CORRECTIONAL MANAGED HEALTH CARE COMMITTEE

March 18, 2013

Chairperson:	Margarita de la Garza-Grahm, M.D.
CMHCC Members Present: **CMHCC Members Absent:**	Cynthia Jumper, M.D., Lannette Linthicum, M.D., Harold Berenzweig, M.D., Ben G. Raimer, M.D., Kyle Janek, M.D.
Partner Agency Staff Present:	Denise DeShields, M.D., Jerry Hoover, Texas Tech University Health Sciences Center; Jerry McGinty, Bryan Collier, Rick Thaler, Robert Williams, M.D., George Crippen, Texas Department of Criminal Justice; Anthony Williams, Stephen Smock, Kelley Coates, Dr Owen Murray, Lauren Sheer, Stephanie Zepeda, Dr. Archer, UTMB; Allen Hightower, Stephanie Harris, Lynn Webb, CMHCC Staff.
Others Present:	Frank Calhoun, Richard Ponder with J & J; T. Colon, Kay Ghaxremani with HHSC; Alex Blum, UT Austin Student
Location:	7 West Building, 8610 Shoal Creek Boulevard, Conference Room 112, Austin, 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 9:00 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 **- Margarita de la Garza-Grahm**	Dr. de la Garza-Grahm thanked everyone for being in attendance. Dr. de la Garza-Grahm introduced Dr. Kyle Janek who was named by the Governor to serve as CMHCC's ex officio as a nonvoting member.		
III. Approval of Excused Absence **- Margarita de la Garza-Grahm**	There were no absences to approve from March 18, 2013 Meeting.		
IV. Approval of Consent Items **- Margarita de la Garza-Grahm**	Dr. de la Garza-Grahm stated next on the agenda is the approval of the Minutes from the meeting held on March 18, 2013: 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. Berenzweig moved to approve the minutes and consent items as found in Tab A of the board agenda. Dr. Jumper seconded the motion. The motion passed by unanimous vote.

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V. Executive Director's Report - **Allen Hightower**	Dr. de la Garza-Grahm then called on Mr. Hightower to provide the Executive Director's report. Member's things are moving fast and happening fast and we are under Sunset Review. And Sunset review is set for tomorrow afternoon at 1:30 or upon adjournment. If I have to leave early which hopefully I won't I must be at Representative Price's office at 1:00 who is the house sponsor of the Sunset Legislation. The appropriation bill has already been marked up in both the house and the senate. They both have to pass the respected houses and then go to conference. I would encourage if there is any interaction that you need to make with your house member or your senate member to post haste that connection needs to be made as soon as possible. Like I said both the house & senate are moving probably as fast as I have ever seen them move thru the legislative session. Dr. Janek in case you haven't had time to read our Sunset Bill, there is some extra work in there for the Health & Human Services that you might want to take a peek at before it is already passed and you are already given the duties. Madam Chairwoman I don't really want to get into the minutia while the legislature is in session of what might or may not happen. Let's just say that the house will have it's version of the sunset bill as it did the appropriation bill. The senate will have its version of both. Both bills will end up in conference and we'll know by the end of May and probably before the end of May what form the Sunset bill will finally take. I dare not predict what the appropriation bill will do because with as many issues and as many funding decisions that have to be made with health & human services and funding education and higher education. That may be the end of the session and it may take an additional day or two of a special session as they did last session. So with that I will answer questions if there are any.	Dr. de la Garza-Grahm commented the Sunset bill that we've seen battered around and the thing I worry about Mr. Hightower and I have discussed this before is the liability to the State of Texas. I think that we this committee with the physicians involved in this committee	

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V. Executive Director's Report (Cont'd)		service a cushion to liabilities to Texas where if this committee is abolished by Sunset, TDCJ will be making medical decisions and I find that a little bit disturbing but be that as it may that is what we are facing right now. Mr. Hightower added that right now the committee is not…. the Sunset's recommendation when Sunset came out with their first recommendation before the Sunset committee of house and senate members voted was to make this committee an advisory committee. Advisory to the Department of Criminal Justice Board. The house and senate members rejected that recommendation. In both the house and senate versions the committee stays as a separate agency. My meetings this afternoon at the capital deal with the issues you brought up what the committees concerns and I have talked with each party represented here at the meeting with what our concerns are with the arms length relationship with the medical professionals in the system not making recommendations but making medical decisions and the Department of Criminal Justice making security decisions and the other decisions. So both meetings that I am having this afternoon will go straight to the point of two or three places in the bill that someone else may find minor are still major to me after dealing my whole legislative career with Ruiz with the shalls and the mays be in the right place and the words recommendation as opposed to making decisions be in the right places. So that is what my meetings are about this afternoon.	
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. If you would flip to Tab C you will notice that actually December is in there and because of the legislative		

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VI. Performance and Financial Status Report (Cont'd)	session we are a month ahead of time getting numbers out there and somehow that got into Tab C and you should have a corrected insert beginning with September 2012 – November 2012 for the First Quarter of FY2013 that we will be going over at this point. As represented on (Table 2), the average daily offender population has decreased significantly to 149,336 for the First Quarter Fiscal Year 2013. Through this same quarter a year ago (FY 2012), the daily population was 153,350, a decrease of 4,014 or (2.62%). 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 significant rate as opposed to the overall offender population to 13,931 as of 1st Quarter FY 2013. This is an increase of 490 or about 3.7% from 13,441 as compared to this same first 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 first quarter of FY 2013 was 213 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 first quarter of FY 2013 was 4,603 for both the Texas Tech and UTMB Sectors. The overall HIV+ population has remained relatively stable throughout the last few years at 2,246 through 1st Quarter FY 2013 (or about 1.50% of the population served). The two mental health caseload measures have remained relatively stable: The average number of psychiatric inpatients within the system was 1,735 through the First Quarter of FY 2013.		

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	This inpatient caseload is limited by the number of available inpatient beds in the system. Through the First Quarter of FY 2013, the average number of mental health outpatient visits was 19,064 representing 12.8% of the service population. Health Care Costs (Table 3 breaks out the Three Healthcare Strategy's we track): Third Page Overall health costs through the First Quarter of FY 2013 totaled $122.9M. On a combined basis, this expense amount is more than overall revenues earned by the university providers by approximately $3.9M. UTMB's total revenue through the first quarter was $94.5M; expenditures totaled $99.3M, resulting in a net shortfall of $4.8M. Texas Tech's total revenue through the first quarter was $24.4M; expenditures totaled $23.6M, resulting in a net gain of $871K. Examining the healthcare costs in further detail on (Table 4 the next page) indicates that of the $122.9M in expenses reported through the First Quarter of FY 2013: Onsite services comprised $57.0M, or about 46.4% of expenses: Pharmacy services totaled $11.5M, about 9.4% of total expenses: Offsite services accounted for $40.9M or 33.3% of total expenses: Mental health services totaled $10.3M or 8.3% of the total costs: and Indirect support expenses accounted for $3.2M, about 2.6% of the total costs. Table 5 past 4a: shows that the total cost per offender per day for all health care services statewide through the First Quarter FY 2013, was $9.04, compared to $8.68 through the First Quarter of the FY 2012. This is an increase of 4.2% in costs year over year from the previous fiscal year. The average cost per offender per day for the last four fiscal years was $9.51. As a point of reference healthcare costs was $7.64 per day in FY03. This would equate to an 18.3% increase since FY03 or approximately 1.98% increase per year average, well below the national average.		

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VI. Performance and Financial Status Report (Cont'd)	Aging older offenders access the health care delivery system at a much higher acuity and frequency than younger offenders: Table 6 on the next page shows that encounter data through the 1st Quarter FY 2013 indicates that older offenders had a documented encounter with medical staff a little more than 1.2 times as often as younger offenders. Table 7 on the next page indicates that hospital and outpatient clinic costs received to date this Fiscal Year for older offenders averaged approximately $933 per offender vs. $166 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 more than 5.6 times higher than the younger offenders. While comprising only 9.3% of the overall service population, older offenders account for 36.7% of the hospitalization and outpatient clinic costs received to date. Also, per Table 8 on the next page, older offenders are represented 5.1 times more often in the dialysis population than younger offenders. Dialysis costs continue to be significant, averaging about $22.8K per patient per year. Providing dialysis treatment for an average of 208 patients through the First Quarter of FY 2013 cost $1.2M. Drug Costs, Table 9 on the next page shows that total drug costs through the 1st Quarter FY 2013 totaled $9.7M. Of this, $4.8M (or $1.6M per month) was for HIV medication costs, which was about 49.3% of the total drug cost. Psychiatric drugs costs were approximately $601K, or about 6.2% of overall drug costs. Hepatitis C drug costs were $339K and represented about 3.5% of the total drug cost.		

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VI. Performance and Financial Status Report (Cont'd)	Reporting of Reserves 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 no such reserves and reports an operating loss of $4.8M as reflected through the end of the 1st Quarter of Fiscal Year 2013. Texas Tech reports that they hold no such reserves and report a total operating gain of $871,336 through the 1st Quarter FY 2013. A summary analysis of the ending balances of revenue and payments through November 30th FY 2013, on (Table 10 on the next page) for all CMHCC accounts are included in this report. The summary indicates that the net unencumbered balance on all CMHCC accounts on November 30, 2012 is $101,617.11. This amount includes $79,991.45 which is the excess amount from FY 2012 that will lapse back to TDCJ Unit and Mental Health Strategy C.1.7 funding. 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 September 2012 through November 2012 found all tested transactions to be verified with appropriate backup documentation but with one classification error that was corrected the following month. The testing of detail transactions performed on UTMB's financial information for September 2012 through November 2012 found all tested transactions to be verified with appropriate 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.		

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VI. Performance and Financial Status Report (Cont'd)		Dr. Linthicum asked to go back to the Key Population Indicators Table 2, section on Mental Heath Inpatient Census. Mr. Webb how did you arrive at those numbers. The UTMB numbers include what components? Mr. Webb replied that UTMB & Texas Tech break out the 15 thousand... Dr. Linthicum added lets go to the UTMB component of psychiatric inpatient average, what components are you measuring? Mr. Webb responded it encompasses a report they send and… Dr. Linthicum added Skyview, Jester IV and what about Mt View the crises management beds. Ok, what about Texas Tech what components are there because these numbers look very low. We have two inpatient facilities in West Texas, Bill Clements & Montford so why are we down in the 700s? Mr. Webb responded that he knew that in the prior years we've been in the 20,000 overall I'm just saying it's… Dr. Linthicum corrected Mr. Webb and said 2,000. Mr. Webb continued again and said 20,000 overall and Dr. Linthicum again corrected Mr. Webb and said 2,000 overall not 20,000. Dr. Linthicum said that this is inpatient. Mr. Webb responded, oh your talking about inpatient. That has been relatively stable over the years. Dr. Linthicum noted I know but look at the numbers. Montford is an inpatient psychiatric facility who's capacity is over 500-550 and	

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VI. Performance and Financial Status Report (Cont'd)		then we have Bill Clements who's over 500, so why are down in the 7s and 6 for Texas Tech inpatient average. We need to check these numbers. Mr. Webb responded I will check but these numbers are what I have been reporting for almost 6 years. Dr. Linthicum noted yes I know but something is wrong. Dr. de la Garza asked so you're telling me that those hospitals are almost to full capacity. Dr. Linthicum answered absolutely we are doing hundreds of people in the constant direct observation because we don't have any inpatient beds. Mr. Webb responded I will give you the break out of the details. Like I said for the 6 years these numbers have been especially on the inpatient side pretty much stable. Dr. Linthicum added what I'm trying to say is that these numbers are not correct. If you look we're always at capacity at inpatient psych. We never have open beds. So something needs to be done, we need to go back and try to figure this out. Mr. Webb responded with I guess my question is 6 years ago we probably should have when I was first reporting. Dr. Linthicum noted that these are our inpatient facilities. We have Skyview, Jester IV, we have crises management beds at Mt. View for the females, and we have Montford & Bill Clements. And if you look at the total capacity of those units they are well above this number and that's what I'm saying and we stay full. So	

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VI. Performance and Financial Status Report (Cont'd)		I don't know what's happening. Dr. Raimer added that he shared Dr. Linthcum's concern that it looks like it's under reported to me just historically over the years. I hate for people to get the impression that our numbers are going down because it's not. Mr. Webb added the inpatient has been stable for years and years and I guess I'm kind of blind sided because I've been reporting these now for 6 years and this is the first time it's come up. Dr. Linthicum noted that we also report to the LLB the performance measures from our budget office and it's based on the capacity of these units. I just think that we need to get together and look at this and correct it if it's not right. Mr. Webb added actually the LBB sends out a report and I know that TDCJ does report these same numbers because they want to tie them into the strategies of the financial… Dr. Linthicum noted that we haven't taken any beds off our capacity in terms of mental health and these numbers are below what our census is running in those facilities. Dr. de la Garza-Grahm asked Mr. Webb when we come back on the next quarter would you please… Mr. Webb added that he would have a detailed break down. And I know that TDCJ has been very hesitate especially that these are reported quarterly to the LBB and if there is any significant changes they want to know why. If it's been reported this way for the last 6 yrs and there is any changes in reporting they want to know why because they look at consistency. But I will have that break out next time. Dr. de la Garza-Grahm also wanted in addition	

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VI. Performance and Financial Status Report (Cont'd)		to that information to also give the committee the numbers you have reported for the last three years. Mr. Webb so noted this additional request.	
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 have two critical vacancies, Chief Public Health Officer, which is a Physicians position that has changed from a full time to a part time position. We have made a management decision to place that position on hold. But currently we are filling that function with a Registered Nurse and a part time infectious disease specialist physician. And we continue to struggle and trying to recruit for a Director of the Office of Mental Health Monitoring & Liaison. The position is posted and has remained posted since Dr. Montrose who retired the end of May this past year. We haven't had much success in recruiting anyone at the current salary. The same applies for our Associate Psychologist position. There are recent openings of Grievance Investigators in the Office of Professional Standards. Those positions were vacated thru retirements. We have requested permission to post and have those positions filled. There is also another psychologist at the bachelors level who recently took a job on the unit at another division of TDCJ and we have requested permission to have that position filled as well. There is a LVN Nurse in the Office of Special Monitoring who recently took a newly created LVN position in the Office of Public Health. So for that position, the decision memorandum has been prepared, we have several applicants and they will be hiring for that as well. Our Staff Services Officer V is our office manager she recently retired this past month. We are also preparing paperwork to have that filled. There is a Patient Liaison Investigator in the Beto Unit up		

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VII. Medical Director's Updates **- Critical Vacancies**	in the Palestine area which will also be filled. That position has been posted and there are applicants. Dr. de la Garza-Grahm asked if there were any questions and then called on Dr. DeShields to present TTUHSC position vacancies.		
- **Denise DeShields, M.D. (TTUHSC)**	Dr. DeShields began with Texas Tech again we continuing to struggle with the PAMIO Medical Director in the Amarillo Clements. That position which has been vacant for four years. It is currently being covered with a contract physician. We continue to advertise in both again in local & national publications. We utilize recruiting agencies. We've canvassed psychiatric programs. And we have even resorted to some cold calls. We did interview an applicant interview for that position 4 months ago and unfortunately they declined and fortunately we do have another applicant to interview at the end of this month, so we will keep our fingers crossed.		
VII. Medical Director's Updates **- Critical Vacancies**	Staff Psychiatrists we were 2 down at the Montford Facility and just at the end of the first quarter we were able to hire one. We still have one remaining that we are currently recruiting for.		
	And lastly the Medical Director position at the Smith Unit which has been vacated for about 8 months or so and we are currently again utilizing the same avenues of advertisement to recruit a medical director to that facility.	Dr. Raimer asked Dr. DeShields how much of your recruitment problems are related to salary structures. Dr. DeShields responded that probably heavly weighed. I mean we know of a position that has been open for 4 solid years and even with increase in salary that we have been able to do within the confines of our budget. It's just not high enough to recruit psychiatrists particularly in this supply and demand market that we're seeing nationally. Dr. de la Garza-Grahm asked what's the number that we are offering. Dr. DeShields answered for that position $208,000.	

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VII. Medical Director's Updates - Critical Vacancies		Dr. Linthicum added the same for my Ph. D Psychologist positions that have been vacant since May. No one is interested due to it's salary which is around $98,000. Dr. de la Garza-Grahm added and you have West Texas. Dr. Raimer asked Dr. Deshields you would say probably at what range would the salary need to be to attract? Dr. DeShields responded again I could say $225,000 to $250,000 would be a reasonable salary but I don't know again there is such a shortage of psychiatrists and they are commanding so much higher salaries, $300,000, $350,000 or $400,000. I don't know that we would be able to attract someone. Dr. de la Garza-Grahm asked how much are we spending on locums and contract per year, do we know that number? Dr. Deshields responded that we have that number. Again, the vast majority of times, using contract agency help is generally about twice the amount for a full time FTE. Dr. de la Garza-Grahm added that it just doesn't make any sense to me to use that amount of money when we could increase the salary to fill that position. That just doesn't make any sense. What do we need to do to do that. The money is somewhere we got to pay the contract guys, we got to pay the locum tenens, the money is there already. Mr. Hightower added he couldn't give the answer to that. I mean there is money left over at the end of the year. Dr. Deshields responded correct there is money	

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VII. Medical Director's Updates - Critical Vacancies		left at the end of the year was from lapse salaries. We RIF a certain number of people, we then we had an additional 41 people walking off their job, retirement, resignation so again you don't have that money until the 4th quarter. Further discussion on how to raise salaries for these positions were had between Dr. de la Garza-Graham, Dr. Deshields, Dr. Linthicum, Dr. Raimer & Dr. Jumper.	
- **Owen Murray, D.O. (UTMB)**	Dr. de la Garza-Grahm then called upon Dr. Murray to present UTMB's vacancies. Dr. Murray began that their most recent challenge actually rest with Nurse Managers. As you know in our last reduction in force we use to have a nurse manager on every facility. We had 85 facilities and 85 nurse managers and actually when you look at the inpatient environment we had some additional staff coverage over that. We are now down to about 53 total nurse managers throughout the entire system, which creates a situation where we have a nurse manager covering multiple facilities. We've just had in the last quarter we've had four of those nurse managers resign putting us over 10 for the entire vacancy in that particular position. The disturbing piece about it and I think that it speaks for an alarming trend was these were not new hires these were people that had been in the system for a lot of years and the reason they left that they clearly stated on their HR exit interview was salary. They were getting paid anywhere from 18 to 25% more out in the free world facilities and could no longer justify the salary difference between what we were asking for them to do certainly in a less than an ideal circumstances and what they could find in the free world. So again you know certainly that Dr. Deshields, Dr. Linthicum and myself have been out discussing the need for these salary adjustments and I know that we have certainly have gotten some movement in the right direction but I really do think this particular area when		

