responded with I just don't see that changing, do ya'll see that changing? Dr. Linthicum responded with no. Dr. Owen asked the volume or the staff? Dr. de la Garza-Grahm said staff. Dr. Owen responded with again that is obviously that is a decision for the state. And I think that bringing what Dr. Linthicum just reported in terms in our own failure to meet some of our standards. I think to bring antidote that reflect not just a system issue but a public health concern. We've had two cases of Tuberculosis that spilled outside of the facility. In fact in both officers and our health care workers and they returned to their communities. I'll tell you 15 yrs ago when we first started we had the best CID program in the entire country. We didn't have these issues when TB was much more visible and much more of a concern given the troubles of HIV and now we have eroded that system to basically nothing. And we have CID nurses in title but because we have such limited staff that they get pulled to do day to day clinical duties. And so in some of our larger facilities we really don't have a CID program at all and so if the state feels comfortable with these things continuing to happen within their prison system	

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VIII. Medical Director's Updates (Cont'd.)		then we will not have any additional staff. If there is no dollars for trying to find competitive salaries and trying to find a place to at least to reward those folks who are currently doing the work in what are very adverse circumstances then we will see further erosion of our work force. And ultimately it really gets back to I think Dr. Linthicum commented on this much more clearly than I can. When you erode your facility resources that is the focal point that some federal court will come look at it. It won't be the isolated sub specialty care or this or that. It will be our day to day basis for those patients that have serious medical problems and certainly diagnosed medical and mental illness. Are you providing a fair and reasonable access to care and a fair and reasonable level quality of care and if our own documents state that we are not doing that, I would struggle to think how we are going to muster a defense at some point and time down the road in a federal court. And again I think that's just the reality the state has to look at and make a decision as to whether they want to head in that direction. Dr. de la Garza-Grahm commented that she wasn't sure that the state actually knows all these numbers we have discussed here today. Dr. Linthicum added that various legislative offices do. But we'll have an opportunity during the legislative session. Because Correctional Managed Health Care is an interim charge in Appropriations, Senate Finance and Corrections and House. Dr. de la Garza-Grahm asked wouldn't that be an opportunity for us to discuss. If they call the committee, they call Mr. Hightower and put the committee on the	

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VIII. Medical Director's Updates (Cont'd.)		agenda. And I'm sure they will since the Correctional Managed Health Care is an interim charge in all three committees and hopefully we'll have….. Mr. Hightower added that it's a difficult issue now for the committee, I'm not saying it's the right thing or the wrong thing to do but with TDCJ now negotiating the contract it's not that I'm not willing to go before those committees to testify as to those things but now if their asking TDCJ contract, budget to negotiate. Dr. Linthicum added but I think those committees are going to be looking at Correctional Managed Health as a whole and trying to sort thru what's going to be the best model for the state. So all of us will be at the table to give our opinion on that, I hope. Dr. Owen commented that I think that legislatures weren't everywhere when they made those reductions, we provided them a wealth of information, not that we want to be a carmat, but quite frankly everything that we laid out has materialized due to the reductions in staff, the inability to pay market rates and again we have been doing this long enough now to know exactly what you know that A leads to B and B leads to C. We made that very clear to the legislature and it's become their issue to act upon. Dr. Linthicum commented not only that most of these legislators, I mean the state was in the thirty plus years lawsuit with Ruiz class action. Mr. Hightower added that there's very few of us left. Dr. Linthicum added I mean it was historical and then they're still those left over there that know how much we paid in Ruiz and knew that	

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VIII. Medical Director's Updates (Cont'd.)	Dr. de la Garza asked if there were any questions for our medical directors.	the entire health care system was found unconstitutional and not only that we were left with 5 general orders and the consent degree. And the consent degree wasn't vacated until 2002 so we're not that far away from it. And Managed Health Care started in 1994 so we were still under a federal judge and under a consent degree from 1994 till we vacated that judgment in 2002. Mr. Hightower added that from our side Dr. David Smith from TTUHSC and Dr. Linthicum were the states expert witnesses from when we got relieved from the court order. I know Owen and Dr. Raimer had been in meetings with me and so have Tech people and Dr. L. We have explained this to the leadership and the House & Senate members. Further discussions were had between Mr. Hightower, Dr. de la Garza-Grahm, Dr. Owen, Dr. Linthicum and Dr. de la Garza-Grahm. Dr. de la Garza-Grahm added that there was one thing that she wanted to bring up from our last meeting that was suggested when you gave your presentation Owen on how to understand our acuity and we had discussed about bringing the medical directors together to try to come up with suggestions, I think on page 11. Dr. Murray responded with we have not got together on that because we're really working on the Hep C issue which is another unfunded kind of change in therapy and other issues. Both from an organizational operational stand point which is a challenge let alone how do we do it and manage with we are already running a deficit in the pharmacy strategy as is. Again you know Dr. Linthicum has us together and we will…	

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VIII. Medical Director's Updates (Cont'd.)		Dr. Linthicum added that she was glad that you mentioned that Owen because that was suppose to be part of my medical directors report to ask the chairman if she would allow the joint Hepatitis C working group to reconvene. That's a committee under the CMHC so that we can begin looking at the new recommendations for management of Hep C. What happens Dr. de la Garza-Grahm is that you say to us as medical directors to reconvene the membership and then we'll bring back recommendations back to the committee. Dr. de la Garza-Graham responded so be it. She asked where do you get your members from. Dr. Linthicum commented that each medical director appoints a committee members and we ask each university to appoint a specialist or sub specialist to serve with us. Like a GI they have a Hepatoligist, you ask if they can serve on the committee. Tech in the past has appointed an infectious disease consultant.	
IX. Public Comments	Dr. de la Garza-Grahm then stated that the next agenda item is where the Committee at each regular meeting provides an opportunity to receive public comments. Dr. de la Garza-Grahm noted that there was no such request at this time.		
X. Date / Location of Next Meeting **- Margarita de la Garza-Grahm, M.D.**	Dr. de la Garza-Grahm next noted that the next CMHC meeting will announced at a later date.		

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XI. Adjourn	Dr. de la Garza-Grahm asked if there were any other questions. Hearing none adjourned the meeting.		

for Dr. de la Garza-Grahm – Harold Kleinman, M.D.
Margarita de la Garza-Grahm, M.D., Chairperson
Correctional Managed Health Care Committee

10/24/12
Date: