CORRECTIONAL MANAGED HEALTH CARE

COMMITTEE

AGENDA

June 18, 2013

9:00 a.m.

Frontiers of Flight Museum
6911 Lemmon Ave., Conference Rm #1
Dallas, Texas

CORRECTIONAL MANAGED HEALTH CARE COMMITTEE
June 18, 2013
9:00 a.m.

Frontiers of Flight Museum
6911 Lemmon Ave, Conference Rm #1
Dallas, Texas

I. Call to Order

II. Recognitions and Introductions

III. Approval Excused Absence

IV. Consent Items

1. Approval of Minutes, March 18, 2013

2. TDCJ Health Services Monitoring Reports
   - Operational Review Summary Data
   - Grievance and Patient Liaison Statistics
   - Preventive Medicine Statistics
   - Utilization Review Monitoring
   - Capital Assets Monitoring
   - Accreditation Activity Summary
   - Active Biomedical Research Project Listing
   - Administrative Segregation Mental Health Monitoring

3. University Medical Director's Report
   - The University of Texas Medical Branch
   - Texas Tech University Health Sciences Center

4. Summary of CMHCC Joint Committee / Work Group Activities

V. Executive Director's Report

VI. Financial Reports
1. FY 2013 Second Quarter Financial Report
2. Financial Monitoring Update

EACH ITEM ABOVE INCLUDES DISCUSSION AND ACTION AS NECESSARY

VII. Summary of Critical Correctional Health Care Personnel Vacancies

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

VIII. Medical Directors' Updates

1. Texas Department of Criminal Justice
   - Health Services Division FY2013 Second Quarter Report
2. Texas Tech University Health Sciences Center
3. The University of Texas Medical Branch

IX. CMHCC FY 2013 Second Quarter Performance Status Report

X. Public Comments

XI. Date / Location of Next CMHCC Meeting

XII. Adjourn

Consent Item 1

Approval of Minutes, March 18, 2013

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, Dr. 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

Agenda Topic / Presenter	Presentation	Discussion	Action
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** - **Denise DeShields, M.D. (TTUHSC)** **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. 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. 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.)		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.

Agenda Topic / Presenter	Presentation	Discussion	Action
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		

Agenda Topic / Presenter	Presentation	Discussion	Action
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.**	Dr. de la Garza-Grahm next noted that the next CMHC meeting will be announced at a later date.		
XI. Adjourn	Dr. de la Garza-Grahm asked if there were any other questions or comments. Hearing none adjourned the meeting.		

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

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Date:

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Consent Item 2

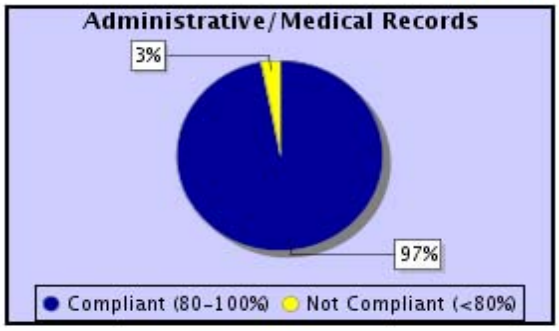
TDCJ Health Services Monitoring Reports

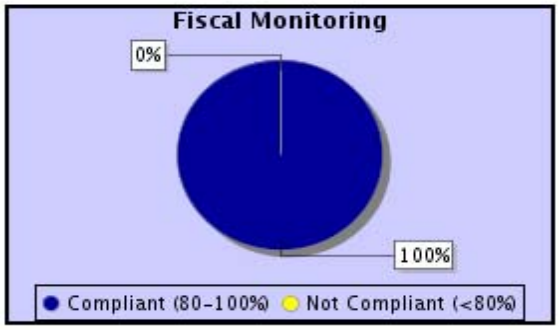
ATTACHMENT 1

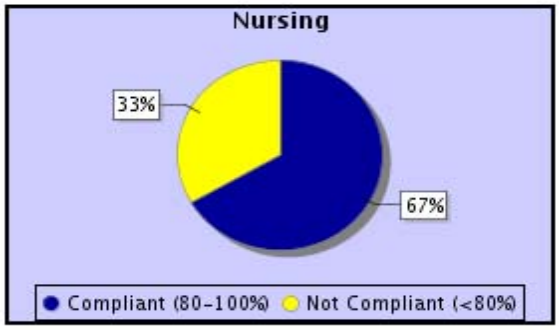
Rate of Compliance with Standards by Operational Categories Second Quarter, Fiscal Year 2013 December 2012 - February 2013																		
Unit	**Operations/ Administration**			**General Medical/Nursing**			**Coordinator of Infectious Disease**			**Dental**			**Mental Health**			**Fiscal**		
	n	**Items 80% or Greater Compliance**		***n***	**Items 80% or Greater Compliance**		***n***	**Items 80% or Greater Compliance**		***n***	**Items 80% or Greater Compliance**		***n***	**Items 80% or Greater Compliance**		***n***	**Items 80% or Greater Compliance**	
Briscoe	33	32	97%	15	10	67%	26	15	58%	12	12	100%	2	2	100%	7	7	100%
Choice Moore	32	32	100%	15	15	100%	30	19	63%	12	12	100%	2	2	100%	4	4	100%
Cole State Jail	33	33	100%	15	15	100%	32	25	78%	12	12	100%	16	15	94%	4	4	100%
Cotulla	31	31	100%	15	12	80%	25	16	64%	2	2	100%	2	2	100%	5	5	100%
Gurney	32	30	94%	17	10	59%	34	18	53%	13	9	69%	18	18	100%	4	4	100%
Kegans State Jail	32	16	50%	10	7	70%	27	15	56%	NA	NA	NA	8	8	100%	4	4	100%
Lockhart	34	34	100%	17	12	71%	27	17	63%	12	11	92%	9	8	89%	4	4	100%
Lychner State Jail	34	32	94%	17	8	47%	37	18	49%	13	11	85%	18	13	72%	4	4	100%
Michael	33	32	97%	20	12	60%	34	29	85%	12	12	100%	16	15	94%	7	7	100%
Skyview	34	33	97%	18	10	56%	35	26	74%	3	1	33%	41	41	100%	6	6	100%

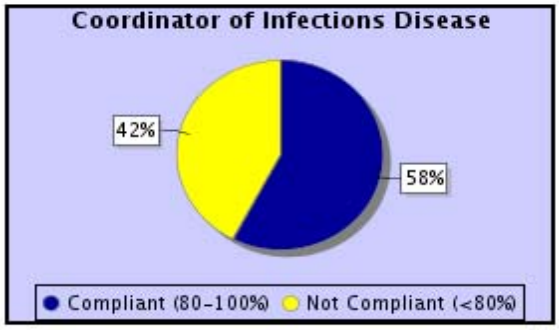
n = number of applicable items audited.

Compliance Rate By Operational Categories for
BRISCOE FACILITY
December 11, 2012

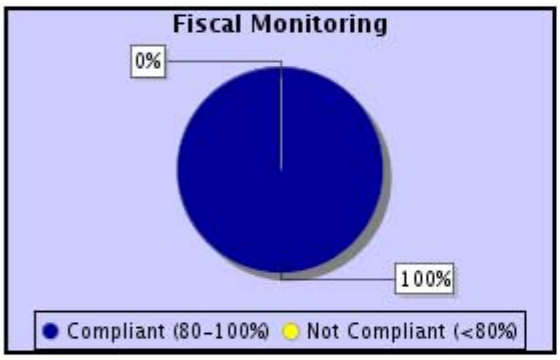


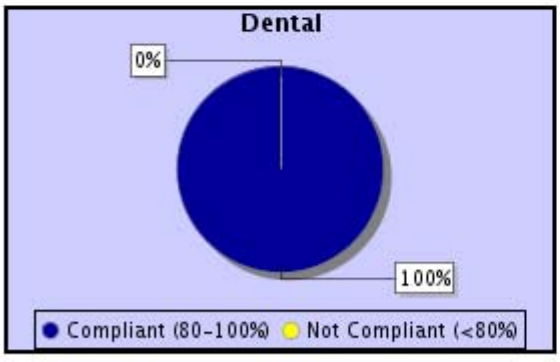


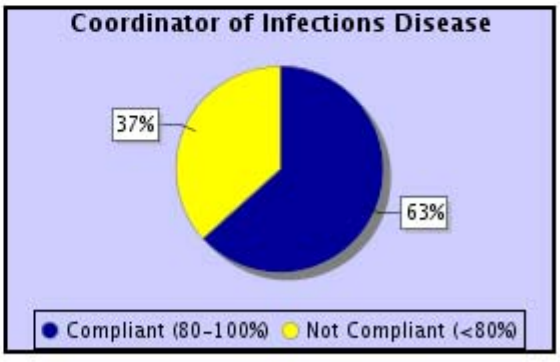




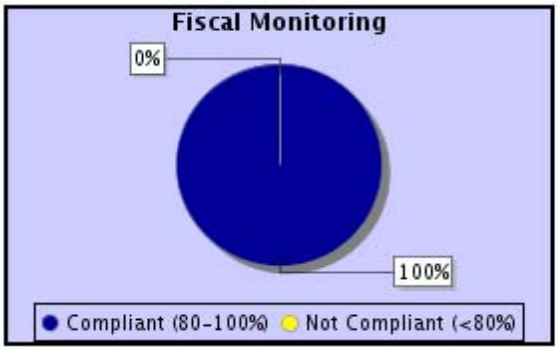
Compliance Rate By Operational Categories for
MOORE (C) FACILITY
January 08, 2013

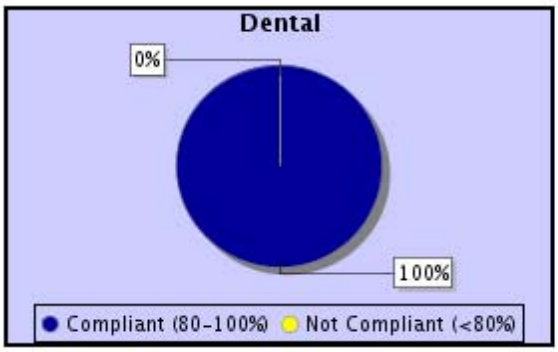


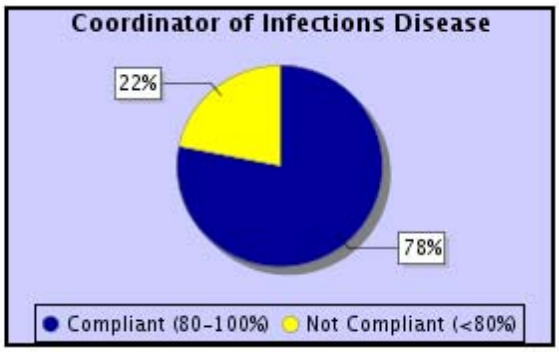




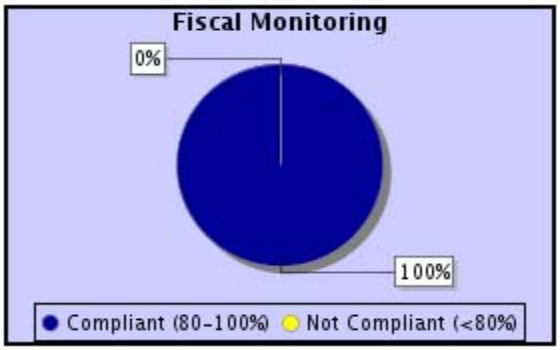
Compliance Rate By Operational Categories for
COLE STATE JAIL FACILITY
January 08, 2013

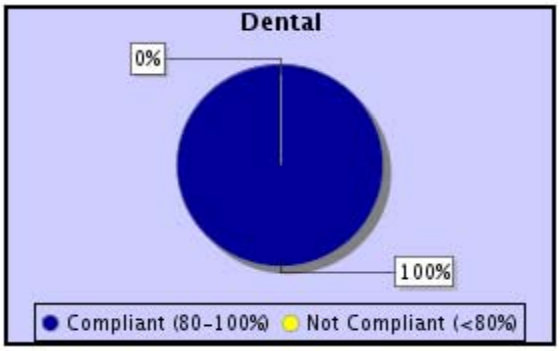


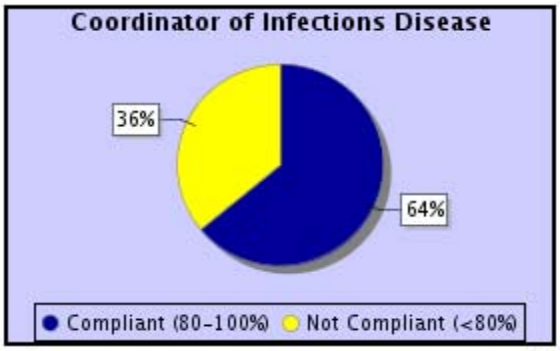




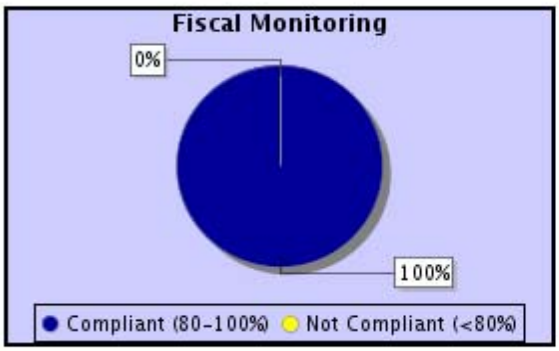
Compliance Rate By Operational Categories for
COTULLA FACILITY
December 11, 2012

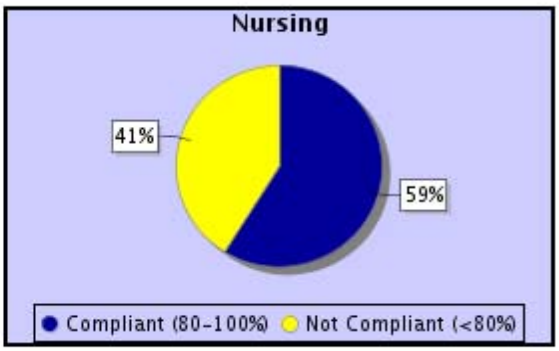


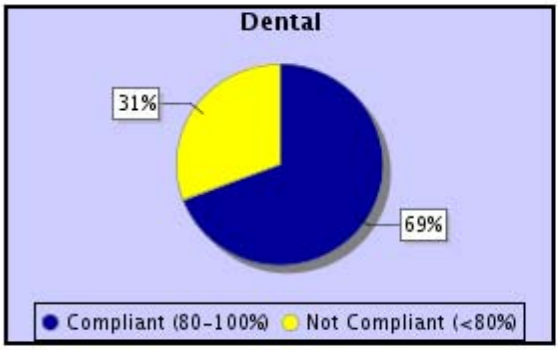


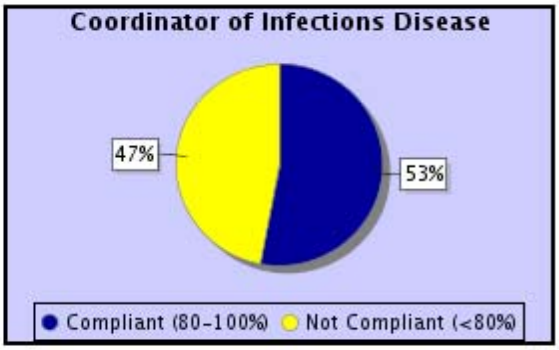


Compliance Rate By Operational Categories for
GURNEY FACILITY
January 07, 2013

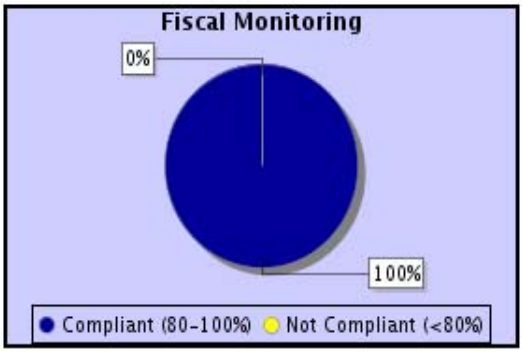




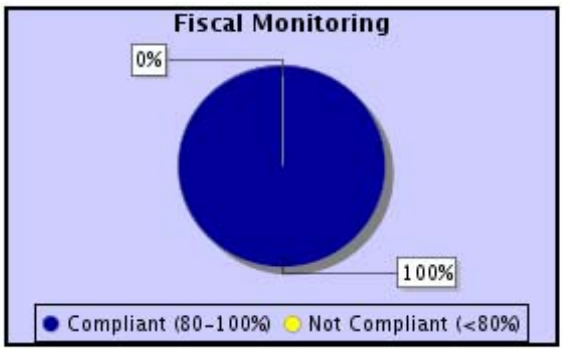


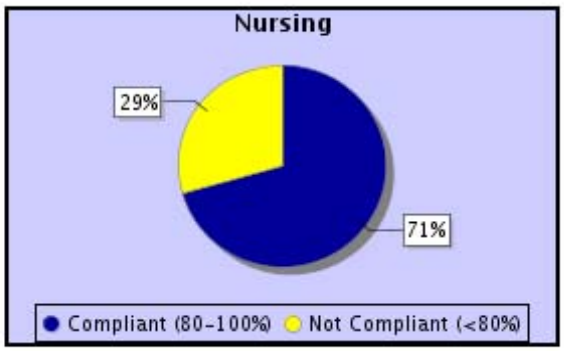


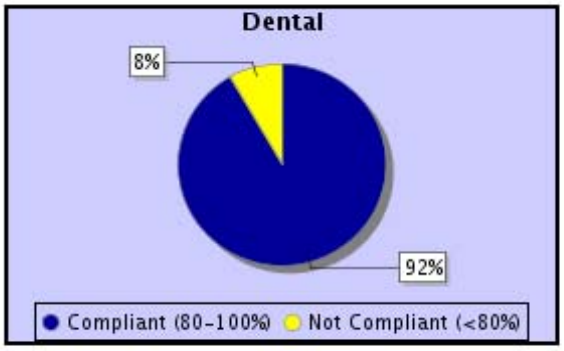
Compliance Rate By Operational Categories for
KEGANS STATE JAIL FACILITY
February 04, 2013

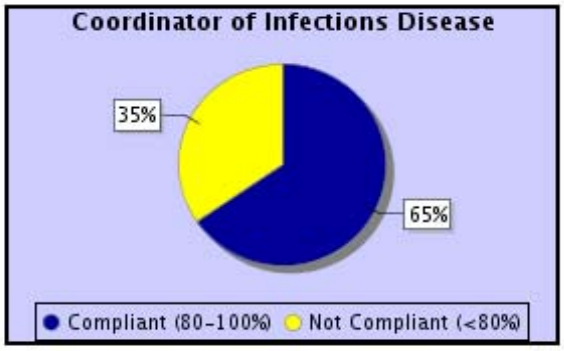


Compliance Rate By Operational Categories for
LOCKHART FACILITY
February 05, 2013

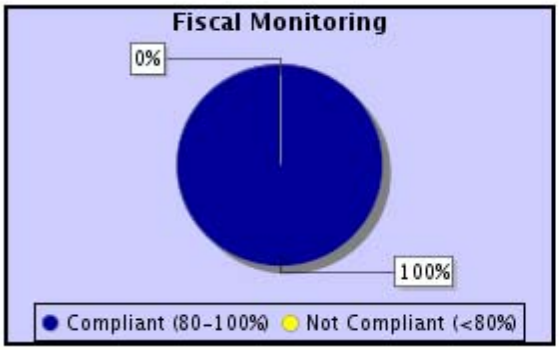


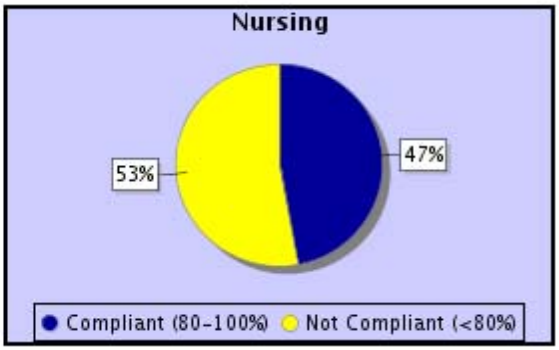


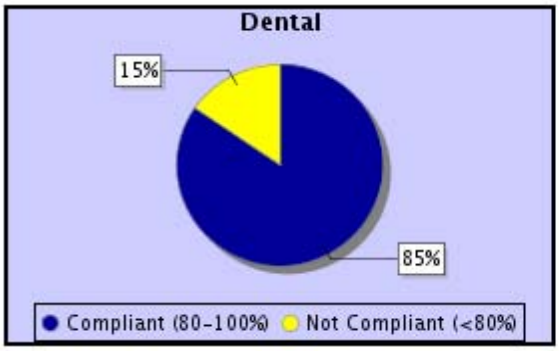


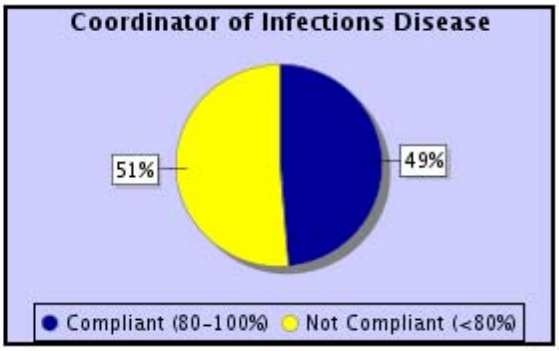


Compliance Rate By Operational Categories for
LYCHNER STATE JAIL FACILITY
February 06, 2013

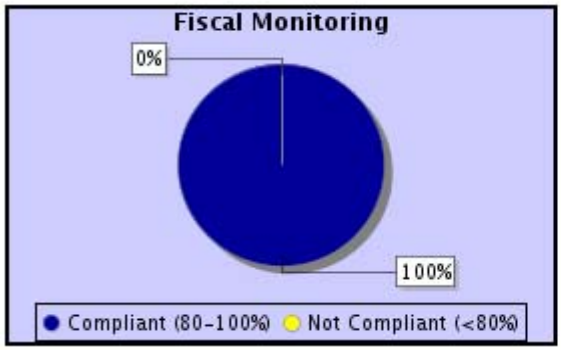


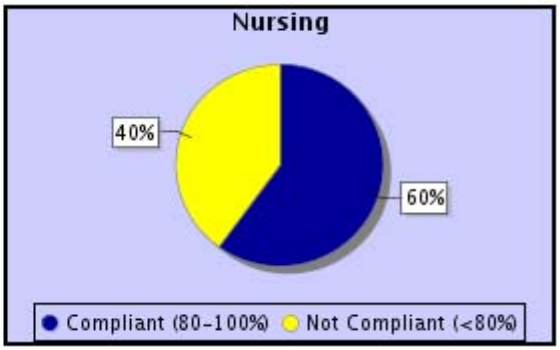


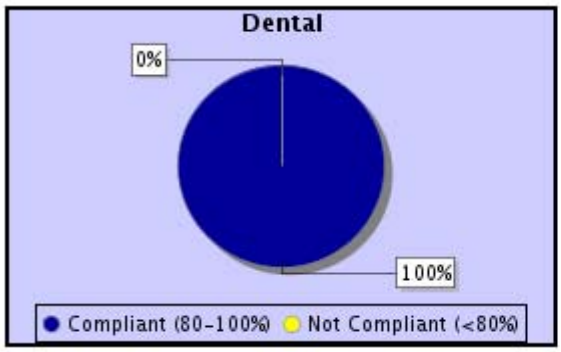


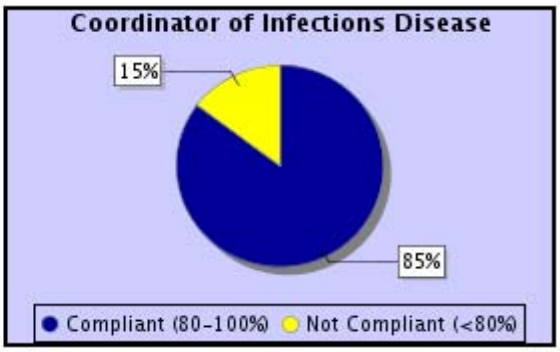


Compliance Rate By Operational Categories for
MICHAEL FACILITY
January 08, 2013

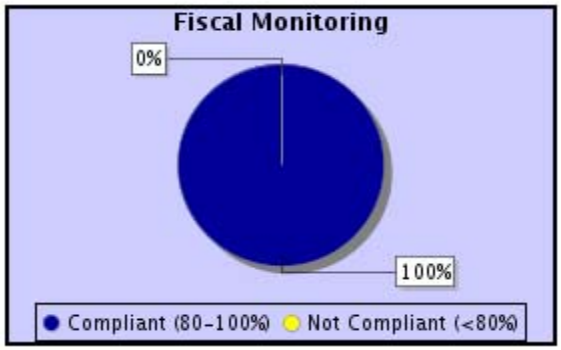


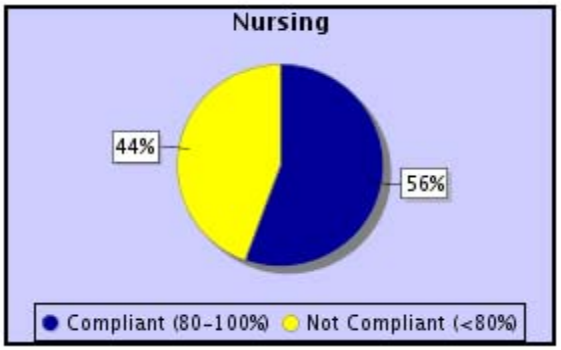


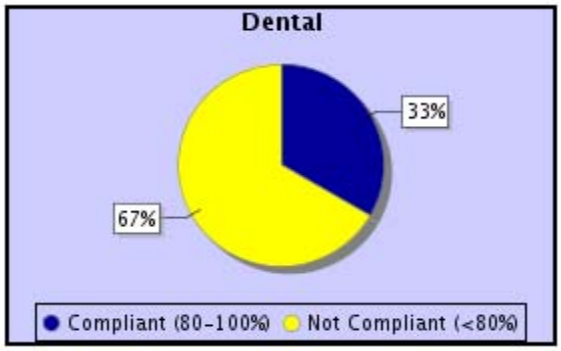


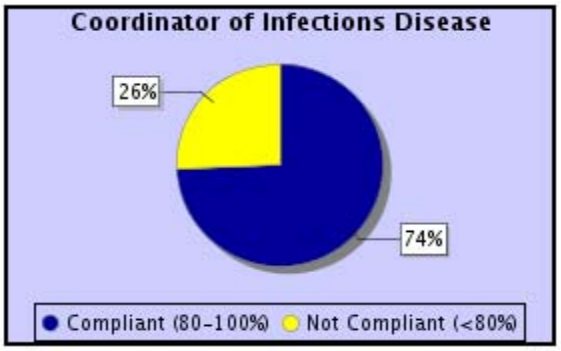


Compliance Rate By Operational Categories for
SKYVIEW FACILITY
February 07, 2013









Dental Quality of Care Audit
Urgent Care Report
For the Three Months Ended February 28, 2013

Urgent Care Definition: Individuals, who in the dentist's professional judgment, require treatment for an acute oral or maxillofacial condition which may be accompanied by pain, infection, trauma, swelling or bleeding and is likely to worsen without immediate intervention. Individuals with this designation will receive definitive treatment within 14 days after a diagnosis is established by a dentist. Policy CMHC E-36.1

Facility	Charts Assessed by TDCJ as Urgent	Urgent Care Score *	Offenders receiving treatment but not within timeframe **	Offenders identified as needing definitive care***
Beto	10	**100%**	0	0
Cleveland	10	**90%**	1	0
Coffield	10	**100%**	0	0
Dawson	10	**60%**	1	3
Estelle	20	**75%**	1	4
Estes	10	**100%**	0	0
Ferguson	10	**100%**	0	0
Glossbrenner	10	**100%**	0	0
Gurney	10	**100%**	0	0
Huntsville	10	**100%**	0	0

Hutchins	10	**100%**	0	0
Lopez	10	**80%**	2	0
Michael	10	**100%**	0	0
Powledge	10	**100%**	0	0
Segovia	10	**100%**	0	0
Willacy	10	**70%**	2	1

* Urgent Care score is determined: # of offenders that had symptoms and received definitive treatment with 14 days = 100%
Total # of offenders in audit.

** A Corrective Action is required by TDCJ Health Services if the Urgent Care score is below 80%
*** A Corrective Action is required by TDCJ Health Services giving the date and description of definitive care.

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

STEP II GRIEVANCE PROGRAM (GRV)

Fiscal Year 2013	Total number of **GRIEVANCE** Correspondence Received Each Month	Total number of **GRIEVANCE** Correspondence Closed Each Month	Total number of Action Requests (Quality of Care, Personnel, and Process Issues)	Percent of Action Requests from Total # of **GRIEVANCE** Correspondence	Total numberof Action Requests Referred to **University of Texas Medical Branch-Correctional Managed Health Care**			Total number of Action Requests Referred to **Texas Tech University Health Sciences Center-Correctional Managed Health Care**			Total number of Action Requests Referred to **PRIVATE FACILITIES**		
						Percent of Total Action Requests Referred	**QOC***		Percent of Total Action Requests Referred	**QOC***		Percent of Total Action Requests Referred	**QOC***
December	476	400	70	17.50%	39	10.75%	4	14	4.00%	2	0	0.00%	0
January	626	759	125	16.47%	81	11.86%	9	31	4.61%	4	0	0.00%	0
February	456	464	85	18.32%	56	14.01%	9	16	4.31%	4	0	0.00%	0
Totals:	**1,558**	**1,623**	**280**	**17.25%**	**176**	**12.20%**	**22**	**61**	**4.37%**	**10**	**0**	**0.00%**	**0**

PATIENT LIAISON PROGRAM (PLP)

Fiscal Year 2013	Total numberof **Patient Liaison Program** Correspondence Received Each Month	Total numberof **Patient Liaison Program** Correspondence Closed Each Month	Total number of Action Requests (Quality of Care, Personnel, and Process Issues)	Percent of Action Requests from Total number of **Patient Liaison Program** Correspondence	Total number of Action Requests Referred to **University of Texas Medical Branch-Correctional Managed Health Care**			Total number of Action Requests Referred to **Texas Tech University Health Sciences Center-Correctional Managed Health Care**			Total number of Action Requests Referred to **PRIVATE FACILITIES**		
						Percent of Total Action Requests Referred	**QOC***		Percent of Total Action Requests Referred	**QOC***		Percent of Total Action Requests Referred	**QOC***
December	462	305	17	5.57%	11	3.61%	0	3	0.98%	0	0	0.00%	0
January	608	645	36	5.58%	19	3.72%	5	7	1.24%	1	4	0.62%	0
February	583	666	19	2.85%	12	2.55%	5	1	0.15%	0	0	0.15%	1
Totals:	**1,653**	**1,616**	**72**	**4.46%**	**42**	**3.22%**	**10**	**11**	**0.74%**	**1**	**4**	**0.31%**	**1**
GRAND TOTAL=	**3,211**	**3,239**	**352**	**10.87%**									

***QOC= Quality of Care**

Texas Department of Criminal Justice
Office of Public Health
Monthly Activity Report

December 2012

Reportable Condition	Reports			
	2012 This Month	2011 Same Month	2012 Year to Date*	2011 Year to Date*
Chlamydia	3	1	40	58
Gonorrhea	1	1	17	6
Syphilis	47	68	901	801
Hepatitis A	0	0	1	0
Hepatitis B, acute	0	1	4	4
Hepatitis C, total and (acute[£])	215	242	3054 (2)	3082 (0)
Human immunodeficiency virus (HIV) +, known at intake	147	351	2386	1885
HIV screens, intake	5385	8628	72,192	77,263
HIV +, intake	31	46	517	509
HIV screens, offender- and provider-requested	663	1534	10,343	11,926
HIV +, offender- and provider-requested	1	1	16	15
HIV screens, pre-release	2674	4245	53,052	55,267
HIV +, pre-release	1	1	17	7
Acquired immune deficiency syndrome (AIDS)	2	12	61	68
Methicillin-resistant *Staph Aureus* (MRSA)	44	76	742	1052
Methicillin-sensitive *Staph Aureus* (MSSA)	28	37	507	651
Occupational exposures of TDCJ staff	14	25	153	139
Occupational exposures of medical staff	2	7	27	35
HIV chemoprophylaxis initiation	2	5	27	34
Tuberculosis skin test (ie, PPD) +, intake	218	321	3792	3619
Tuberculosis skin test +, annual	44	27	587	535
Tuberculosis, known (ie, on tuberculosis medications) at intake	1	1	14	13
Tuberculosis, diagnosed at intake and attributed to county of origin	0	0	0	2
Tuberculosis, diagnosed during incarceration (identified after 42 days of incarceration)	0	1	21	18
Tuberculosis cases under management	22	18		
Peer education programs[¶]	0	0	100	98
Peer education educators[∞]	71	31	3,341	2,844
Peer education participants	5,255	6,012	78,013	80,139
Sexual assault in-service (sessions/units)	5/7	1/4	26/28	43/37
Sexual assault in-service participants	83	6	269	454
Alleged assaults and chart reviews	73	49	839	654
Bloodborne exposure labs drawn on offenders	14	16	184	165
New Sero-conversions d/t sexual assault ±	0	0	0	0
New Sero-conversions NOT from sexual assault	2	0	15	1

[*] Year-to-date totals are for the calendar year. Year-to-date data may not equal sum of monthly data because of late reporting.
[£] Hepatitis C cases in parentheses are acute cases; these are also included in the total number reported. Only acute cases are reportable to the Department of State Health Services
[¶] New programs are indicted in the column marked "This Month"; total programs are indicated in the column marked "Year to Date."
[∞] New peer educators are indicted in the column marked "This Month"; total peer educators are indicated in the column marked "Year to Date."
± New sero-conversions. * New reporting beginning August 1, 2011

Texas Department of Criminal Justice
Office of Public Health
Monthly Activity Report

January 2013

Reportable Condition	Reports			
	2013 This Month	2012 Same Month	2013 Year to Date*	2012 Year to Date*
Chlamydia	7	6	7	6
Gonorrhea	0	1	0	1
Syphilis	76	69	77	69
Hepatitis A	0	0	0	0
Hepatitis B, acute	0	1	0	1
Hepatitis C, total and (acute£)	147	168	147 (0)	168 (0)
Human immunodeficiency virus (HIV) +, known at intake	196	220	196	220
HIV screens, intake	7,134	6,870	7,134	6,870
HIV +, intake	39	38	39	38
HIV screens, offender- and provider-requested	885	977	885	977
HIV +, offender- and provider-requested	0	1	0	1
HIV screens, pre-release	4,678	4,529	4,678	4,529
HIV +, pre-release	1	2	1	2
Acquired immune deficiency syndrome (AIDS)	7	2	7	2
Methicillin-resistant *Staph Aureus* (MRSA)	63	61	63	61
Methicillin-sensitive *Staph Aureus* (MSSA)	35	32	35	32
Occupational exposures of TDCJ staff	5	18	5	18
Occupational exposures of medical staff	1	5	1	5
HIV chemoprophylaxis initiation	1	0	1	0
Tuberculosis skin test (ie, PPD) +, intake	261	275	261	275
Tuberculosis skin test +, annual	100	43	100	43
Tuberculosis, known (ie, on tuberculosis medications) at intake	0	0	0	0
Tuberculosis, diagnosed at intake and attributed to county of origin (identified before 42 days of incarceration)	3	0	3	0
Tuberculosis, diagnosed during incarceration (identified after 42 days of incarceration)	2	1	2	1
Tuberculosis cases under management	23	14		
Peer education programs¶	0	0	100	98
Peer education educators∞	21	142	3362	2655
Peer education participants	5346	5234	5345	5234
Sexual assault in-service (sessions/units)	2/2	2/2	2/2	2/2
Sexual assault in-service participants	48	13	48	13
Alleged assaults and chart reviews	91	74	91	74
Bloodborne exposure labs drawn on offenders	22	27	22	27
New Sero-conversions d/t sexual assault ±	0	0	0	0
New Sero-conversions NOT from sexual assault	1	1	1	1

Texas Department of Criminal Justice
Office of Public Health
Monthly Activity Report

February 2013

Reportable Condition	Reports			
	2013 This Month	**2012 Same Month**	**2013 Year to Date***	**2012 Year to Date***
Chlamydia	2	2	9	8
Gonorrhea	1	2	0	3
Syphilis	81	58	157	127
Hepatitis A	0	0	0	0
Hepatitis B, acute	2	0	2	1
Hepatitis C, total and (acute£)	195	258	342 (0)	424 (0)
Human immunodeficiency virus (HIV) +, known at intake	206	209	402	429
HIV screens, intake	5,493	5,577	12,627	12,447
HIV +, intake	40	51	79	89
HIV screens, offender- and provider-requested	1,110	938	1,995	1,905
HIV +, offender- and provider-requested	0	2	0	2
HIV screens, pre-release	4,226	5,294	12,764	9,823
HIV +, pre-release	1	1	2	3
Acquired immune deficiency syndrome (AIDS)	5	1	12	3
Methicillin-resistant *Staph Aureus* (MRSA)	56	76	119	135
Methicillin-sensitive *Staph Aureus* (MSSA)	36	40	71	72
Occupational exposures of TDCJ staff	11	15	16	33
Occupational exposures of medical staff	2	0	3	5
HIV chemoprophylaxis initiation	2	1	3	2
Tuberculosis skin test (ie, PPD) +, intake	306	363	567	638
Tuberculosis skin test +, annual	28	57	128	106
Tuberculosis, known (ie, on tuberculosis medications) at intake	0	1	0	1
Tuberculosis, diagnosed at intake and attributed to county of origin (identified before 42 days of incarceration)	0	0	3	0
Tuberculosis, diagnosed during incarceration (identified after 42 days of incarceration)	2	2	4	3
Tuberculosis cases under management	11	14		
Peer education programs¶	0	0	100	98
Peer education educators∞	47	39	3409	2538
Peer education participants	5915	5567	10,824	10,801
Sexual assault in-service (sessions/units)	2/1	6/6	4/3	8/8
Sexual assault in-service participants	25	44	73	57
Alleged assaults and chart reviews	41	56	132	131
Bloodborne exposure labs drawn on offenders	10	4	32	26
New Sero-conversions d/t sexual assault ±	0	0	0	0

Health Services Liaison Utilization Review Hospital and Infirmary Discharge Audit

During the Second Quarter of Fiscal Year 2013, ten percent of the UTMB and TTUHSC hospital and infirmary discharges were audited. A total of 157 hospital discharge and 52 infirmary discharge audits were conducted. This chart is a summary of the audits s

Freeworld Hospital Discharges in Texas Tech Sector

Month	Audits Performed	Vital Signs Not Recorded[1] (Cases with Deficiencies)		Appropriate Receiving Facility[2] (Cases with Deficiencies)		No Chain-In Done[3] (Cases with Deficiencies)		Unscheduled Care within 7 Days[4] (Cases with Deficiencies)		Lacked Documentation[5] (Cases with Deficiences)	
December	6	0	0.00%	0	0.00%	0	0.00%	1	16.70%	1	16.70%
January	7	1	14.30%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
February	5	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Total/Average		0.33	4.77%	0	0.00%	0	0.00%	0.33	5.57%	0.33	5.57%

Freeworld Hospital Discharges in UTMB Sector

Month	Audits Performed	Vital Signs Not Recorded[1] (Cases with Deficiencies)		Appropriate Receiving Facility[2] (Cases with Deficiencies)		No Chain-In Done[3] (Cases with Deficiencies)		Unscheduled Care within 7 Days[4] (Cases with Deficiencies)		Lacked Documentation[5] (Cases with Deficiences)	
December	18	2	11.10%	0	0.00%	0	0.00%	1	5.56%	0	0.00%
January	15	2	13.30%	0	0.00%	1	6.67%	0	0.00%	0	0.00%
February	14	6	42.85%	0	0.00%	0	0.00%	1	7.00%	0	0.00%
Total/Average		3.33	22.42%	0.00	0.00%	0.33	2.22%	0.67	4.19%	0.00	0.00%

UTMB Hospital Galveston Discharges

Month	Audits Performed	Vital Signs Not Recorded[1] (Cases with Deficiencies)		Appropriate Receiving Facility[2] (Cases with Deficiencies)		No Chain-In Done[3] (Cases with Deficiencies)		Unscheduled Care within 7 Days[4] (Cases with Deficiencies)		Lacked Documentation[5] (Cases with Deficiences)	
December	28	0	0.00%	0	0.00%	3	10.70%	1	3.57%	0	0.00%
January	34	0	0.00%	0	0.00%	10	29.00%	3	8.80%	0	0.00%
February	30	0	0.00%	0	0.00%	1	3.00%	2	6.00%	0	0.00%
Total/Average		0.00	0.00%	0.00	0.00%	4.67	14.23%	2.00	6.12%	0.00	0.00%

GRAND TOTAL: Combined Hospital Discharges (Texas Tech Sector, UTMB Sector and Hospital Galveston)

Month	Audits Performed	Vital Signs Not Recorded[1] (Cases with Deficiencies)		Appropriate Receiving Facility[2] (Cases with Deficiencies)		No Chain-In Done[3] (Cases with Deficiencies)		Unscheduled Care within 7 Days[4] (Cases with Deficiencies)		Lacked Documentation[5] (Cases with Deficiences)	
December	52	2	3.70%	0	0.00%	3	3.57%	3	8.61%	1	4.18%
January	56	3	9.20%	0	0.00%	11	11.89%	3	2.93%	0	0.00%
February	49	6	14.28%	0	0.00%	1	1.00%	3	4.33%	0	0.00%
Total/Average		3.67	9.06%	0	0.00%	5	5.49%	3	5.29%	0.33	1.39%

Texas Tech Infirmary Discharges

Month	Audits Performed	Vital Signs Not Recorded[1] (Cases with Deficiencies)		Appropriate Receiving Facility[2] (Cases with Deficiencies)		No Chain-In Done[3] (Cases with Deficiencies)		Unscheduled Care within 7 Days[4] (Cases with Deficiencies)		Lacked Documentation[5] (Cases with Deficiences)	
December	9	4	44.40%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
January	12	3	25.00%	0	0.00%	1	8.33%	0	0.00%	0	0.00%
February	8	0	0.00%	0	0.00%	2	25.00%	1	12.50%	0	0.00%
Total/Average		2.33	23.13%	0.00	0.00%	1.00	11.11%	0.33	4.17%	0.00	0.00%

UTMB Infirmary Discharges

Month	Audits Performed	Vital Signs Not Recorded[1] (Cases with Deficiencies)		Appropriate Receiving Facility[2] (Cases with Deficiencies)		No Chain-In Done[3] (Cases with Deficiencies)		Unscheduled Care within 7 Days[4] (Cases with Deficiencies)		Lacked Documentation[5] (Cases with Deficiences)	
December	7	0	0.00%	0	0.00%	2	28.60%	0	0.00%	0	0.00%
January	10	3	30.00%	0	0.00%	1	20.00%	0	0.00%	0	0.00%
February	6	2	33.33%	0	0.00%	2	33.33%	0	0.00%	0	0.00%
Total/Average		1.67	21.11%	0.00	0.00%	1.67	27.31%	0.00	0.00%	0.00	0.00%

GRAND TOTAL: Combined Infirmary Discharges (Texas Tech and UTMB)

Month	Audits Performed	Vital Signs Not Recorded[1] (Cases with Deficiencies)		Appropriate Receiving Facility[2] (Cases with Deficiencies)		No Chain-In Done[3] (Cases with Deficiencies)		Unscheduled Care within 7 Days[4] (Cases with Deficiencies)		Lacked Documentation[5] (Cases with Deficiences)	
December	16	4	22.20%	0	0.00%	2	14.30%	0	0.00%	0	0.00%
January	22	6	27.50%	0	0.00%	2	14.17%	0	0.00%	0	0.00%
February	14	2	16.67%	0	0.00%	4	29.17%	1	6.25%	0	0.00%
Total/Average		4.00	22.12%	0	0.00%	2.67	19.21%	0.33	2.08%	0	0.00%

Footnotes: 1. Vital signs were not recorded on the day the offender left the discharge facility. 2. Receiving facility did not have medical services available sufficient to meet the offender's current needs. 3. Chart not reviewed by a health care member

FIXED ASSETS CONTRACT MONITORING AUDIT
BY UNIT
SECOND QUARTER, FISCAL YEAR 2013

December 2012	Numbered Property On Inventory Report	Total Number of Deletions	Total Number of Transfers	Total Number of New Equipment
Briscoe	31	1	3	1
Cotulla	15	0	0	4
Total	46	1	3	5

January 2013	Numbered Property On Inventory Report	Total Number of Deletions	Total Number of Transfers	Total Number of New Equipment
Choice Moore	36	0	0	0
Cole State Jail	34	0	0	0
Gurney	56	0	1	0
Michael	64	0	0	11
Total	190	0	1	11

February 2013	Numbered Property On Inventory Report	Total Number of Deletions	Total Number of Transfers	Total Number of New Equipment
Kegans State Jail	7	0	0	0
Lockhart	26	0	0	0
Lychner State Jail	49	0	0	0
Skyview	110	0	15	30
Total	192	0	15	30

CAPITAL ASSETS AUDIT
SECOND QUARTER, FISCAL YEAR 2013

Audit Tools	December	January	Feburary	Total
Total number of units audited	2	4	4	10
Total numbered property	46	190	192	428
Total number out of compliance	0	0	0	0
Total % out of compliance	0.00%	0.00%	0.00%	0.00%

AMERICAN CORRECTIONAL ASSOCIATION
ACCREDITATION STATUS REPORT
Second Quarter FY-2013

University of Texas Medical Branch

Unit	Audit Date	% Compliance	
		Mandatory	Non-Mandatory
Ellis	December 2012	100%	97.9
Stevenson	December 2012	100%	98.6
Hutchins	January 2013	100%	98.4
Clemens	February 2013	100%	97.9
Scott	February 2013	100%	97.9
Duncan	February 2013	100%	99.0

Texas Tech University Health Science Center

Unit	Audit Date	% Compliance	
		Mandatory	Non-Mandatory
Lynaugh/Ft Stockton	January 2013	100%	97.4

The ACA Winter Conference - Congress of Corrections was held in Houston, Texas January 25-30, 2013. During this conference, the following units were awarded Reaccreditation by the ACA Panel of Commissioners: Havins, Boyd, Hamilton, Pack, Powledge, Tulia and Neal.

Project Number: 664-AR12

Researcher: Scott Walters

IRB Number: 2011-125

Application Received: 11/12/2012

Completed Application: 11/16/2012

Title of Research:
In-Person vs. Computer Interventions for Increasing Probation Compliance

Peer Panel Schedule: 01/16/2013

Proponent:
University of North Texas Health Science Center

Panel Recommendations:

Project Status:
Pending Peer Panel Review

Project Number: 669-AR13

Researcher: Chad Trulson

IRB Number: University IRB is reviewing. Researcher requests review and approval contingent upon IRB approval

Application Received: 02/07/2013

Completed Application: Pending IRB

Title of Research:
Criminal Behavior and Criminal Prosecutions in the Texas Department of Criminal Justice

Peer Panel Schedule:

Proponent:
University of North Texas, Department of Criminal Justice

Panel Recommendations:

Project Status:
Pending OIG

Executive Services
Active Monthly Medical Research Projects
Health Services Division
FY-2013 Second Quarterly Report: December, January, and February

Project Number: 623-RM11

Researcher:	IRB Number:	IRB Expiration Date:	Research Began:
Maurice Willis	10-191	06/15/2013	11/23/2011

Title of Research:
E1208: A Phase III randomized, Double-Blind Trial of Chemoembolization with or without Sorafenib in Unresectable Hepatocellular Carcinoma (HCC) in Patients with and without Vascular Invasion

Data Collection Began:
11/23/2011

Data Collection End:

Proponent:
University of Texas Medical Branch at Galveston

Project Status:	Progress Report Due:	Projected Completion:
Data Collection	04/11/2013	Will depend on enrollment

Project Number: 650-RM12

Researcher:	IRB Number:	IRB Expiration Date:	Research Began:
Mary Brinkman	12-011	01/10/2013	04/13/2012

Title of Research:
Evaluation of Patients Enrolled in Newly Instituted Pharmacist-Led Chronic Kidney Disease Clinics in the Correctional Managed Healthcare Setting

Data Collection Began:
04/13/2012

Data Collection End:
05/13/2012

Proponent:
University of Texas Medical Branch at Galveston

Project Status:	Progress Report Due:	Projected Completion:
Pending Final Product Review	09/13/2013	09/13/2013

Executive Services
Pending Monthly Medical Research Projects
Health Services Division

FY-2013 Second Quarterly Report: December, January, and February

Project Number: **615-RM10**

Application Received:
04/29/2011

Researcher
John Petersen

IRB Number:
11-069

Completed Application:
04/28/2011

Title of Research:
Serum Markers of Hepatocellular Cancer

Proponent:
University of Texas -Galveston / Correctional Managed Health Care

Peer Panel Schedule:
05/27/2011, 06/05/2011
01/05/2012

Project Status:
Pending Peer Panel 3rd Review

Panel Recommendations:
Recommended revisions,
Revised, resubmitted
06/06/2011

University Medical Director Review Sent:
01/04/2012

University Medical Director Approval:
01/05/2012

Project Number: **630-RM11**

Application Received:
05/18/2011

Researcher
Jacques Baillargeon

IRB Number:
11-067

Completed Application:
05/18/2011

Title of Research:
The Older Prisoner

Proponent:
University of Texas -Galveston / Correctional Managed Health Care

Peer Panel Schedule:
06/24/2011

Project Status:
Pending Peer Panel

University Medical Director Review Sent:
07/07/2011, 12/30/2011

Panel Recommendations:

University Medical Director Approval:

Project Number: **633-RM11**

Application Received:
06/17/2011

Researcher
Robert Morgan

IRB Number:
502838

Completed Application:
06/23/2011

Title of Research:
Thinking Patterns of Mentally Disordered Offenders

Proponent:
Texas Tech University Department of Psychology

Peer Panel Schedule:
11/22/2011, 01/17/2012, 02/15/2012

Project Status:
Pending Peer Panel 3rd Review

University Medical Director Review Sent:
07/7/2011

Panel Recommendations:

University Medical Director Approval:
11/15/2011

Project Number: **635-RM11**

Application Received:
07/06/2011

Researcher
Bryan Schneider

IRB Number:
11-101

Completed Application:
07/08/2011

Title of Research:
Lactulose compliance levels among patients admitted to a prison system hospital with a hepatic diagnosis

Proponent:
University of Texas -Galveston / Correctional Managed Health Care

Peer Panel Schedule:
02/06/2012

Project Status:
Pending Peer Panel

Panel Recommendations:

University Medical Director Review Sent:
07/19/2011

University Medical Director Approval:
08/31/2011

Project Number: **649-RM12**

Application Received:
01/13/2012

Researcher
Jacques Baillargeon

IRB Number:
11-098

Completed Application:
01/13/2012

Title of Research:
Prevalence of Major Psychiatric Disorders in the Texas Prison System

Proponent:
University of Texas -Galveston / Correctional Managed Health Care

Peer Panel Schedule:
03/14/2013

Project Status:
Pending Peer Panel Approval

Panel Recommendations:

University Medical Director Review Sent:
09/10/2012

University Medical Director Approval:
09/14/2012

Project Number: **658-RM12**

Application Received:
08/28/2012

Researcher
Robert Morgan

IRB Number:
L12-103

Completed Application:
08/28/2012

Title of Research:
Comparing Telehealth and Face-to-Face Interview Modalities In Referring Offenders with Mental Illness to Treatment

Proponent:
Texas Tech University

Peer Panel Schedule:
01/29/2013

Project Status:
Pending Peer Panel Approval

Panel Recommendations:

University Medical Director Review Sent:
8/29/2012

University Medical Director Approval:
01/28/2013

Project Number: **663-RM12**

Application Received:
11/12/2012

Researcher **IRB Number:**
Luca Cicalese 12-145

Completed Application:
11/12/2012

Title of Research:
Collection of Human Samples (Liver, Intestine, Blood, Urine, And Feces) and Hepatocellular Carcinoma (HCC) and Other Liver Diseases

Proponent:
University of Texas Medical Branch at Galveston

Peer Panel Schedule:
01/23/2013

Project Status:
Pending Peer Panel Approval

Panel Recommendations:

University Medical Director Review Sent:
01/18/2013

University Medical Director Approval:
01/22/2013

Project Number: **667-RM13**

Application Received:
01/24/2013

Researcher: **IRB Number:**
Emily Tong 12-280

Completed Application:
01/24/2013

Title of Research:
The Effectiveness of Switching Virologically Suppressed HIV-1 infected Patients From Emtricitabine (FTC) and Emtricitabine-Containing Products to Lamivudine (3TC)

Peer Panel Schedule:
02/22/2013

Proponent:
UTMB

Panel Recommendations:
Approved 02/25/2013

Project Status:
Pending OGC Approval

University Medical Director Review Sent:
02/15/2013

University Medical Director Approval:
02/19/2013

2nd Quarter FY 2013
TDCJ Office of Mental Health Monitoring & Liaison
Administrative Segregation

Date	Unit	Observed	Interviewed	Referred	Requests Fwd	911 Tool	ATC 4	ATC 5	ATC6
12/5-12/6/12	Hughes	478	119	0	8	100	100	100	100
12/6/12	Murray	114	32	0	3	100	100	100	100
12/11/12	Pack	17	14	0	0	100	100	100	100
12/12-12/13/12	Michael	487	147	0	7	100	100	100	100
12/19-12/20/12	Estelle	458	152	1	5	100	100	100	100
1/8/2013	Lychner	25	23	0	3	100	100	100	100
1/9-1/10/2013	Smith ECB	326	93	0	6	100	100	100	100
1/16/2013	Gist	21	19	0	10	100	100	100	100
1/16-17/2013	Stiles	466	141	1	5	100	100	100	100
1/23-24/2013	Telford	459	63	1	6	100	100	100	100
1/29/2013	Clemens	9	9	0	0	100	100	100	100
2/6-2/7/13	Coffield	570	126	1	6	100	100	100	100
2/12/13	Bartlett	13	13	1	1	100	100	100	100
2/13/13	Travis	8	8	0	1	100	100	100	100
2/13-2/14/13	Ferguson	307	31	0	2	100	100	100	100
2/20-2/21/13	Eastham	340	54	0	7	100	100	100	100
2/26-2/27/13	Robertson	464	79	1	4	100	100	100	100
2/27/13	Formby	23	2	0	1	N/A	N/A	N/A	N/A
Grand Total	**18 units**	**4585**	**1125**	**6**	**75**	**100%**	**100%**	**100%**	**100%**

INTAKE MENTAL HEALTH EVALUATION (MHE) AUDIT

Conducted in 2nd Quarter 2013

Period Audited—October 2012

FACILITY	Charts Reviewed	Charts Requiring MHE (1)	MHE's completed within 14 days (at Intake Unit)	Charts Excluded (2)	MHE Audit Score
Bartlett State Jail	20	5	4	0	80%
Baten ISF	0	0	0	0	N/A
Bradshaw State Jail	20	4	3	0	75%
Byrd Unit	20	13	11	0	85%
Dominguez State Jail	20	12	10	0	84%
Formby State Jail	20	8	7	0	88%
Garza Transfer Facility	20	7	4	1	67%
Gist State Jail	20	11	9	1	90%
Glossbrenner SAFPF	20	3	3	0	100%
Gurney Transfer Facility	20	5	4	0	80%
Halbert SAFPF	20	10	8	0	80%
Holliday Transfer Facility	20	10	8	0	80%
Hutchins State Jail	20	6	4	0	67%
Jester I SAFPF	20	19	19	0	100%
Johnston SAFPF	20	7	7	0	100%
Kyle SAFPF	16	5	4	0	80%
Lindsey State Jail	20	7	7	0	100%
Lychner State Jail	20	5	5	0	100%
Middleton Transfer Facility	20	4	4	0	100%
Plane State Jail	20	12	11	1	100%
Sanchez State Jail	20	9	6	0	67%
Sayle SAFPF	20	6	5	0	83%
Travis State Jail	20	12	11	0	92%
Woodman State Jail	20	17	3	2	20%
GRAND TOTAL	**456**	**197**	**157**	**5**	**80%**

1. Offenders entering TDCJ who are identified during the Intake Mental Health Screening/Appraisal process as having a history of treatment for mental illness, currently receiving mental health treatment, history of self-injurious behavior or current symptoms/complaints of symptoms of mental illness will have a Mental Health Evaluation (MHE) completed by a Qualified Mental Health Professional (QMHP) within 14 days of identification.
2. Charts are excluded from the sample of charts requiring a MHE if the offender was transferred from the intake unit before 14 days with the MHE not completed.

Corrective Action required of all units scoring below 80% is to prepare a Detailed Written Plan and to retrain with TDCJ Health Services Division. Units scoring between 80 to 89% were required to provide documentation of an in-service. Any offender identified as requiring a MHE on the day of audit was entered into the Mental Health Quality of Care Concerns Database and an action request was made that relevant offender receive the evaluation.

COMPELLED PSYCHOACTIVE MEDICATION AUDIT

2nd Quarter 2013

Audit Period—December 2012-February 2013

UNIT	Audit Month	Criteria for Compelled Meds Documented in Medical Record[1]				
		Reviewed	**Applicable**	**Compliant**	**Score**	**Corrective Action**
Jester IV	December 2012	5	5	5	100	N/A
Clements	December 2012	0	N/A	N/A	N/A	N/A
Skyview	December 2012	4	4	4	100	N/A
Montford	December 2012	2	2	2	100	N/A
Montford	January 2013	7	7	7	100	N/A
Clements	January 2013	0	0	0	N/A	N/A
Skyview	January 2013	7	7	7	100	N/A
Jester IV	January 2013	2	2	2	100	N/A
Montford	February 2013	5	5	5	100	N/A
Clements	February 2013	0	0	0	N/A	N/A
Skyview	February 2013	5	5	5	100	N/A
Jester IV	February 2013	4	4	4	100	N/A

1. Documentation supports that psychoactive medication was compelled because the patient refused to voluntarily comply and failure to take the medication would have resulted in: 1.Emergency - imminent likelihood of serious harm to the patient and/or to others, or 2. Non-emergency – likelihood of continued suffering from severe and abnormal mental, emotional and physical distress or deterioration of the patient's ability to function independently.

Corrective Action was required of all units scoring below 100%.

TEXAS DEPARTMENT OF CRIMINAL JUSTICE
HEALTH SERVICES DIVISION

OFFICE OF MENTAL HEALTH MONITORING AND LIAISON

Monthly Mental Health Quality of Care Concerns Database Report

Quality Assurance Committee Meeting

2nd Quarter 2013
December 2012-February 2013 Data

CATEGORY	TTUHSC	UTMB	PNF[1]	TOTAL
Medically Necessary Care				
Continuity of Care				
Evaluation	0	14	0	14
Medications				
Other				
Referrals				
Special Needs/Classification				
Treatment				
Total	0	14	0	14

Cases remaining open: ____0___

Cases Closed in December 2012-February 2013: ___14_ __

[1]**Private Non-CMHC Facility**

This information is privileged and confidential. It is prepared and distributed in accordance with Vernon's Annotated Civil Statutes, Health and Safety Code, Chapter 161.032 and 161.033.

Mental Health Access to Care Accuracy Evaluation

2nd Quarter 2013
Conducted December 2012-February 2013 by the Office of Mental Health Monitoring and Liaison

Unit	Audit Month*	SCR's Rev.	Methodology Evaluation Scores				
			WRO	Triage	CC	Provider	Overall
Cole State Jail	Nov 2012	20	100%	100%	100%	100%	95%
Gurney Transfer Facility	Nov 2012	20	NWR	90%	100%	100%	97%
Michael Unit	Nov 2012	20	NWR	100%	100%	100%	98%
Moore Transfer Facility	Nov 2012	10	NWR	100%	100%	88%	96%
Cole State Jail	Nov 2012	20	100%	100%	100%	100%	95%
Kegans State Jail	Dec 2012	5	NWR	100%	80%	100%	94%
Lockhart Unit	Dec 2012	9	50%	50%	25%	33%	36%
Lychner State Jail	Dec 2012	20	NWR	90%	90%	90%	84%
Skyview Unit	Dec 2012	20	NWR	100%	90%	100%	97%
West Texas ISF	Nov 2012	8	NWR	86%	86%	71%	73%

The audit results within this report were reported in the Quality Assurance Meeting.

*The "Audit Month" was the most current Unit ATC Methodology Audit available on the date of the evaluation.

SCR's Rev. - Number of **Sick Call Request Reviewed** in the ATC Audit
WRO - Sick Call Requests responded to with **Written Response Only**
NWR - **No Written Response**
CC - **Chief Complaint**
NSP - **No Sick Call Request Presented**

Corrective Action Required: Personnel who perform ATC Methodology Audit on those units with scores below 80% are required to schedule and attend additional training at TDCJ Health Services Administration Headquarters.

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Consent Item 3(a)

University Medical Director's Report

The University of Texas Medical Branch

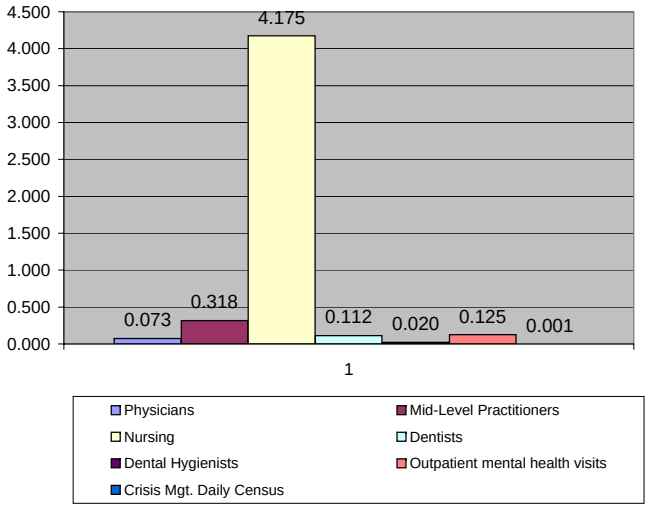
Correctional Health Care
MEDICAL DIRECTOR'S REPORT

SECOND QUARTER
FY 2013

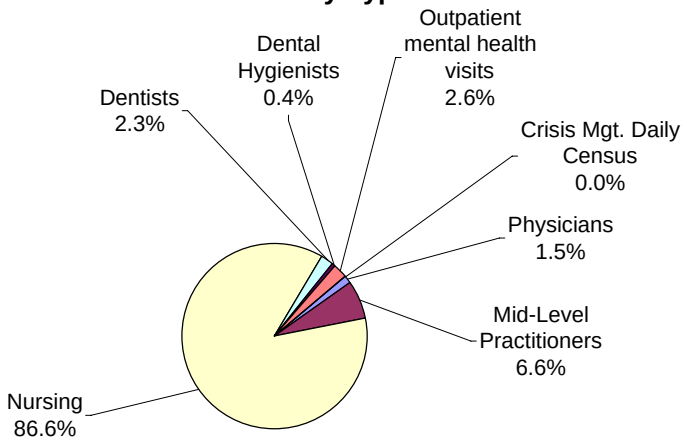
Medical Director's Report:

	December		January		February		Qtly Average	
Average Population	**118,204**		**117,794**		**117,931**		**117,976**	
	Number	**Rate Per Offender**	**Number**	**Rate Per Offender**	**Number**	**Rate Per Offender**	**Number**	**Rate Per Offender**
Medical encounters								
Physicians	8,427	0.071	9,136	0.078	8,336	0.071	**8,633**	**0.073**
Mid-Level Practitioners	32,965	0.279	41,174	0.350	38,280	0.325	**37,473**	**0.318**
Nursing	489,756	4.143	537,368	4.562	450,697	3.822	**492,607**	**4.175**
Sub-total	**531,148**	**4.493**	**587,678**	**4.989**	**497,313**	**4.217**	**538,713**	**4.566**
Dental encounters								
Dentists	10,835	0.092	14,679	0.125	14,060	0.119	**13,191**	**0.112**
Dental Hygienists	2,046	0.017	2,454	0.021	2,519	0.021	**2,340**	**0.020**
Sub-total	**12,881**	**0.109**	**17,133**	**0.145**	**16,579**	**0.141**	**15,531**	**0.132**
Mental health encounters								
Outpatient mental health visits	13,409	0.113	15,607	0.132	15,078	0.128	**14,698**	**0.125**
Crisis Mgt. Daily Census	58	0.000	59	0.001	62	0.001	**60**	**0.001**
Sub-total	**13,467**	**0.114**	**15,666**	**0.133**	**15,140**	**0.128**	**14,758**	**0.125**
Total encounters	**557,496**	**4.716**	**620,477**	**5.267**	**529,032**	**4.486**	**569,002**	**4.823**

Encounters as Rate Per Offender Per Month



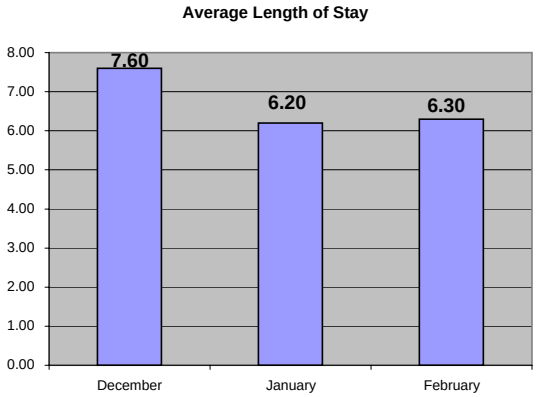
Encounters by Type

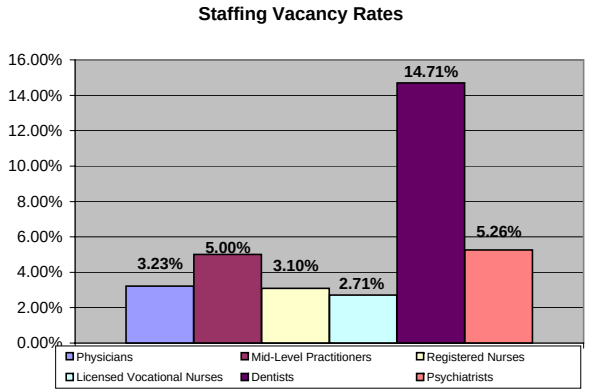


Medical Director's Report (Page 2):

	December	January	February	Qtly Average
Medical Inpatient Facilities				
Average Daily Census	67.40	70.80	67.10	**68.43**
Number of Admissions	276.00	355.00	297.00	**309.33**
Average Length of Stay	7.60	6.20	6.30	**6.70**
Number of Clinic Visits	3,324.00	4,643.00	4,310.00	**4,092.33**
Mental Health Inpatient Facilities				
Average Daily Census	1,044.35	1,045.75	1,036.04	**1,042.05**
PAMIO/MROP Census	686.97	693.64	699.86	**693.49**
Telemedicine Consults	7,306	9,280	8,743	**8,443.00**

	Average This Quarter			Percent
Health Care Staffing	Filled	Vacant	Total	Vacant
Physicians	60.00	2.00	62.00	3.23%
Mid-Level Practitioners	114.00	6.00	120.00	5.00%
Registered Nurses	219.00	7.00	226.00	3.10%
Licensed Vocational Nurses	539.00	15.00	554.00	2.71%
Dentists	58.00	10.00	68.00	14.71%
Psychiatrists	18.00	1.00	19.00	5.26%





Consent Item 3(b)

University Medical Director's Report

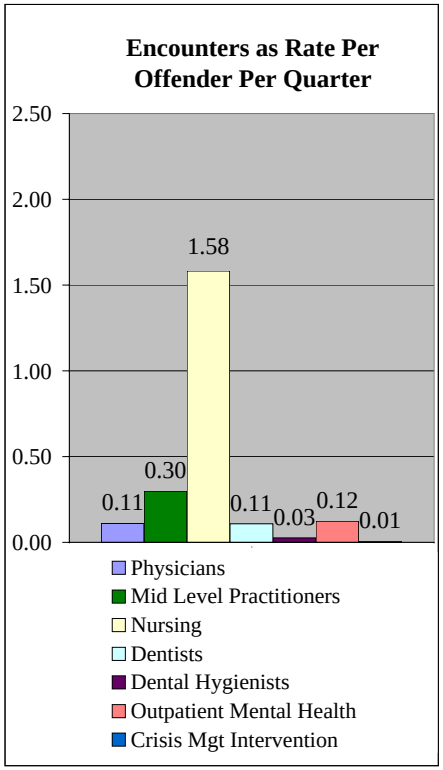
Texas Tech University
Health Sciences Center

Correctional Managed Health Care
MEDICAL DIRECTOR'S REPORT

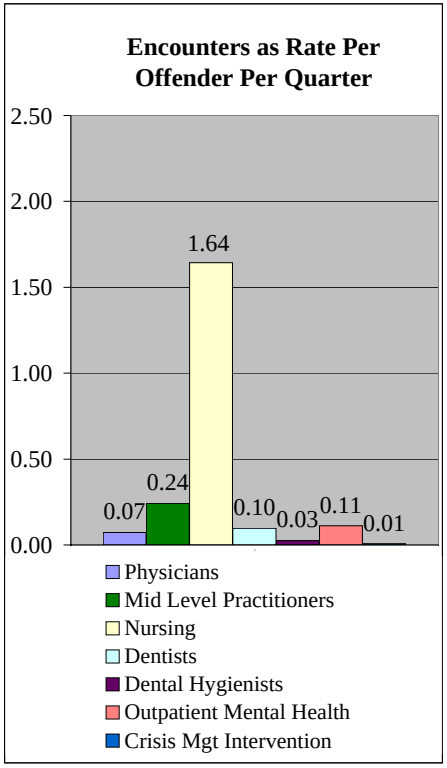
SECOND QUARTER
FY 2013

Medical Director's Report:

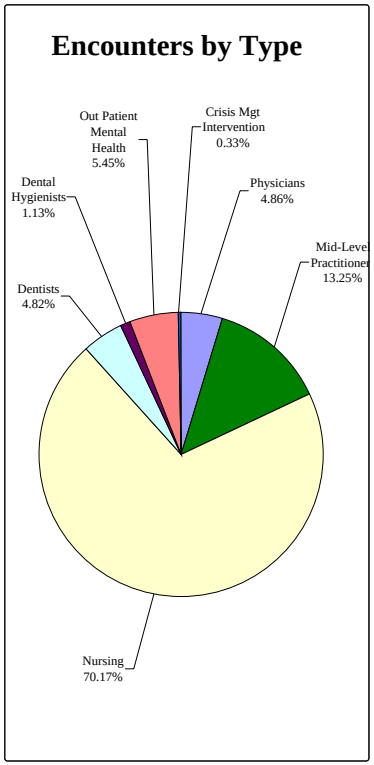
	December		January		February		Quarterly Average	
Average Population	30,627.92		30,262.03		30,146.05		30,345.33	
Medical Encounters	Number	Rate Per Offender	Number	Rate Per Offender	Number	Rate Per Offender	Number	Rate Per Offender
Physicians	2,524	0.082	2,171	0.072	1,941	0.064	2,212	0.073
Mid-Level Practitioners	6,385	0.208	8,292	0.274	7,342	0.244	7,340	0.242
Nursing	47,360	1.546	53,771	1.777	48,451	1.607	49,861	1.643
Sub-Total	**56,269**	**1.837**	**64,234**	**2.123**	**57,734**	**1.915**	**59,412**	**1.958**
Dental Encounters								
Dentists	2,597	0.085	3,390	0.112	2,862	0.095	2,950	0.097
Dental Hygienists	625	0.020	829	0.027	910	0.030	788	0.026
Sub-Total	**3,222**	**0.105**	**4,219**	**0.139**	**3,772**	**0.125**	**3,738**	**0.123**
Mental Health Encounters								
Outpatient mental health visits	3,168	0.103	3,568	0.118	3,459	0.115	3,398	0.112
Crisis Mgt. Interventions	220	0.007	247	0.008	190	0.006	219	0.007
Sub-Total	**3,388**	**0.111**	**3,815**	**0.126**	**3,649**	**0.121**	**3,617**	**0.119**
Total Encounters	**62,879**	**2.053**	**72,268**	**2.388**	**65,155**	**2.161**	**66,767**	**2.200**



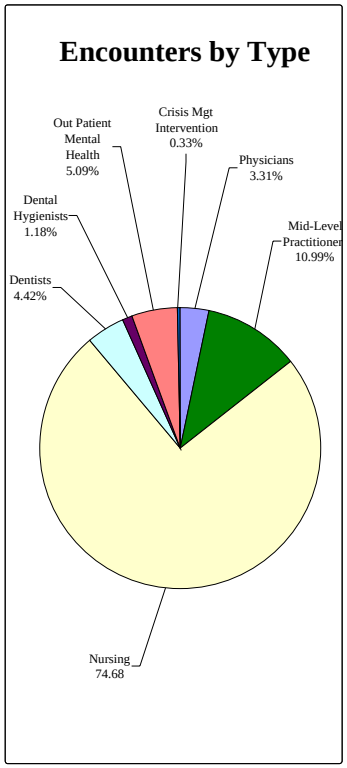
1st Quarter 2013



2nd Quarter 2013



1st Quarter 2013

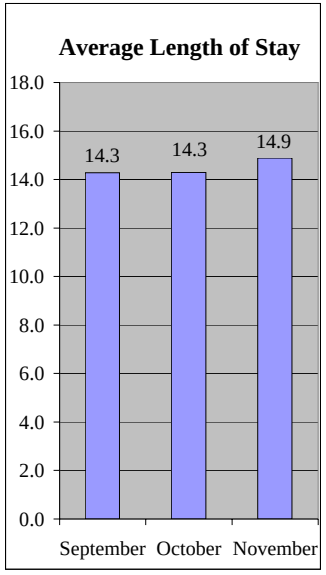


2nd Quarter

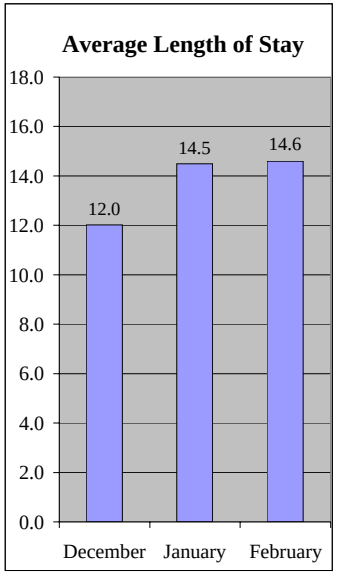
Medical Director's Report (page 2):

	December	January	February	Quarterly Average
Medical Inpatient Facilities				
Average Daily Census	111.07	114.87	114.57	**113.50**
Number of Admissions	154	181	166	**167.00**
Average Length of Stay	12.02	14.49	14.59	**13.70**
Number of Clinic Visits	619	729	592	**646.67**
Mental Health Inpatient Facilities				
Average Daily Census	398	422	426	**415.33**
PAMIO/MROP Census	260	263	282	**268.33**
Specialty Referrals Completed	1013	1083	789	**961.67**
Telemedicine Consults	763	863	846	**824.00**

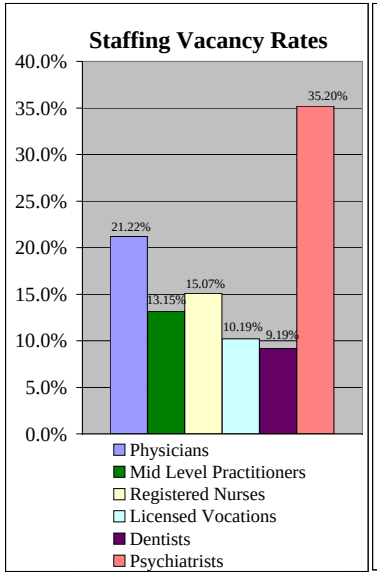
	Average This Quarter			Percent
Health Care Staffing	Filled	Vacant	Total	Vacant
Physicians	13.91	5.65	19.56	28.89%
Mid-Level Practitioners	29.83	5.67	35.50	15.97%
Registered Nurses	126.82	24.47	151.29	16.17%
Licensed Vocational Nurses	276.68	27.32	304.00	8.99%
Dentists	17.30	1.75	19.05	9.19%
Psychiatrists	7.39	1.70	9.09	18.70%



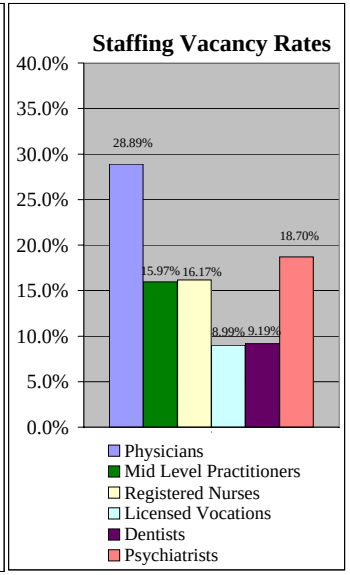
1st Quarter



2nd Quarter



1st Quarter
2013



2nd Quarter

Consent Item 4

Summary of CMHCC Joint Committee \ Work Groups

Correctional Managed Health Care
Joint Committee/Work Group Activity Summary
For June 2013 CMHCC Meeting

The CMHCC, through its overall management strategy, utilizes a number of standing and ad hoc joint committees and work groups to examine, review and monitor specific functional areas. The key characteristic of these committees and work groups is that they are comprised of representatives of each of the partner agencies. They provide opportunities for coordination of functional activities across the state. Many of these committees and work groups are designed to insure communication and coordination of various aspects of the statewide health care delivery system. These committees work to develop policies and procedures, review specific evaluation and/or monitoring data, and amend practices in order to increase the effectiveness and efficiency of the program.

Many of these committees or work groups are considered to be medical review committees allowed under Chapter 161, Subchapter D of the Texas Health and Safety code and their proceedings are considered to be confidential and not subject to disclosure under the law.

This summary is intended to provide the CMHCC with a high level overview of the ongoing work activities of these workgroups.

Workgroup activity covered in this report includes:

- System Leadership Council
- Joint Policy and Procedure Committee
- Joint Pharmacy and Therapeutics Committee
- Joint Infection Control Committee
- Joint Dental Work Group
- Joint Mortality and Morbidity Committee
- Joint Nursing Work Group

System Leadership Council

Chair: Dr. Denise DeShields

Purpose: Charged with routine oversight of the CMHCC Quality Improvement Plan, including the monitoring of statewide access to care and quality of care indicators.

Meeting Date: May 9, 2013
Key Activities:

(1) Approval of Minutes

Reports from Champions/Discipline Directors:

A. Access to Care-Dental Services
B. Access to Care-Mental Health Services
C. Access to Care-Nursing Services
D. Access to Care-Medical Staff
E. Sick Call Request Verification Audit-SCRVA
F. FY2013 SLC Indicators
    1. Dental: Total Open Reminders with Delay > 180 Days
    2. Mental Health: Vital Signs Prior to Transfer to Crisis Management
    3. Nursing: Refusal of Treatment (ROT)
    4. Inpatient Physical Therapy
    5. Missed Appointments (No Shows)

Standing Issues

A. Monthly Grievance Exception Report
B. New SLC Indicators
C. Hospital and Infirmary Discharge Audits

Miscellaneous/Open for Discussion Participants:

A. CMHCC Updates
B. Joint Nursing Committee Update
C. Chronic Disease Audit Update
D. ATC Accuracy Evaluation
E. QA Nurse Protocol Audits
F. Nursing QA-QI Site Visit Audits

Adjournment

Joint Policy and Procedure Committee

Co-Chair: Dr. Robert Williams, TDCJ Health Services Division
Co-Chair: Allen Hightower, Executive Director, CMHC

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

Meeting Date: April 11, 2013

Sub Committee Updates:

None

Old Business:

None

New Business:

The Following Policies Are Scheduled For Review At This Time.

A-05.1, A-06.1, A-06.2, A-07.1, A-08.1, A-08.2, C-19.2*, C-20.1, D-28.2, D-28.3, D-28.4, E-34.4, E-35.1, E-35.2, E-36.4*, E-37.1*, E-37.2, E-37.3, E-37.4, E-37.5, F-47.1, F-48.1, G-51.6, G-51.7, G-51.8*, G-51.9*, G-51.10, H-60.2*, I-68.4*

The Following Policies Have Been Submitted With Changes or For Discussion.

A-08.6 Medically Recommended Intensive
Attachments A, B Supervision (MRIS) Screening
E-31.2 Organ or Tissue Donation
Attachment B
G-55.1 Pregnant Offenders
I-70.1 Informed Consent
E-34.2 thru G-51.10 Lisa Lopez has requested Discussion Regarding Documenting Offender Annual Physical On A Chronic Care Clinic Note.

Adjournment

- Next Meeting Date is July 11, 2013 at 1:00 P.M.

Joint Pharmacy and Therapeutics Committee

Chair: Dr. Benjamin Leeah

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

Meeting Date: May 9, 2013

Key Activities:

Approval of Minutes from March 14, 2013 Meeting

Reports from Subcommittees:

- **A.** DMG Triage – Dr. Sandmann
- **B.** ESLD - Dr. Roberts
- **C.** HIV - Dr. Sandmann
- **D.** Psychiatry - Dr. Koranek

Monthly Reports

- **A.** Adverse Drug Reaction Report (none)
- **B.** Pharmacy Clinical Activity Report
- **C.** Drug recalls (March - April 2013)
- **D.** Nonformulary Deferral Reports
    1. UTMB Sector (February - April 2013)
    2. Texas Tech Sector (February - March 2013)
- **E.** Quarterly Medication Error Reports – 2nd Quarter FY13
    1. UTMB Sector
    2. Texas Tech Sector
    3. Medication Dispensing Error Report
- **F.** Utilization Reports – (January – March 2013)
    1. HIV Utilization
    2. Hepatitis C Utilization
    3. Hepatitis B Utilization
    4. Psychotropic Utilization
- **G.** Policy Review Schedule

New Business

- **A.** Action Request
    1. Chronic Kidney Disease Patient Education
    2. Review of Warfarin DMG and Recommendations for Supratherapeutic INR
    3. Consider New Disease Management Guidelines for Gout and Thyroid
    4. Prednisone Taper Schedule
    5. Disaster Formulary Medication

B. Drug Category Review
1. Gastrointestinal Agents
2. Tropical Agents

C. FDA Medication Safety Advisories
D. Manufacturer Shortages and Discontinuations
E. Policy and Procedure Revisions
1. Self-Administration of Medication (50-10)
2. Drug Therapy Management by a Pharmacist (55-10)
3. Therapeutic Interchange (55-15)
4. Clozapine Protocol (55-25)
5. Disease Management Guidelines (55-25)
6. Ordering Erythropoiesis Stimulating Agents (55-30)
7. Emergency Drugs (60-05)
8. Requisition of Drugs by EMS (60-10)
9. Credential Requirements for Administration of Medication (65-05)
10. Medication Safety (75-30)

F. Miscellaneous

Adjournment

Joint Infection Control Committee

Co-Chair: Dr. Carol Coglianese
Co-Chair: Chris Black-Edwards, RN, BSN

Purpose: Charged with the review, monitoring and evaluation of infection control policies and preventive health programs.