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VIII. Medical Director's Updates	you start losing your 10 yr. people specifically for salary and that you know that long term retirement does not play into the decision making process anymore you really are at your critical juncture. I think that we're at that right now four years of no salary. Address has left us in a significant hull and I really do think that if there is not what we've recommended which was actually conservative adjustments to salary. I think if we don't go back to our employees with something reasonable, we're going to see this trend to continue and I think our use of secondary labor is going to go up and the problem with secondary labor it really is only a fine act benefit. Number one they're not as functional on the facility and number two we've got so many places you can't find secondary labor. So, I know again I know we have talked and talked and talked about this and have looked at some of the metrics that Dr. Linthicum reports and it all relates back to us having staff. And if we don't have staff, we don't have a system and I really do feel that in these next 60 to 90 days a real decision is going to be made about the future of our staffing at these facilities.	Mr. Hightower added one thing we haven't talked about and I know you have heard me say in public testimony in the last couple of weeks before the legislature, it's not just a matter of venue, it's not just the matter of the dollars. There is also that component, even if we get close to putting that magic average number is, we're still asking people to work in correctional institutions. Now I made the comment several weeks ago Madam Chairman, to the appropriation committee or legislature. My wife is a school teacher and if she had the opportunity to make more at HISD or go out to Windham School District for less and work in a prison environment, my advice to her would be not to go into a prison environment. The fact that it's a prison environment is one honest, my honest appraisal of some of the reason why if we cannot meet the basic financial of the free world how do we expect to be able to attract and retain people in a correctional institution. It's very difficult. That's one intangible that I don't like to leave out when we get the big picture, that they are not the safest places to in the world. TDCJ does the very best they can and they have very good qualified people but they're patients and they're patients to their doctors in both	

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VIII. Medical Director's Updates (Cont'd.)		sectors. I've been to enough units, I've been to Hospital Galveston to know the inmates are they're patients and that's the way that they are treated. It's still a part of the equation that I don't want to leave out if we are globally going to look at what our problem is attraction and retention. It's not just dollars, it's some people just don't want to function or can't function in a prison environment. It takes a special person. Dr. Raimer also added that it's an issue that I know Owen has asked this is asking people to work overtime, but they are just burned out also. Overtime sometimes is good, because you earn more money and they like to do that but it gets really old. So getting that balance back up to have enough people to staff is real critical. One of the issues facing the legislature is to ask for money to make salary adjustment and to restore staff that Dr. Linthicum knows needs to be there. Senate has taken certainly a very good stand on that. I really appreciate the work that TDCJ has done on making that a priority item and they have been incredible supportive of that this year. So that message is out there and we just need to underscore it. Certainly Madam Chairman a call from you to key committees would be very helpful to let them know that that's a priority. Dr. de la Garza-Grahm responded that she could do that.	

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VIII. Medical Director's Updates (Cont'd.) **-Lannette Linthicum, M.D. (TDCJ)** **- Operational Review Audit**	Dr. de la Garza-Grahm asked if there were any other comments and then called on Dr. Linthicum for the TDCJ Health Services Medical Directors' Review. Dr. Linthicum responded with yes and if you would turn to Tab E. My report will focus on the 1st Qtr monitoring of FY2013 for the months of September, October, and November, 2012. During that quarter there were 11 Operational Review Audits conducted at the units listed on the first bullet. The items most frequently below 80 percent compliance conducted during the 1st Quarter FY2013 are as follows. Item 6.040 offenders receiving anti-tuberculosis medication at the facility have a Tuberculosis Patient Monitoring Record completed. Ten of the eleven facilities were not in compliance with this requirement. The next area requires documentation that three Hemoccult cards were collected from offenders 40 years of age or greater, or that they refused the screening test, within 60 days of their annual date of incarceration. Nine of the eleven facilities were not in compliance with this requirement. The next item requires offenders with a positive tuberculin skin test be evaluated for active disease or the need for chemoprophylaxis by a physician or mid-level practitioner before initiation of medication. Nine of the eleven facilities were not in compliance with this requirement. 6.350 requires all Hepatitis C Virus infected patients with AST Platelet Ratio Index score greater than 0.42 or with abnormal liver function (Prothrombin Time, Total Bilirubin, or Albumin) that do not have a documented contraindication for antiviral therapy be referred to the designated physician, clinic, or be appropriately treated according to Correctional Managed Heal Care Hepatitis C Evaluation and Treatment Pathway. Eight of the eleven facilities were not in compliance with this requirement. Next 6.360 requires the provider to document the reason if treatment for Hepatitis C Virus is determined to not be indicated for offenders with chronic Hepatitis C Virus infection. Eight of the eleven facilities were not in compliance with this requirement. The next item requires the pneumococcal vaccine be offered to offenders with certain chromic diseases and		

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VIII. Medical Director's Updates (Cont'd.)	conditions, and all offenders 65 years of age or older. Eight of the eleven facilities were not in compliance with this requirement. Item 1.100 requires interpreter services to be arranged and documented in the medical records for monolingual Spanish-speaking offenders. Seven of the eleven facilities were not in compliance with this requirement. The next item requires offender with diagnoses documented in the medical record that qualify for a special diet included on the Master diet List. Seven of the eleven facilities were not in compliance with this requirement. Item 5.210 requires an annual physical exam for offenders 50 years of age or greater to be documented in the medical record within 30 days of their annual date of incarceration. Seven of the eleven facilities were not in compliance with this requirement. Item 6.010 is especially important to us which requires screening for tuberculosis performed offenders annually at the facility. Seven of the eleven facilities were not in compliance with this requirement. The next item requires Texas Department of State Health Services Tuberculosis Elimination Division (TB-400) form must be completed for offenders receiving Tuberculosis chemoprophylaxis, all TD suspect cases, active TB cases, and upon termination or completion of TB therapy. Seven of the eleven facilities were not in compliance with this requirement. The next item requires seasonal influenza vaccine offered annually to offenders. Seven of eleven facilities were not in compliance with this requirement. The last item related to the follow-up serologies for the tested positive of Syphilis. Seven of the eleven facilities were not in compliance. The Operational Review Audit is a compliance audit that is done at units on a schedule of every two years. We try to alternate that with the time that the American Correctional Accreditation Association is actually on sight for accreditation determination. So most units don't go longer than eighteen months without an on sight audit. I think some of the areas of non compliance that we are seeing here just to emphasis with Dr. Murray and Dr. DeShields just spoke about is the lack of staff on the units. Particularly the		

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VIII. Medical Director's Updates (Cont'd.)	our nursing staff we've taken huge reduction in forces over the last two physical years in nursing staff. The correction medicine model is a nursing model. Nurses are our first responders. Many of these functions that where we have seven out of eleven facilities out of compliance. These are functions that nurses do day in and day out. If you don't have the public health nurses or what we call the coordinators of infectious diseases to do these functions and then these things slip. And as you know tuberculosis offenders in general are communicable in infectious diseases and are just proportionally represented in that population particularly unified tuberculosis, HIV, etc. Being in an institutional setting this TB issue can quickly get out of hand. We have already had the United States Center for Diseases Control and Prevention come in a couple of months ago. There was this special TB dna genotype that was found only here in Texas and nowhere else in the world. In some of the county jails here and in TDCJ. So the CDC came down and made some major recommendations to DISHES and they are in the process of trying to implement some of these things. But this I think highlights the concern we have as medical directors who are responsible for the day to day operations in terms of the health services delivery of the ominous sign of where we are with our staffing. If we can't get our staffing levels up and we can't provide services and then they start to deteriorate. This is an example of what is happening.		
- Capital Assets Monitoring	Dr. Linthicum continued that on page 96. The Capital Assets Monitoring I am pleased to announce audited 11 units and all 11 units were within the required compliance range.		
- Urgent Care Audit Dental	We also have a dentist that is involved in conducting the Dental audits. During the 1st Qtr audits they were conducted at five facilities. The items most frequently below 80 percent again were again a nursing function. Where there are chain-in intra-system offender transfers are reviewed by the facility dental department within seven days of arrival. The reason I say that this is a nursing function is the chain-in is a nursing function. If there are dental issues the nurses are expected to refer that over to the dental department. The dental department is not doing the		

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VIII. Medical Director's Updates (Cont'd.)	chain-in and in order for the dental department to know that they need to do things we need the nurses to do the chain-in.		
- Grievances and Patient Liaison	Dr. Linthicum continued with her report on the top of page 97 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 first quarter of FY2013, the Patient Liaison Program and the Step II grievance Program together received 3,708 correspondences. The Patient Liaison Program received 1,808 correspondences and Step II Grievance program received 1,900 grievances. As a result of us investigating there were 698 Corrective Action Requests generated. UTMB and Texas Tech combined had a sustained percentage of offender grievances that was at 11%. Performance for UTMB separate their percentage was 12% and Texas Tech was 8%.		
- Quality Improvement (QI) Access to Care Audits	Next is the Quality Improvement Access to Care Audits, are what we call the Sick Call Request Verification Audits. These are audits that are done to ensure Access to Care in the Correctional Managed Health Care Statue 501.150. The department has to insure access to care. The audits are done by nurses and patient liaison investigators and the office of professional standards that go out on the units and verify sick call requests and make sure they are seen. A random sample of Sick Call Requests was also audited by the Office of Professional Standards staff. A total of 375 indicators were reviewed at 44 facilities and 19 of the indicators fell below the 80 percent. We are so focused on ensuring access to care because it's a constitutional requirement that I think we do that at the exclusion of everything else, so our preventive medicine services and		

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VIII. Medical Director's Updates (Cont'd.)	chronic care services are deteriorating but that access to care is there because that's where we're focusing all of our resources.		
- Office of Public Health	The Office of Public Health monitors cases of infectious diseases in newly incarcerated offenders as well as new cases that occur in the offenders within TDCJ. And the data is reported by the facilities for 11 infectious diseases and they are all listed there on page 97. The ones that we know when they report on at this meeting are Hepatitis C 740 cases were identified in the first quarter compared to 802 identified during the fourth quarter FY2012. Of course you know we have mandatory testing for HIV at intake. 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. There are two categories of offenders do not require pre-release testing: those already known to be HIV positive and those whose intake test were drawn within 6 months of an offender's release date. HIV during the first quarter there were 18,069 offenders intake testing, and 123 are newly identified as having HIV infections. And the fourth quarter FY2012 there were 18,359 offenders had intake test, and 148 were HIV positive. During first quarter FY2013 Another 12,385 offenders had pre-release tests, which is also statutory and three were HIV positive compared to seven a year ago. We had 230 cases of suspected Syphilis were reported during the first quarter, 186 Methicillin-Resistant Staphylococcus Aureus cases, and 21 active Tuberculosis cases compared to 19 during the fourth quarter of FY2012. Also we have in the Office of Public Health a SANE Registered Nurse (Sexual Assault Nurse Examiner). Although the SANE Coordinator does not teach the SANE Curriculum because of restrictions imposed by the State Attorney General's Office, this person provides in-service training to facility providers and staff in the performance of medical examination, evidence collection and documentation, and the use of sexual assault kits. During the first quarter FY2013, in-service was conducted on 12 units with a total of 171 participants. There were 224 charts		

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VIII. Medical Director's Updates (Cont'd.)	reviewed of alleged sexual assaults performed for the first quarter FY2013. There were no deficiencies found. There were 51 blood borne exposure baseline labs drawn on exposed victims and no seroconversions as a result of sexual assault for this quarter. Also during this quarter the Gurney Unit received a three day training which included the Wall Talk Train. The Peer Education program I am pleased to report that 100 of the 111 facilities in TDCJ now have active peer education programs. That is a real achievement.		
- Mortality and Morbidity	The Joint Mortality and Morbidity Committee during the first quarter FY2013 reviewed 107 deaths and of those 9 were referred to per review committees as you can see at the chart at the bottom of page 98 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. The Texas Department of Mental Health Mental Retardation CARE database during the first quarter FY2013 21 Ad Seg facilities were reviewed for 4,422 offenders who were received into Intermediate Sanction Facilities. Of that number 2,199 of them were interviewed and 7 offenders were referred to the university providers for further evaluation. Access to Care 4 met 98 percent compliance for the 21 facilities. Access to Care 5 met 98 percent compliance for the 21 facilities that received Sick Call Requests from offenders in Ad Seg. All 21 facilities were 99 percent compliant for Access to Care 6. Four inpatient mental health facilities: Clements, Jester IV, Montford, and Skyview were audited to ensure that ll incidents of compelled psychoactive medication documented on the Security Use of Force Log. All facilities were 100 percent compliant. The 24 intake facilities were audited to ensure offenders entering TDCJ with potential mental health needs received a mental health evaluation within 14 days of identification.		

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VIII. Medical Director's Updates (Cont'd.)	17 facilities met or exceeded the 80 percent compliance for completing mental health evaluations within 14 days. There were 6 facilities that did not meet 80 percent compliance. Corrective action plans were requested from these 6 units and have been received. The Office of Mental Health Services Monitoring & Liaison we review the mental health records of all pregnant offenders being considered for the Baby and Mother Bonding Initiative (BAMBI) to determine if they are any mental health issues that precludes participation. In the first quarter FY2013, 3 offenders were reviewed and 3 of them were allowed to participate in the BAMBI program.		
- **Office of Health Services Liaison**	The Office of Health Services Liaison office which is an office of register nurses. They are responsible for intake entities for TDCJ from all county jails, all offenders with special medical needs. In addition to doing that they do auditing and monitoring of offenders discharged from hospitals and infirmaries in the TTUHSC and UTMB sectors. In the first quarter FY2013 they conducted 151 hospitals and 58 infirmary discharge audits. Of the 151 hospital discharge audits conducted, 134 were from the UTMB sector and 17 were from the TTUHSC sector. There were 25 deficiencies identified for UTMB and 30 identified for TTUHSC. There were 7 deficiencies identified from UTMB and 5 for TTUHSC.		
- **Accreditation**	The American Correctional Association awarded ACA Re-Accreditation: Havins, Boyd, Hamilton, Pack, Powledge, Tulia and Neal.		
- **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. There were 30 Correctional Institutions Div. active monthly research projects, 7 Correctional Institutions Div. monthly research projects, 2 Health Services Div. Active monthly medical research projects and 8 Health Services Div. Pending medical research projects. Madam Chairman that ends my report.		

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VIII. Medical Director's Updates (Cont'd.) - **Dr. Stephanie Zepeda** - **Hepatitis C Policy**	Dr. de la Garza-Grahm thanked Dr. Linthicum and introduced Dr. Stephanie Zepeda who is the Director of the Pharmacy in Huntsville and I had the privilege of actually visiting the pharmacy to see how it ran, how medications are packaged and I do have to say that is one of the most efficient places that I have been to I must say. Thank you. Good Morning Madam Chairman and members. Thank you for giving me the opportunity to come and speak with you today. I was actually asked to attend the meeting to present some changes to the health systems Hepatitis C Policy and Program and ask the committee to formally adopt the changes due to the financial impact that this policy has. So today I'm going to briefly review the rationale for the policy and it's changes, summarize the important changes, talk a little bit of the cost impact that's expected & then what we think we need to do in terms of implementation. There was a special workgroup that was appointed. We had membership from TDCJ, Texas Tech & UTMB. We had two individuals who were to be considered specialist, a virologist as well as a hepatologist from UTMB & Texas Tech. The policy was actually taken to the Joint Infection Control Committee and approved by the committee and complimentary disease management guideline was approved by the Joint Pharmacy & Therapeutics last week. Just briefly why do we want to treat Hepatitis C? Hep C is a significant healthcare problem in the US as well as in corrections. Recent data shows that in prisons and in state jails 1 out of 3 offenders have Hep C. In terms of TDCJ data dated back to 2001 shows incidents as high as 29.7 % for males and 48.6% for females. So roughly 57% patients known to have HCV in prison are baby boomers. So again we do see Hep C more commonly in prison. Also, while they are in prison we have the opportunity identify and treat these patients and keep from the spreading of this infectious disease. It also represents a significant burden on healthcare system in terms of economics. There is a recent study that has shown that costs are expected to		

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VIII. Medical Director's Updates (Cont'd.)	double in the next 20 years and the death rate is expected to triple in the next 20 years. If you look at the chart with TDCJ's budget back in 2012 representing nearly 6.2% of TDCJ's total budget. This fiscal year we are tracking about 3.4% of the total track budget. So that is a recent decline that Mr. Webb recently reported. It is thought that if we identify these patients that we increase our screening that we may prevent the delayed progression of in stage liver disease which is more costly to treat. Historically combination therapy with Peginterferon and Ribavirin has been a standard of treatment. In May 2011, the FDA approved some more new drugs, first drugs of their class were approved. They are called Protease inhibitors. So now those patients that have the genotype 1 chronic Hep C can be treated with those three agents. The cure rates have gone to about to 40 % to as high as 75% in treatment of naive patients and as low as 59% in treatment in experienced patients so it is a significant increase in number of patients who responded therapy. However, these new agents are difficult to administer. They are given every 8 hours which is a challenge in a correctional health care setting and they are associated with a significant number of drug interactions. And they are also susceptible for resistant of patients who aren't compliant. So there are complex regiments to administer. Because of these new drug approvals the national guidelines were changed. The CDC also recently recommended some new screening criteria that was incorporated into the policy. And more importantly in the next two to three years there will be newer & better therapies available as well. Perhaps or less complex to administer. The policy changes were rewritten into three separate policies. We split them out for Hep A, B and C to facilitate future revisions. There was some additional screening criteria added to the policy, screen for those that are baby boomers, those with elevated liver enzymes and those that have received hemodialysis. So this new policy may mean the identification of more patients to treat than we have historically. There is also some additional testing required		