Meeting Date: April 11 2013
Key Activities:

Reviewed and Approved Minutes

Public Health Update

A. Connie Adams, LVN – HIV
B. Latasha Hill, LVN – Occupational Exposure, MRSA & MSSA
C. Anthony Turner – Syphilis
D. Mary Parker - Tuberculosis
E. Charma Blount, RN – Sexual Assault Nurse Examiner
F. Dianna Langley – Peer Education

New Business

A. B-14.07 - Immunization - Tabled from February 14, 2013 meeting
B. B-14.50 - Housing and Job Restrictions

Policy Under Reviews -

a. B-14.11 Human Immunodeficiency Virus (HIV) Infection
b. B-14.12 Syphilis
c. B-14.14 Varicella and Shingles
d. B-14.15 Meningitis
e. B-14.16 Skin and Soft Tissue Infection
f. B-14.18 Clostridium Difficile
g. B-14.19 Disease Reporting

Adjourn

- Next Meeting – August 8, 2013
- Policies to be reviewed are B-14.20 through B-14.26

Joint Dental Work Group

Chair: Dr. Billy Horton

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

Meeting Date: May 15, 2013

Systems Director Meeting

- TDCJ Health Services Director, Dr. Manual "Bubba" Hirsch
- Western Sector Dental Services Director, TTUHSC, Dr. Brian Tucker
- Eastern Sector Dental Services Directors, UTMB-CMC, Dr. Billy Horton
- Dental Utilization Quality Review committee, Chairperson: Dr. Scott Reinecke
- Oraline
- Lunch
- Dental Hygiene Manager, Ms. Pam Myers
- Policy review – D-28.2, E-36.6 and B-14.1

UTMB – CMC Director's Meeting

- Eastern Sector Dental Services
    - Region 1, Dr. Scott Reinecke
    - Region 2, Dr. John Beason
    - Region 3, Dr. Joseph Sheringo

- Adjourn

Joint Mortality and Morbidity Committee

Co-Chair: Dr. Glenda Adams
Co-Chair: Dr. Robert Williams

Key Activities:
Review and discussion of reports on offender deaths and determinations as to the need for peer review.

Purpose:

- Charged with the ongoing review of morbidity and mortality data, including review of each offender death.

For the Three Months Ended May 31, 2013

- There were 108 deaths reviewed by the Mortality and Morbidity Committee during the months of March, April, and May 2013. Of those 108 deaths, 10 were referred to peer review committees.

Joint Nursing Work Group

Chair: Mike Jones, RN, BSN

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

Meeting Date: April 10, 2013

- Potential Closure Dawson Plan - Gary
- Emergency Equipment - George
- Nurse Protocols - George
- DNR Wrist Bands - Mike
- DNA Fingerprinting by Nursing - Mike
- PREA - Mike
- Nail Clipping for Non-IDDM Inmates in Medical - Mike
- E-32.1 - Mike, Justin
- Next Meeting Schedule - July 10, 2013

Adjourn

CORRECTIONAL MANAGED HEALTH CARE COMMITTEE

1300 11th Street, Suite 415, Huntsville, Texas 77340
(936) 437-1972 ♦ Fax: (936) 437-1970

Allen R. Hightower
Executive Director

Date: June 18, 2013

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

From: Allen Hightower, Executive Director

Subject: Executive Director's Report

Legislative Updates.

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Correctional Managed Health Care

Quarterly Report
FY 2013 Second Quarter

September 2012 – February 2013

Summary

This report is submitted in accordance with Rider 55; page V-24, House Bill 1, 82nd Legislature, and Regular Session 2011. The report summarizes activity through the second quarter of FY 2013. Following this summary are individual data tables and charts supporting this report.

Background

During Fiscal Year 2013, approximately $429.0 million within the TDCJ appropriation has been allocated for funding correctional health care services. This funding included:

- $135.3M in general revenue appropriations in strategy C.1.8 (Hospital and Clinic Care)
- $242.2M in general revenue appropriations in strategy C.1.7 (Unit and Psychiatric Care).
- $51.5M in general revenue appropriations in strategy C.1.9 (Pharmacy Care).

Of this funding, $428.5M (99.9%) was allocated for health care services provided by UTMB and TTUHSC. And $474K (0.1%) was allocated for funding of the operation of the Correctional Managed Health Care Committee.

These payments are made directly to the university providers according to their contracts. Benefit reimbursement amounts and expenditures are included in the reported totals provided by the universities.

Report Highlights

Population Indicators

- Through the second quarter of this fiscal year, the correctional health care program has decreased in the overall offender population served. The average daily population served through the second quarter of FY 2013 was 149,829. Through this same quarter a year ago (FY 2012), the average daily population was 152,924, a decrease of 3,095 (2.02%). While overall growth has decreased, the number of offenders age 55 and over has continued to steadily increase year over year.
  - Consistent with the trend for the last several years, the number of offenders in the service population aged 55 or older has continued to rise at a near double digit rate. Through the second quarter of FY 2013, the average number of older offenders in the service population was 14,010. Through this same quarter a year ago (FY 2012), the average number of offenders age 55 and over was 13,534. This represents an increase of 476 or about 3.5% more older offenders than a year ago.
  - Hospital Inpatient Census is a new statistical indicator established to reflect the health care dollars spent in the C.1.8 Strategy "Hospital and Clinic Costs". The hospital inpatient average daily census (ADC) served through the second quarter of FY 2013 was 215 for both the Texas Tech and UTMB Sectors.
  - Outpatient Clinic and ER Visits is another new statistical indicator established to reflect the health care dollars spent in the C.1.8 Strategy "Hospital and Clinic Costs". The medical outpatient clinic and ER visits served through the second quarter of FY 2013 was 4,983 for both the Texas Tech and UTMB Sectors.
  - The overall HIV+ population has remained relatively stable throughout the last few years and continued to remain so through this quarter, averaging 2,229 (or about 1.5% of the population served).
  - Two mental health caseload measures have also remained relatively stable:
    - The average number of psychiatric inpatients within the system was 1,728 through the second quarter of FY 2013, as compared to 1,817 through the same quarter a year ago (FY 2012). The inpatient caseload is limited by the number of available inpatient beds in the system.
    - Through the second quarter of FY 2013, the average number of mental health outpatients was 18,580 representing 12.5% of the service population.

Health Care Costs

- Overall health costs through the second quarter of FY 2013 totaled $249.3M. This amount is above the overall revenues earned by the university providers by $12.3M.
  - UTMB's total revenue through the second quarter was $188.3M. Their expenditures totaled $201.3M, resulting in a net loss of nearly $13M. On a per offender per day basis, UTMB earned $8.82 in revenue and expended $9.42 resulting in a loss of $0.60 per offender per day.
  - TTUHSC's total revenue through the second quarter was $48.7M. Expenditures totaled $48.1M, resulting in a net gain of $651,601. On a per offender per day basis, TTUHSC earned $8.73 in revenue, but expended $8.62 resulting in a gain of $0.11 per offender per day.
- Examining the health care costs in further detail indicates that of the $249.3M in expenses reported through the second quarter of the year:
  - Onsite services (those medical services provided at the prison units) comprised $113.8M representing about 45.6% of the total health care expenses:
    - Of this amount, 82.9% was for salaries and benefits and 17.1% for operating costs.
  - Pharmacy services totaled $23.4M representing approximately 9.4% of the total expenses:
    - Of this amount 20.0% was for related salaries and benefits, 3.5% for operating costs and 76.5% for drug purchases.
  - Offsite services (services including hospitalization and specialty clinic care) accounted for $84.1M or 33.7% of total expenses:
    - Of this amount 69.4% was for estimated university provider hospital, physician and professional services; and 30.6% for Freeworld (non-university) hospital, specialty and emergency care.
  - Mental health services totaled $21.1M or 8.5% of the total costs:
    - Of this amount, 97.9% was for mental health staff salaries and benefits, with the remaining 2.1% for operating costs.
  - Indirect support expenses accounted for $6.9M and represented 2.8% of the total costs.

- The total cost per offender per day for all health care services statewide through the second quarter of FY 2013 was $9.26. Prior year 2nd Quarter FY 2012 total cost per offender per day was $8.78 an increase of 5.5%. However, when benchmarked against the average cost per offender per day for the prior four fiscal years of $9.51, the decrease is at (2.6%).
    - For UTMB, the cost per offender per day was $9.42. This is lower than the average cost per offender per day for the last four fiscal years of $9.60.
    - For TTUHSC, the cost per offender per day was $8.62, lower than the average cost per offender per day for the last four fiscal years of $9.20.
    - Differences in cost between UTMB and TTUHSC relate to the differences in mission, population assigned and the acuity level of the offender patients served.

Aging Offenders

- As consistently noted in prior reports, the aging of the offender population has a demonstrated impact on the resources of the health care system. Offenders age 55 and older access the health care delivery system at a much higher level and frequency than younger offenders:
    - Encounter data through the second quarter of FY 2013 indicates that offenders aged 55 and over had a documented encounter with medical staff a little more than 1.2 times as often as those under age 55.
    - An examination of hospital admissions by age category found that through this second quarter of the fiscal year, hospital costs and outpatient clinic costs received to date for charges incurred this fiscal year for offenders over age 55 totaled approximately $1,887 per offender. The same calculation for offenders under age 55 totaled about $329. In terms of hospitalization and clinic costs, the older offenders were utilizing health care resources at a rate of more than 5.7 times higher than the younger offenders. While comprising about 9.4% of the overall service population, offenders age 55 and over account for 37.4% of the hospitalization costs received to date.
    - A third examination of dialysis costs found that, proportionately, older offenders are represented 5.7 times more often in the dialysis population than younger offenders. Dialysis costs continue to be significant, averaging $23,131 per patient per year. Providing medically necessary dialysis treatment for an average of 218 patients through the second quarter of FY2013 cost $2.5M.

Drug Costs

- Total drug costs through the second quarter of FY 2013 totaled $17.4M.
    - Pharmaceutical costs related to HIV care continue to be the largest single component of pharmacy expenses.
        - Through this quarter, $8.4M in costs (or about $1.4M per month) for HIV antiretroviral medication costs were experienced. This represents 48.2% of the total drug cost during this time period.
        - Expenses for psychiatric drugs are also being tracked, with approximately $1.2M being expended for psychiatric medications through the second quarter, representing 6.7% of the overall drug cost.
        - Another pharmacy indicator being tracked is the cost related to Hepatitis C therapies. These costs were $644K and represented about 3.7% of the total drug cost.

Reporting of Fund Balances

- UTMB reports that they have a total loss of $12,962,375 through this second quarter of this fiscal year. TTUHSC reports that they have a total gain of $651,601 through this second quarter of this fiscal year. Please note Table 3 - All Health Care Summary of this financial report for the details of the Overall Revenue and Expense Summary by the Three Healthcare Strategies that we follow.

- A summary analysis of the ending balances, revenue and payments through the second quarter for the CMHCC account is included in this report. That summary indicates that the ending balance on the CMHCC account on February 28, 2013 was $155,144.70. This amount includes FY 2012 funds of $79,991.45 that has lapsed back to TDCJ Unit and Mental Health Strategy C.1.7 with a December 2012 transaction.

Financial Monitoring

Detailed transaction level data from both university providers is being tested on a monthly basis to verify reasonableness, accuracy, and compliance with policies, procedures, and contractual requirements.

The testing of detail transactions performed on TTUHSC's financial information for December through February 2013 found all tested transactions to be verified and found all back up detail to be validated.

The testing of detail transactions performed on UTMB's financial information for December through February 2013 found all tested transactions to be verified and found all back up detail to be validated.

Concluding Notes

The combined operating loss for the university providers through the second quarter of FY 2013 is $12.3 M. The university providers are continuing to monitor their expenditures closely, while seeking additional opportunities to reduce costs in order to minimize their operating losses.

Listing of Supporting Tables and Charts

Table 1

Correctional Managed Health Care

FY 2013 Budget Allocations

Distribution of Funds

Allocated to	FY 2013
University Providers	
The University of Texas Medical Branch	
Unit and Psychiatric Care	$187,310,012
Hospital and Clinic Care	$110,016,885
Pharmacy Care	$41,018,720
Subtotal UTMB	$338,345,617
Texas Tech University Health Sciences Center	
Unit and Psychiatric Care	$54,370,960
Hospital and Clinic Care	$25,291,922
Pharmacy Care	$10,481,280
Subtotal TTUHSC	$90,144,162
SUBTOTAL UNIVERSITY PROVIDERS	$428,489,779
Correctional Managed Health Care Committee	$474,062
TOTAL DISTRIBUTION	**$428,963,841**

Source of Funds

Source	FY 2013
Legislative Appropriations	
SB 1, Article V, TDCJ Appropriations	
Strategy C.1.7. Unit and Psychiatric Care	$242,155,034
Strategy C.1.8. Hospital and Clinic Care	$135,308,807
Strategy C.1.9 Pharmacy Care	$51,500,000
TOTAL	**$428,963,841**

Note: In addition to the amounts received and allocated by the CMHCC, the university providers receive partial reimbursement for employee benefit costs directly from other appropriations made for that purpose.