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VIII. Medical Director's Updates (Cont'd.)	in the policy. Visual acuity for all patients and funduscopic examinations for high risk patients (hypertension, diabetes, history of ophthalmologic disorder), chest x-rays and EKG for high risk patients. There is additional housing criteria for patients receiving standard dual therapy to be housed for 12 hours and triple therapy housed at units open 24 hours. Again because of the every 8 hour treatment to be given. Ultrasound is now recommended for screening hepatocellular carcinoma for those that are cirrhotic. Treatment isn't generally recommended if time left in systems is insufficient to complete workup and treatment, patient is actively participating in high risk behaviors known to be related to the spread of chronic Hep C. Those who are poorly compliant to pre-treatment follow ups, clinical appointments and laboratory draws, and those that have not previously responded to treatment at all. Again, the policy is emphasizing because these new therapies are coming out and because the likely hood of progression of cirrhosis is low and early stages of chronic Hep C. It may be prudent to wait until these newer therapies come out to see if they are better tolerated. If they are not treated, policy recommends patients should be followed in chronic care clinic and periodically reevaluated. Those that would be offered treatment would be those that have a marker of at least 2 fibrosis or higher, none to have cirrhosis, or these other markers greater than 0.42 or someone that doesn't contraindications to treatment. The old regiment the dual therapy with Peginterferon and Ribavirin would be offered for patients that have genotypes 2 or 3 or contraindications to the new therapies. Those that are co-infected with HIV and other genotypes like 4, 5 & 6 because the data isn't there to actually use agents in those patients. Triple therapy would be offered for those with genotype 1 patients which is a majority of our patients which is about 70%. In terms of cost impact, I'm going to base this data on historical numbers prior to this past fiscal year because we had an unusual decrease in treatment for a couple of different reasons. So this projection is based on the		

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VIII. Medical Director's Updates (Cont'd.)	assumption we are treating what we normally treated which is about 400 patients. About 35% are treated by Texas Tech and 65% are treated by UTMB. And approximately 50% of those with genotype 1 can be treated for 6 months instead of 12 months which is one of the advantages of the new agents. So basically the incremental annual increase in cost depending on the agent that we use would be anywhere from 5.4 to 10.7 million dollars just for drug therapy. For the UTMB sector we tried to project what the increase lab monitoring might cost for this patient is estimated upwards of $100,000 additional lab monitoring. For ultrasounds for those that we currently know have cirrhosis that would be another $34,000 a year. In terms of funduscopic exams for our high risk patients and probably another $14,000 a year and there is some other cost that we really can't measure yet and I will elaborate on this in just a little bit. In terms of implementation we are asking the committee to adopt this policy. Like I said with the caveat there are some questions to be answered like which is the best practice to deliver this medication, staff training, implementation, and estimation of other costs. For example the increased screening for the baby boomers that may lead to increase in patients eligible for treatment. These drugs are very complex and we need a case management program to monitor patients to ensure critical laboratories are drawn in a timely manner and to ensure continuum of care. Also these drugs have utility rules so that the viral load is detectable at certain points at therapy. Drug therapy is futal and the drugs should be discontinued. We don't want to mess up these critical time periods and continue these therapies unnecessarily because we are going from $8,000 a year per patient to $40,000 - $60,000 a year per patient depending on which drug because there are two available. We also aren't sure which agent we should be using we might take the next several months to work with our industry partners to see if we can get a more advantages price for those two agents so that is something else we need to do to see if can work on that price tag. Also if you think that these patients should be at centers of excellence. So do		

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VIII. Medical Director's Updates (Cont'd.)	we need additional staff resources at those units to take care of these patients, I'm not sure. And again I think we need to work to take at look at that further. So, instead of having them all over the state because they have critical lab draws that need to be done because resistance develops so quickly the drugs aren't given correctly, because there is critical time points that if they are not responding we can stop therapy, reduce the risk of unnecessary adverse affects. I think we need to have these patients at centers of excellence where those providers, those nursing staff actually are knowledgeable of the treatment of Hep C drug interaction if you watch these patients closely and I don't think they should be treated all over the state. And lastly we envision that this could be started as a pilot and as early as September where we would have one in the Texas Tech Sector and we would have four pilots in the UTMB Sector: so one male and 1 female State Jail; one male and one female State Prison. Again to gain some more experience to determine what's our best practice, our best delivery model and to give the two universities a little more time to try to identify some of the additional cost other than the drugs that will be associated to this treatment change. I will be happy to answer any questions.	Dr. Berenzweig commented that he was strongly in favor for doing this I mean this is standard of care for treatment of patients, genotype 1 triple therapy. And my concern is not the direct cost I mean that's a concern. My concern revolves around the ability for the system to be able to administer in a safe and effective way that doesn't in fact harm the environment by creating a population that has drug resistance. I have voiced concerns before about the short comings of the system and Dr. Linthicum summarized the concerns of all the physicians have had at this table regarding the labor gaps and what has been assured to be paperwork problems as opposed to the delivery of medic problems. As outlined there are a lot of complexities for this to be done properly including making sure viral loads are	

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VIII. Medical Director's Updates (Cont'd.)		measured and acted upon whether your successful in shortening the duration of treatment or whether you realize that it has to continue delivery of medicine in acute rates. All these things are serious concerns in the population is larger than the population for example TB. So I thing that the committee should adopt this recommend this but I think it should be tied in some fashion to ask the legislature to fund this properly and salaries are adjusted properly otherwise this ends up being a futile and maybe even harmful to the society or perhaps being beneficial to the individual inmates. Dr. Zepeda stated I definitely agree it needs to be administered in the context of a center of excellence and not statewide. Dr. Berenzweig I don't disagree. I'm just saying the direct cost are just part of what the cost are going to be. Because I agree it should be at a center of excellence and we need to make sure the patients are monitored and we need to make sure it's safe for them and that it's effective treatment. Dr. Raimer asked Dr. Zepeda have you been able to do this with HIV patients have you not as far as center of excellence. Dr. Zepeda responded, yes sir. Dr. Raimer continued to ask To effectively put that in to assure that people stay on medication and your not building up drug resistance, etc. Do you have some experience with that, I mean this to be a positive question here Stephanie, that you do know how to do that. I think it's important that people understand that and that this is not your first rodeo. Dr. Murray responded with no the Stiles facility	

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VIII. Medical Director's Updates (Cont'd.)		was set up with that intention and much to your point we started out with a different paradign in that building and recognized we couldn't have 1,600 HIV patients at that facility and do that therapy well. At this was back in time when we had significantly more staff so and the complexity of the disease was not as what we are looking at here and we all share your concerns and certainly starting slow and if you look at what other states have done. They all have done this in a very very methodical way and we will have to look at that. And we have to ask where do we get the additional staff and that will be a struggle. Which we have asked for additional staff in our appropriations request but before we get staff we need to fix salaries first or we'll just have more vacancies. Dr. Linthicum added that we have been working on this under the umbrella of the committee the Joint Hepatitis C Working Group. Each one of us made our appointments and have been working on this for awhile. When you look at the whole field of corrections medicine Texas we are behind the eight ball on this. Most states are far ahead of us by a year or more in terms of their treatment, guidelines and they are actually treating patients. We need to move forward and we need to be ready by September 1st to do these pilots on male and female units and to get going on this. Because we're putting ourselves in what I think is not a good medical legal defensible position if we don't move forward. Sooner or later we are going to be legally challenged because that is just inevitable. We have had wonderful expertise on our committee in terms of representations. We've had gastroenterologists, infectious disease physicians and for me let me just say as the TDCJ Medical Director that is what I appreciate most about this committee that we are able to tap into the medical expertise that the universities are able to provide us thru this	

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VIII. Medical Director's Updates (Cont'd.)		strategic partnership. It's really been a life saver to be able to tap into the subspecialist, the hepatologist and infectious disease people and to prolugate policies in the State of Texas in the corrections that is superior to anything and stands up in federal courts. We've been challenged before with both our HIV and Hep C polices in the past and it's really been this umbrella of the committee and the expertise that comes into the strategic partnership with these universities that has saved the state. So we want to move forward with this. So Madam Chair today we're asking for the committee to consider adopting the changes that have been presented with all the caveats we're still going to have all the working groups to work out the implementation of the day to day mechanics of how we do this, how we assign the offenders to the appropriate units where we do the pilots. Again we don't want this all over the place we're going to have to do special training with the health care staff, correctional staff, security, wardens, everybody because the way these medicines have to be dosed the offenders have to be right there. These offenders have to be turned out on time and be on schedule. There is still a lot of work to be done but a lot of progress has been made in terms of getting to this point. Dr. Deshields added that Owen's point is well taken as well as Dr. Linthicum, that this is community standard of care. However, we do have the caveats with our vacancies and we're asking primary care providers in a lot of these situations to deal with very complex regiments. And as Dr. Linthicum pointed out there are still some issues with implementation and some litigating circumstance within our system that speak to the nuances of corrections with regard to involving food service, many of these medications have to be administered with meals,	

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VIII. Medical Director's Updates (Cont'd.)		some with fatty meals and making sure that we put medical hold on patients so they don't get moved out of those units or go to the hospital and miss their 24 hrs. of dosing. So there are a lot of things we still have to consider and of course on top of that funding to manage this because there is a lot of cost that are at this point unrealized. Dr. Jumper asked so how do we go about approving a policy that has no funding attached to it. Because this is not included in Texas Tech's LAR. This has been in progress and I think we are at the bare minimum we can be. We're how many out of compliance things that we have already been thru. And I don't know how we can approve a policy that has no funding attached to it, because if we make it policy we're going to be responsible for it. And we're going to be just as medically liable if we don't approve it than if we approve it and have no funding and can't provide it. And then we'll have the rest of the problem of having resistant strains that are partially treated and inappropriately treated. So I have that out for the committee that's going to have to vote on how do we going to approve a policy that standard of care for those that have funding not the 28% of Texans that have no funding this will not be a standard of care. So how do we go about approving a policy that we can't comply with at the moment. Dr. de la Garza-Grahm added that she was sitting here just dumbfounded because we can't even get nurse staffing we're down 20%. We cannot get physicians and now we're being asked to approve a policy which I think we absolutely have to do. How do we do it if we don't have the funding for it. Dr. Linthicum responded that this committee has	

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VIII. Medical Director's Updates (Cont'd.)		been in place almost 20 years and I guess I have been on it almost the entire time and we have faced the same struggles over the years as the standard of care changed when the first time the National Institute of Health promulgated the guideline for the management of Hep C. When we had dual therapy with ribavirin and peginterferon and had no funding for that and we've functioned the way we always functioned as physicians. We do the right thing by our patients We practice medicine consistent with the public safety and welfare and if there is a national guideline that sets the standard of care that's what we do. And we sort of and correct me if I am wrong Dr. Raimer, we've done the right by our patients as we run deficits in our funding and we've gone back to the legislature and ask for supplemental appropriations. We have to as physicians do the right thing. Our care cannot be budget driven. I've stood in front of enough federal judges in my career of 27 years and I'm here to tell you that budget fiscal issues is not a defense with a federal judge. We have to do the right thing. And it's not a defense at the medical board when the offenders file a complaint on me or Dr. Murray, I can't go to the Executive Director of the Medical Board and say well I'm not treating your diabetes and hypertension because we have fiscal issues. Well they are going to yank my license. I still have an ethical obligation to practice medicine in this state consistent with the public safety and welfare and so I think we go forward with a policy that meets the standard of care and we continue to do our work with the elected officials and talk about our budgetary needs. Which Dr. Murray & I are in Austin every single week talking to who ever will talk to us. On the Senate Finance side, on the House Appropriations side on the House Corrections and Senate Criminal Justice side and we will continue to do that. Our Chief	

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VIII. Medical Director's Updates (Cont'd.)		Financial Officer, Mr. Jerry McGinty is here and he's hearing some of our fiscal issues and working with us with the LBB or whoever else. We just got approval to go beyond something. So people understand the plight that we have but we certainly can't take the stance that we are going to practice substandard medicine We are going to practice medicine in a fashion that we as licensed health care providers in the state will be unacceptable to our professional licensing boards we cannot take that position, I will not take that position. I won't practice medicine that way. I think people understand what we are facing in terms of these fiscal issues and we have to keep talking all of us have to keep talking who ever we can talk to have a united front that this is what we must do to practice medicine in a way that is acceptable not only in the state but in the country.	
	Dr. de la Garza-Grahm asked if there were any comments.	Dr. Jumper added that she has no plans to practice substandard medicine and that's not her goal she would just still like to know. Dr. Raimer you brought up what kind of trouble ya'll got in to after the hurricane where ya'll were so short of money at Galveston. Struggling with educational roles. I just think I want us to discuss that. We just got this policy for the first time. How big are the testing sites, is that 5 patients in each one, is that 20 patients at each testing site. That's something if we're going to vote on testing sites is that going to be half of how many people we have. I just don't have enough information. Dr. Zepeda responded that the centers of excellence for the pilots. Dr. Jumper added is that 4 pilots. Dr. Zepeda responded Suggested yea, 4 for	

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VIII. Medical Director's Updates (Cont'd.)		UTMB 1 male and 1 female both in the State Jail as well as.. Dr. Jumper asked so your just going to do 4 patients or 4 sites? Dr Zepeda responded No, no 4 facilities. Dr. Jumper asked so how many at each site? Dr. Zepeda responded I think that is still to be determined. We talked about maybe a dozen patients initially in each sector. And then to determine best practices, how do we best deliver these medications with the timing and the lab draws and we have to educate our staff and see how things go. Dr. Jumper asked and that will go for one year? Dr. Zepeda responded I don't have answers to those questions yet but I don't anticipate we can go a year with only treating 12 patients when we have 30,000 known. But that is not a decision that I will be making. Sorry I can't answer that question. Dr. Linthicum responded that right now what happens Dr. Jumper in the UTMB side I'm not sure I think Dr. DeShields will know what happens on the Tech side. But the unit doctors are not treating these patients. They are following the policy guidelines and then they get referred to a specialist. An infectious disease doctor, who is Dr. Kahn. And Dr. Kahn makes all the decision making on who actually gets placed on the medication. So that is a control there because she has the expertise and then she outlines the individualized treatment plan for everybody that is enrolled in therapy to make sure they get all of these tests. That's what we envision to continue because that's the current model. To where she controls the enrollment of	

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VIII. Medical Director's Updates (Cont'd.)		the patients and who goes on therapy. That would happen for those subsets of patients that would go on to the triple drug therapy who are currently the genotype 1 in our system. Most are dual therapy. And then a certain subset of those will be decided if they need triple drug therapy. But she will be the decision maker and if there is an Institutional Division inmate they will go to the pilot unit for ID, we'll have 1 male & 1 female and if they are State Jail offender then they will go to the pilot unit for State Jail, 1 male & 1 female. And if they are Texas Tech sector I think Denise you will be using one of your regionals to be the decision maker. Dr. DeShields added that again the primary care providers gather all the information presented for approval and the regional medical directors will approve or deny treatment based upon the information submitted. We do this a little bit differently in the Tech Sector in that all patients who meet all criteria without exclusion once they go thru that process that I just described are started on therapy, which are followed by the primary care doctors. The ones that get referred to GI or those that have some exclusionary criteria or some mitigating circumstance that kind of fall into a grey area that would require a little bit more specialized management. Again our issue is just our GI specialist in West Texas. They are few and far between and so we limit those patients that really kind of fall in difficult treatment criteria or difficult treatment areas to be referred to the GI clinic. So that is how we manage it in West Texas. Dr. de la Garza-Grahm asked would this Dr. Kahn will be responsible for screening 30,000 patients. Dr. Zepeda answered that the unit providers screen based on a checklist and then they refer	

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VIII. Medical Director's Updates (Cont'd.)		them up to a HEP C treatment team it's more than Dr. Kahn and there are two mid-levels that support that team. And then they actually do the screening if they are eligible for drug treatment. So they are just following the checklist for potential eligibility and if so then they are referred up to the treatment team and then the treatment team actually makes the decision. Dr. Ramer asked if they were going to use your HIV treatment model the same. If you might want to review the people how you go about treating HIV patients down where people have in their minds a model. Because it seems to me at least having to observe that a very cost effective and efficient with a single doctor in charge. Stephanie, why don't you tell them. Dr. Zepeda added that we have a HEP C treatment team, Dr. Kahn she's actually our Virologist and she also handles our HIV and she also has two mid-level providers. So our primary care providers will be screening these patients and determining are they chronic Hep C positive that's the first question. And then they meet certain criteria, so that's a fibrosis score of 2 or higher, if they have current cirrhosis and they have no contraindications to Peginterferon list. This is the determination they make because it's the back bone of every regiment. And if all those things are true then they refer them up to the treatment team. The treatment team will further evaluate them based on their comorbities, based on time left in the system and based on other drug therapies they are on because there are some medications these new Protease Inhibitors can't be prescribed with. Then they will make a decision whether or not that patient is able and a good candidate to complete actual treatment. That team then will monitor the patient for the course of therapy and see them by telemedicine. So they will see them periodically.	

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VIII. Medical Director's Updates (Cont'd.)		And the new piece to the model that Dr. Kahn is adding for Hep C is she is adding in two clinical pharmacist as well. So the treatment team, the two mid-level providers are Dr. Kahn who actually will do the evaluation, periodic visits, and in between to access for tolerance of therapy as well as to make sure that critical lab draws are on time. They will be seen by a clinical pharmacist by telemedicine and so that team will work in concert together to manage these patients. Hopefully that will identify any sickness they have from adverse affects before they can cause harm to the patient. Also to follow that viral if they are not responding to therapy we get it stopped as soon as possible so we don't treat unnecessarily. Dr. Deshields added that's when you present that model there is a missing piece in Tech as far as having that treatment team. We just don't have the GI resources to actually have that additional piece. And I think with this particular triple therapy it's going to be an important piece. Dr. Zepeda responded that they'll make sure that the labs are drawn and that their adherent to therapy and keeping medical appointments. Dr. Linthicum added that she thinks on the implementation part where we all have said that there is more work to do. I think that the three medical directors need to get together and maybe follow a model we do now with the AIDS patients those that have full blown AIDS are some likeable be placed in the UTMB sector because of this model and maybe we need to move in that direction for those that go on triple therapy. A short discussion was had by Dr. Linthicum, Dr. Murray, Dr. Jumper & Dr. Zepeda referencing 340b pricing.	

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VIII. Medical Director's Updates (Cont'd.)	Dr. de la Garza-Grahm asked Dr. Linthicum what do we need to do now?	Dr. Berenzweig asked for clarification currently right now all new inmates are screened for risk factors for HEP C and if they have them they've tested and if they meet criteria they are treated with dual therapy. With the new policy would that follow CDC guidelines with baby boomers being tested which is a huge input and the other new thing would be triple therapy for genotype 1. Correct. So there are two factors involved that add to the cost. One is the new recommendations and treatment, and probably the more important one is that everyone gets asked or what I would have thought that the inmate population is a much higher rate of risk factors than the general population. So how much is incremental or not I don't know. Is that a correct summary of the differences? Dr. Zepeda responded Right, regardless of risk factors they will screen baby boomers regardless. Dr. Linthicum added that several years ago we did a ceraprevalance study with DISHES and our rate was close to 30% of the incoming offenders, so that translated to almost 50,000 that would be infected with Hep C. Dr. Zepeda added that I think there are about 30,800 something identified currently. Further discussions with Dr. Berenzweig, Dr. Linthicum, Dr. Jumper and Dr. Zepeda. Dr. Linthicum responded that we need to make a motion and vote whether to adopt the policy presented by the Joint Hep C with all of the caveats discussed, which I will do.	Dr. Linthicum requested a motion to adopt the presented Hepatitis C. Policy by the Joint Committee with all the caveats discussed.

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VIII. Medical Director's Updates (Cont'd.)		Dr. Raimer asked Madam Chairman that he would like to request to have a quarterly report on the progress and update on this pilot program including the expenses on this to us. Dr. de la Garza-Grahm asked who would you want to do this report. Dr. Raimer responded that he would like for Dr. Zepeda to do this. Dr. Zepeda responded after September 1, 2013 when we implement our program. Dr. Raimer added I think we really monitor the manpower and total cost of this. Dr. de la Garza-Grahm asked do we even have an Opthamologist to do all the eye screening? Dr. Linthicum responded thru the speciality clinics unless you planned something different. Dr. Murray added that he didn't want to get ahead of this whole movement issue. We probably are going to have to look at because of the ultra sound issue or the imaging concerns related to the cirrhotics. I think right now we would all the number that is thrown out there in terms of our cirrhotics is significantly underestimated I think we quoted a number of about 200. Once we have the level of scrutiny that number will probably double. So we're adding twice annual, ultra sounds, some type liver imaging on top of all of the opthomology work. I think we would maybe go back to some of those retinal screening up at Estelle and send those imaging reads down to the Opthamologist. That would be an efficient way to do this for that large of a group and then talk about potentially putting some imaging ultra sound up at Estelle	Dr. Berenzweig seconded the motion. The motion passed by unanimous vote.

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VIII. Medical Director's Updates (Cont'd.)	Dr. de la Garza-Grahm thanked Dr. Zepeda and called on Dr. Khurana for his report on Chronic Kidney Disease. Dr. Khurana began with last time he had come to a meeting so I will give you an update. Last time I was here we talked about the disease burden of the dialysis patients. We have more of a problem with Chronic Kidney Disease, it's not just about dialysis. We have to look at preventative care as well. First is the burden of CKD in the United States. This is not correctional data, it's general US data. We can see the mortality in 2008 was 88,620. The death rate was 7 times greater. The incidence of prevalence of patients with kidney failure look at where we were in 2008. This is dialysis and non dialysis. Unfortunately our system as we have talked about everything else, aging population hypertension, diabetes, everything is on the upswing. So our disease burden is following this projection as well. The cost and this is based on medicare data. The beauty of the dialysis program is that in the free world medicare tracks everything. Everything is computerized, they use crownweb and every facility in this country reports to medicare. So we can actually take our data and compare ourselves to	so that we don't have people moving across the state to do routine test. We've looked into this, how we would be starting a new fiscal year and how to handle this request. Dr. Jumper asked if that retinal exam could be a telemedicine. Isn't that looking at pictures? I have one other question on HIV but is missing these doses causing more of a health problem. Built into this policy is there a compliance….I know if the prisoners are not compliant they will not be treated but if we fall out of compliance about the down stream public health issues we might have, is it built into here a compliance or we getting all the screening upfront? Dr. Zepeda responded in the modern day tool of medication has to be checked periodically, every 30 days you have to check. And more discussions were had between Dr. Jumper, Dr. Linthicum, Dr. Murray and Dr. Zepeda.	

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VIII. Medical Director's Updates (Cont'd.)	everybody in the country not just the state but all over the United States. If you look at the cost in 2008, to where they are projecting, this is an old slide 2010 data and as you can see the cost has increased significantly. This slide is important for you to understand what we're dealing with and the freeworld as well. If you look here this is chronic kidney disease stage 5, the tip of the iceberg. This is where our focus really should have been, needs to be and will be because this is the population that is coming here. Just like everything else what we know about this population is their getting older and unfortunately their staying incarcerated longer. So they are going to exceed the tip of the iceberg. These are the stages I'm not going to worry with all of this but as you move up the stages your kidney failure worsens and when your stage 5 you can be on dialysis or not on dialysis. In TDCJ if you look at the FY2010, 196 patients were provided dialysis care with an average of 164 patients per month our current capacity if 172. As you can see the average cost per patient was $23,044 per year. The cost per day dialysis patient was $63.13 and $9.88 per patient per day non-dialysis. How are we addressing this issue? The iceberg is the key thing. Our dialysis population is growing more rapidly than we can actually keep up with. What we need to do and what we've done is focused on pre-dialysis and what is called chronic kidney disease so how do we slow this, so early treatment makes a difference. So if we treat at an early stage we add 2 more years of end stage renal disease (ESRD) free survival. And that means 2 additional years of not being on dialysis. So we've done is the right thing for the patient physically and the right thing for the program but that's a lot of these patients if we can keep them off of dialysis longer we are keeping the disease burden down as well as cost. This is an astonishing factor but it is true, according to the National Kidney Foundation, 70% of all cases of kidney failure could have been prevented or delayed with early detection and treatment. This has been a foundation of what we've done with our kidney program. That is why		

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VIII. Medical Director's Updates (Cont'd.)	this was called Chronic Kidney Disease, as we have to look at this as a whole kidney program. So how are we addressing this issue? Education & awareness with providers and patients. So taking it directly to the patient, an educated patient we know is a good patient so they know what they're dealing with. We're taking a multi-disciplinary approach to treatment we're dealing with providers, dieticians, social workers, nurses and we're dealing with a whole of gamut of people who are able to blend this information to the patients in different ways, different manners of dialogue. Key thing, prevention and progression. What do we do? We've developed the clinical pharmacist managed CKD clinic. I'm not talking about this clinic because it is very important. Obviously we've beaten it over the head that we don't have enough providers so we use the resources we have. Main target diabetes and hypertension. The two leading causes of kidney failure in this country. Diabetes being number one and hypertension number two. Interesting enough you will see in my slides in our population high blood pressure being number one and diabetes being number two. In timely consultation and referral to nephrology. Nephrology services in the UTMB sector include me and my colleagues down on the island. Establishing pharmacist in CKD clinics. Medical Director & Nephrology support and consultation essentially that is me. I have established and you will see the entire protocol and you'll see exactly what we do. What we've done is we follow KDOQI guidelines. These are national guidelines that are established that every Nephrologist in this country is using as a basis that's evidence based medicine that we can slow progression of chronic kidney disease. It requires pharm b actually using these guidelines very simple and I will show you how. And then us having meetings monthly to discuss these patients and discuss the data and the impact of this growing population. Pharmacist training include patient identification. What patients have we identified. Obviously the primary provider like the primary care doctor is in the frontline and are very aware & involved. We've establish the chronic		

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VIII. Medical Director's Updates (Cont'd.)	kidney disease stage 3 to establish dialysis early enough intervention that we can slowly add those 2 years of dialysis free. Standardized clinic notes and clinic referral process you will see all of that. Assign topics for review and discussion again I mentioned the KDOQI guidelines and current pertinent literature. Obviously medicine is evolving very quickly things are changing and so we are applying that to our protocol as well. It's facilitated by the clinical pharmacist and as the Director of Dialysis & Nephrologists I am involved in with doing all of this and education. We have ongoing roundtable patient case studies with nephrologist. Again, are these pharmacist making any clinical decisions, absolutely not. This is more of are these patients being treated appropriately with their appropriate medications, do we have intervention and then taking it back to the primary provider or to me. Again, this is the stage of the chronic kidney disease and this is just to show you this is where pharm b partnering in stage 3. One of the things I'll mention here so that you are aware is what we've done is mentioned stage 4 & 5. On stage 5 you can be on or off dialysis and stage 4 means you are preparing for dialysis. We established what's called the pre-ESRD program. So a lot of these patients are relocated to Estelle Unit and come under my care even though they are not on dialysis. Because we are preparing them for the dialysis transition and what we've found with data as well is that we can prolong the dialysis number one if we put them under the care of a nephrologist early on and getting them involved here. Number two having them prepared properly for dialysis, so having the proper type of access to do dialysis, having them on the proper medications to mend bone disease and other risk factors will slow their time of dialysis. Our patient population, this is a breakdown and this is the key to this slide and as you remember I told you that showing hypertension being number one and diabetes being number two. Next is just the administrative codes so you will have available to you.		

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VIII. Medical Director's Updates (Cont'd.)	So here are the treatment goals that the pharm b are looking at. Again this is the standard of care this is outlined by the KDOQI guidelines and every nephrologist in this country should be focusing on these. And if you focus on these goals we know that you slow the progression of chronic kidney disease and you prevent the initiation of dialysis. The other thing that we have seen a lot more data about is that if you diagnose the patient early on based on blood work or you wait to see if the patient has indications clinically for dialysis you take both of these populations. You can actually wait not treat based on blood work but actually do clinical medicine and treat based on the patient. The patients actually do the same in actually the population you waited on and did not treat numbers meaning if a patient has high numbers and have to send to a MD then oh my goodness we have to dialyze. But if the patient is doing well, no nausea, no vomiting, good appetite dialysis is not indicated at that time and can wait. Don't treat the numbers, treat the patient. So what are we doing to better manage. Leveraging technology to better managed ESRD patients. Our EMR and what we've done is amazing. We've replaced all the dialysis machines so that they are interfaced with the existing EMR system. Upgraded the version of the EMR software to Pearl 7 to that programming enhancements could be realized. I'm going to show you you'll see what we were doing was primitive before. Now we have moved to where we can pull data. This collaboration was done the IT team to develop and implement a project plan to transition many paper driven quality control activities to automated reports generated by EMR. Electronic charting and data. A lot of words here and I wanted you to realize that we can pull data now from 60 days previously. I can go back to a moment in time. If you wanted to know if a patient on dialysis from 8:00 am until 12 on Monday, Wednesday, and Friday and you wanted to know what happen exactly at 10:22 on that dialysis treatment day, you can actually pull that up in the EMR anywhere. That's what happening in free world clinics because unfortunately there's a high cause of morbidity and mortality in these patients and we need to be able to		

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VIII. Medical Director's Updates (Cont'd.)	scrutinize our treatments. This is what our summary of reports look like now on page 118 and I will show you what they looked like before. But this basically talks about, and it's a summary of our dialysis patients. What we do is a monthly what is called a quality assurance performance improvement meeting. Every month we meet we look for all the data of the patient and look for trends of negative and positive. Look at outcomes and look at our numbers and we are able to collect this data at a click of a button instead of manually collecting this data. I want you to look at the chart on page on 119 at the CMC dialysis treatment trends and see the 2012 in blue and in yellow 2013. Our treatments have gone up significantly they have already blown thru the roof as it is in 2012 but they are just increasing. Again Our dialysis population unfortunately is growing very, very rapidly and just like everywhere else we're having to be full time keeping up with patients starting on dialysis. On the CMC dialysis patient volume look at the red line capacity, look where we're at above capacity. We are pulling out all the stops to try to absorb these patients. A lot of patients are sitting in hospitals for long periods of time waiting because we don't have a dialysis chair. Unfortunately it's not utilizing resources well because the dialysis program itself runs so efficiently. It's pennies on the dollar compared to leaving them in hospital beds. If you look at our hospital admissions, I broke this down three ways. The red is actually dialysis related hospital admissions. The gray is for vascular access, so patients who were getting who actually need the proper type access for dialysis whether it be a fistula graft because they have catheters not a good way because it drives hospitalization up not a good way due to infection. And yellow is other and that means non dialysis related and everything else. And if you look that's our biggest reason for hospitalization. What are the drivers, infection, and cardiovascular disease. If you look in the free world it's cardiovascular disease and infection. Right now we are flipped and the reason we are flipped because the catheter		

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	rate is so high and we had to get the gray area higher but we got that problem resolved as well. Obviously if we get more patients and this is our average machine hours we will be pushing these machines to the max. with all these patients we are dialyzing. This is a summary of the labs so every month we have to pull up these labs review these labs and collect information on these patients. So 172 dialysis patients have to have all these labs put together and I have to go to all the dialysis patients discuss their labs and make sure we are doing all the right things. This is based on our new system EMR integrated machine. This is what we had to do before on page 124. This is patient and someone had to go thru the computer and write down every single lab drawn. This is just step one and had to be done over and over and over again. This is the way data had to be tracked before because we just didn't track properly and the graphs would go up and down. Again, this is a previous analysis and just to show you. On page 127 is our manually loaded excel sheets that we were doing and writing in on and now this is our data based generated. You can see how much easier it is now. CKD is a growing public health problem. Our resources are obviously limited. We are looking for who is at risk at providing early intervention. The key thing here is	Dr. Linthicum asked if they were reporting to the in state renal disease network? Dr. Khurana responded that was a great question and yes there is a network, the in state renal disease network that gets data from all the dialysis facilities in the state and the country. We report all our data to the in state renal disease network and we compare our data to other dialysis facilities because like we said we don't want to go below the standard of care from a free world facility. And therefore we are to par if not we are exceeding that and a lot of our outcome indicators as you know we are exceeding the free world limits.	

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VIII. Medical Director's Updates (Cont'd.)	obviously is prevention. We have a big problem with dialysis patients and more CKD patients than we know what to do with as well as dialysis patients. These patients of chronic kidney disease are not going away. So that red bar that we exceeded, we will continue to exceed. Our projected growth where we are today two years ago we are actually beyond that right now. So we are going to have to relook at our models and re-graph everything not only is our population has grown but the Tech sector also. And this is just references.	Dr. Linthicum asked keeping it at a summary could he tell us how many dialysis we have like at Carol Young and Estelle. Dr. Khurana responded as we look at the dialysis population at the UTMB sector we have two facilties where we dialyze. At the Estelle Unit & at Carol Young Medical Facility. At the Estelle Unit we have currently 172 and are at capacity. Carol Young was initially created to dialyze females but we had to go to male overflow at Carol Young. and unfortunately had to house those in the infirmary. Where now up to 24 as of last week because we had so many patients sitting at hospitals that we had to expand that program. That program was initially created to only hold 6 female patients. We now have 24, we have 5 females and another spot for a female coming in to the system and the rest are male patients. The scary part is this.. Dr. Linthicum added the males are in the Southern Region Medical facility because there is no housing. Dr. Khurana responded exactly because they are taking up infirmary beds. Are they infirmary patients? Dr. DeShields added that from the Texas Tech sector we had 44 beds on Friday and 42 filled. And again originally the concept was to move those patients into trusty camp beds, patients in the infirmary beds, holding cells, long term care facilities who are on dialysis because we had no	

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VIII. Medical Director's Updates (Cont'd.)		place else to put them. Dr. Murray added and in housing these guys in infirmary beds is a shell game. We have already reported that 70% of our total infirmary beds are taken up with patients that are going to spend their entire length of incarceration in those beds. So you start now adding dialysis patients who don't necessarily need to be there but have to be there because of the service. We're just going to end up everyone backs up into local hospitals Hospital Galveston. I think we do have a good plan. Dr. Linthicum responded that we have a plan, a good expansion plan at Estelle to expand the old dialysis area that we'll be working on jointly for the next contract site. Dr. Khurana added that and the reason why we have to look at this is that the CKD stage 4 & 5 are close to dialysis but not on dialysis. We have over 200 patients just identified and CKD stage 3 we have over 10,000 probably. So here's now to add insult to injury we said that there's of those 200 that are identified and if we have 10 new starts per month one of those new starts is from the identified patients, so 9 of those patients have not been identified as pre dialysis patients. They are getting admitted to hospitals they are getting started on dialysis, we have not identified them. It's easy to identify them, we pump them in the system, these patients have gone to dialysis, we've identified 200 and a majority of these go to Estelle and are being seen by me. They are getting put into the right system. The problem is we have such a hugh disease burden just like any other disease burden that we have that they are putting the dialysis program into overdrive for both sectors.	

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VIII. Medical Director's Updates (Cont'd.)	Dr. de la Garza-Grahm thanked Dr. Khurana and called on Dr. DeShields for her report.	Dr. de la Garza-Grahm asked Dr. Linthicum you said that there is a plan and a place. Will you present that to us in the future. Dr. Linthicum responded that yes we are working on it for the next contract cycle.	
- **Denise DeShields, M.D. (TTUHSC)**	Dr. DeShields began that she didn't have anything more to provide but just wanted to bring to the attention of the committee under Tab A page 62 the graphs at the bottom of the page on the Average Length of Stay & Staffing Vacancy Rates for the fourth quarter are not accurate what we had submitted and we will make sure that is corrected. Dr. de la Garza thanked Dr. DeShields and called on Dr. Murray.		
- **Owen Murray, D.O. (UTMB)**	Dr. Murray just had one thing he wanted to add is just a point getting back to our legislative request items as it relates to capital. This just occurred over the last two weeks and we've talked to Lynn about our radiology equipment being old, obsolete, not to be replaced as well as being difficult finding the film at a reasonable price because nobody makes it anymore because everyone has gone digital. We knew this was going to happen and the radiology equipment went down last week and it happens to be at the Polunsky Unit where we have death row offenders. We've worked with TDCJ to fix the problem. The concern about is how do we provide the services. We still provide access; we just do it out in the free world, either through the emergency room or the hospital. But in this case obviously we don't have radiology equipment and they are going to go out to the local emergency room to get their films done but obviously from a public safety prospective, death row, ad seg and those type of individuals access in care historically we provide at the facility, externally is a concern shared by everybody. I brought this up because Polunsky just happen to be a very visible facility where this occurred first but this will be a series of events that will happen over the next couple of years this equipment will go down so again as we said if there is no funding for that line item there is an option to		

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VIII. Medical Director's Updates (Cont'd.)	provide the service it will be out in the free world as you said Madam Chairman we are going to spend the money one way or the other. We're going to spend it out in the free world or you might as well just bite the bullet and buy the equipment.	Dr. de la Garza-Grahm responded that digital is the way to go because it is so much more efficient. Dr. Linthicum added that we are spending the money because our Prison Director Mr. Thaler is right here and he's not going to have us taking death row offenders to the local ER. Dr. Murray added that actually we have investigated a digital solution and ultimately it does need to be a system wide approach. Well I mean this particular crisis has been resolved and I'm sure in future meetings you will be getting more reports on these issues.	
IX. Performance Status Report	Tab G is for information only. No one will be presenting the Performance Status Report		
X. 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 were no such request at this time.		

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XI. Date / Location of Next Meeting **- Margarita de la Garza-Grahm, M.D.** **XI. Adjourn**	Dr. de la Garza-Grahm next noted that the next CMHC meeting will be announced at a later date. Dr. de la Garza-Grahm asked if there were any other questions or comments. Hearing none adjourned the meeting.		

M. de la Garza Grahm

Margarita de la Garza-Grahm, M.D., Chairperson
Correctional Managed Health Care Committee

Date: 6/18/13