Chart 1

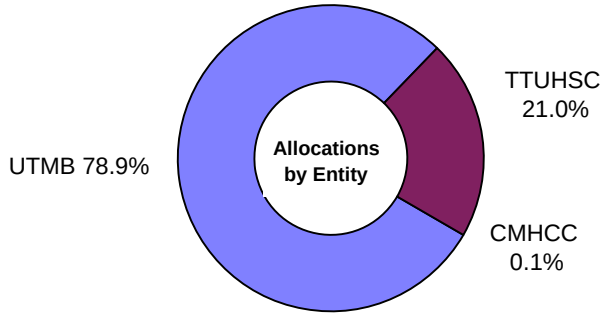


Table 2
FY 2013
Key Population Indicators
Correctional Health Care Program

Indicator	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Population Year to Date Avg.
Avg. Population Served by CMHC:							
UTMB State-Operated Population	106,142	106,021	106,241	106,310	105,925	106,066	106,117
UTMB Private Prison Population*	11,916	11,900	11,899	11,894	11,870	11,865	11,891
UTMB Total Service Population	118,057	117,921	118,140	118,204	117,794	117,931	118,008
TTUHSC Total Service Population	31,234	31,331	31,325	30,629	30,262	30,148	30,821
CMHC Service Population Total	**149,291**	**149,252**	**149,465**	**148,832**	**148,057**	**148,079**	**148,829**
Population Age 55 and Over							
UTMB Service Population Average	11,474	11,519	11,603	11,628	11,734	11,809	11,628
TTUHSC Service Population Average	2,395	2,410	2,391	2,387	2,355	2,356	2,382
CMHC Service Population Average	**13,869**	**13,929**	**13,994**	**14,015**	**14,089**	**14,165**	**14,010**
Medical Health Inpatient Daily Census							
UTMB Hospital Galveston Inpatient ADC	69	68	69	68	71	70	69
UTMB FreeWorld Hospital Inpatient ADC	30	24	24	26	21	21	24
TTUHSC RMF Inpatient ADC	109	108	116	111	115	115	112
TTUHSC FreeWorld Hospital Inpatient ADC	10	9	8	12	9	6	9
CMHC Medical Inpatient Daily Census	**218**	**210**	**217**	**216**	**215**	**211**	**215**
Medical Health Outpatient Visits							
UTMB Specialty Clinic & ER Visits	3,419	4,220	4,087	3,417	4,543	4,898	4,097
TTUHSC FreeWorld Outpatient & ER Visits	416	949	719	1,026	1,301	903	886
CMHC Medical Outpatient Visits	**3,835**	**5,169**	**4,806**	**4,443**	**5,844**	**5,801**	**4,983**
HIV+ Population	**2,267**	**2,239**	**2,233**	**2,207**	**2,200**	**2,226**	**2,229**
Mental Health Inpatient Census							
UTMB Psychiatric Inpatient Average	993	1,016	1,035	1,044	1,033	1,036	1,026
TTUHSC Psychiatric Inpatient Average	757	721	683	658	685	708	702
CMHC Psychiatric Inpatient Average	**1,750**	**1,737**	**1,718**	**1,702**	**1,718**	**1,744**	**1,728**
Mental Health Outpatient Census							
UTMB Psychiatric Outpatient Average	14,691	16,085	14,889	13,409	15,607	15,078	14,960
TTUHSC Psychiatric Outpatient Average	3,520	4,105	3,903	3,168	3,568	3,459	3,621
CMHC Psychiatric Outpatient Average	**18,211**	**20,190**	**18,792**	**16,577**	**19,175**	**18,537**	**18,580**

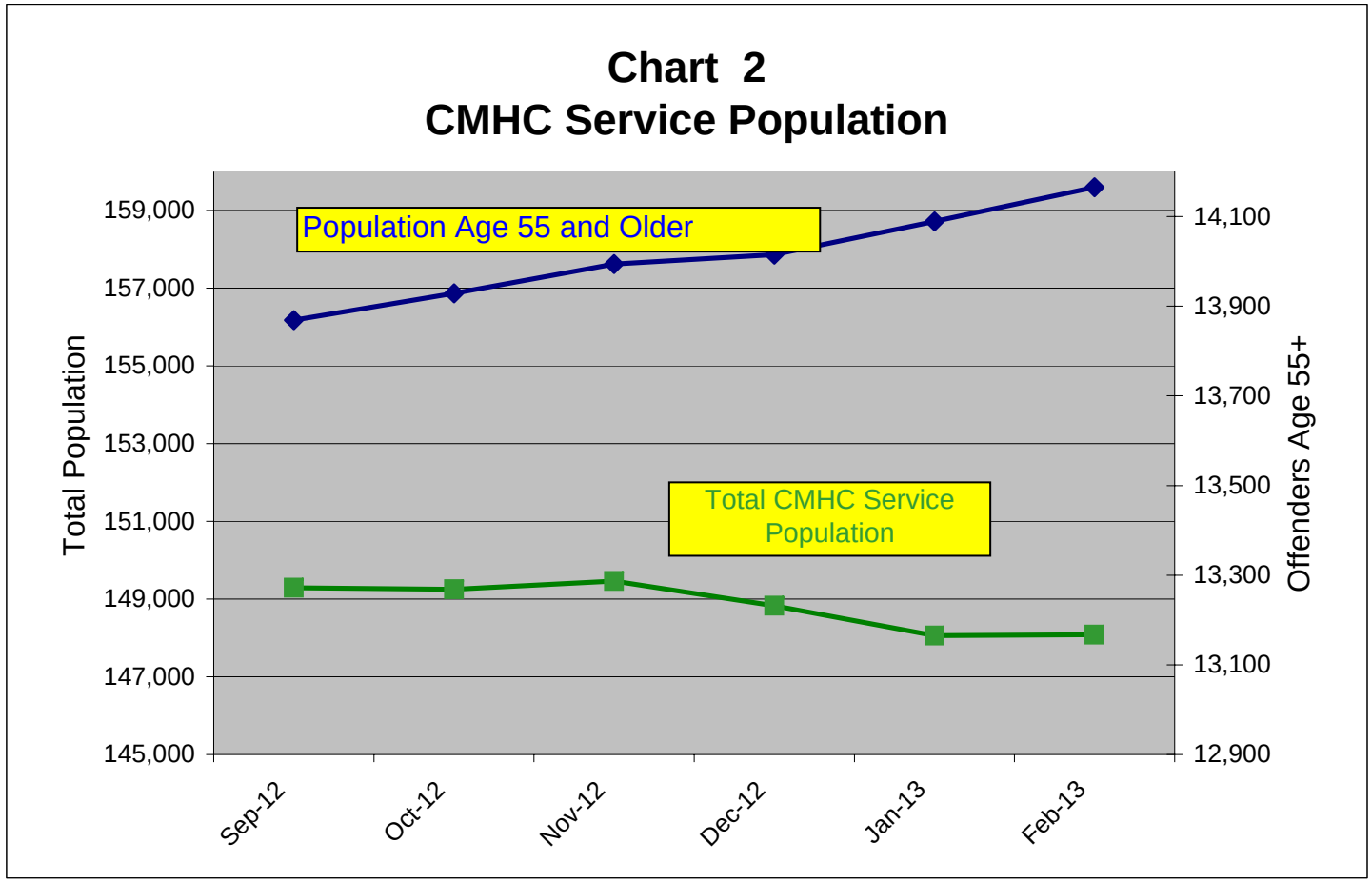


Chart 2
CMHC Service Population
Population Age 55 and Older
Total CMHC Service Population
Total Population
Offenders Age 55+
159,000
157,000
155,000
153,000
151,000
149,000
147,000
145,000
14,100
13,900
13,700
13,500
13,300
13,100
12,900
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13

Table 3
Summary Financial Report: Unit and Mental Health Costs - C.1.7
Fiscal Year 2013 - through February 28, 2013 (Sep 2012 - Feb 2013)

Days in Year: 181

	Unit and Mental Health Services Costs			Unit & Mental Cost Per Day Calculations		
	UTMB	TTUHSC	TOTAL	UTMB	TTUHSC	TOTAL
Population Served	**118,008**	**30,821**	**148,829**			
Revenue						
Capitation Payments	$92,885,239	$26,962,038	$119,847,277	$4.35	$4.83	$4.45
State Reimbursement Benefits	$19,415,099	$3,242,342	$22,657,441	$0.91	$0.58	$0.84
Other Misc Revenue	$42,469	$875	$43,344	$0.00	$0.00	$0.00
Total Revenue	**$112,342,807**	**$30,205,255**	**$142,548,062**	**$5.26**	**$5.41**	**$5.29**
Expenses						
Unit Services						
Salaries	$63,538,257	$8,982,524	$72,520,781	$2.97	$1.61	$2.69
Benefits	$19,609,143	$2,247,831	$21,856,974	$0.92	$0.40	$0.81
Operating (M&O)	$8,799,819	$808,090	$9,607,909	$0.41	$0.14	$0.36
Professional Services	$0	$1,117,182	$1,117,182	$0.00	$0.20	$0.04
Contracted Units/Services	$0	$8,035,703	$8,035,703	$0.00	$1.44	$0.30
Travel	$413,166	$46,008	$459,174	$0.02	$0.01	$0.02
Electronic Medicine	$0	$79,646	$79,646	$0.00	$0.01	$0.00
Capitalized Equipment	$122,243	$11,746	$133,989	$0.01	$0.00	$0.00
Subtotal Onsite Expenses	$92,482,628	$21,328,730	$113,811,358	$4.33	$3.82	$4.22
Mental Health Services						
Salaries	$11,478,915	$5,041,325	$16,520,240	$0.54	$0.90	$0.61
Benefits	$2,905,617	$1,256,243	$4,161,860	$0.14	$0.23	$0.15
Operating (M&O)	$247,420	$47,523	$294,943	$0.01	$0.01	$0.01
Professional Services	$0	$112,115	$112,115			
Contracted Units/Services	$0	$0	$0			
Travel	$38,151	$4,043	$42,194	$0.00	$0.00	$0.00
Electronic Medicine	$0	$0	$0	$0.00	$0.00	$0.00
Capital Expenditures	$0	$0	$0	$0.00	$0.00	$0.00
Subtotal Mental Health Expenses	$14,670,103	$6,461,249	$21,131,352	$0.69	$1.14	$0.78
Indirect Expenses	$5,307,717	$867,084	$6,174,801	$0.25	$0.16	$0.23
Total Unit and Mental Health Expenses	**$112,460,447**	**$28,657,063**	**$141,117,510**	**$5.27**	**$5.12**	**$5.23**
Operating Income (Loss) for C.1.7	**($117,640)**	**$1,548,192**	**$1,430,552**	**($0.01)**	**$0.30**	**$0.06**

Table 3 (Continued)
Summary Financial Report: Hospital and Clinic Costs - C.1.8
Fiscal Year 2013 - through February 28, 2013 (Sep 2012 - Feb 2013)

Days in Year: 181

	Hospital and Clinic Costs			Hospital & Clinic Cost Per Day Calculations		
	UTMB	**TTUHSC**	**TOTAL**	**UTMB**	**TTUHSC**	**TOTAL**
Population Served	**118,008**	**30,821**	**148,829**			
Revenue						
Capitation Payments	$54,556,318	$12,542,022	$67,098,340	$2.55	$2.25	$2.49
State Reimbursement Benefits	$0	$748,179	$748,179	$0.00	$0.13	$0.03
Other Misc Revenue	$0	$0	$0	$0.00	$0.00	$0.00
Total Revenue	**$54,556,318**	**$13,290,201**	**$67,846,519**	**$2.55**	**$2.38**	**$2.52**
Expenses						
Hospital and Clinic Services						
University Professional Services	$8,657,067	$419,091	$9,076,158	$0.41	$0.08	$0.34
Freeworld Provider Services	$12,588,727	$7,076,993	$19,665,720	$0.59	$1.27	$0.73
UTMB or TTUHSC Hospital Cost	$43,982,740	$5,256,442	$49,239,182	$2.06	$0.94	$1.83
Estimated IBNR	$5,132,233	$961,141	$6,093,374	$0.24	$0.17	$0.23
Subtotal Offsite Expenses	$70,360,767	$13,713,667	$84,074,434	$3.29	$2.46	$3.12
Indirect Expenses	$0	$495,260	$495,260	$0.00	$0.09	$0.02
Total Hospital and Clinic Expenses	**$70,360,767**	**$14,208,927**	**$84,569,694**	**$3.29**	**$2.55**	**$3.14**
Operating Income (Loss) for C.1.8	**($15,804,449)**	**($918,726)**	**($16,723,175)**	**($0.74)**	**($0.16)**	**($0.62)**

Table 3 (Continued)
Summary Financial Report: Pharmacy Costs - C.1.9
Fiscal Year 2013 - through February 28, 2013 (Sep 2012 - Feb 2013)

Days in Year: 181

	Pharmacy Health Services Costs			Pharmacy Health Cost Per Day Calculations		
	UTMB	TTUHSC	TOTAL	UTMB	TTUHSC	TOTAL
Population Served	**118,008**	**30,821**	**148,829**			
Revenue						
Capitation Payments	$20,340,790	$5,197,566	$25,538,356	$0.95	$0.93	$0.95
State Reimbursement Benefits	$889,009	$30,031	$919,040	$0.04	$0.01	$0.03
Other Misc Revenue	$164,561	$0	$164,561	$0.01	$0.00	$0.01
Total Revenue	**$21,394,360**	**$5,227,597**	**$26,621,957**	**$1.00**	**$0.94**	**$0.99**
Expenses						
Pharmacy Services						
Salaries	$2,812,723	$914,484	$3,727,207	$0.13	$0.16	$0.14
Benefits	$932,659	$33,290	$965,949	$0.04	$0.01	$0.04
Operating (M&O)	$659,544	$135,589	$795,133	$0.03	$0.02	$0.03
Pharmaceutical Purchases	$14,015,656	$3,916,204	$17,931,860	$0.66	$0.70	$0.67
Professional Services	$0	$0	$0	$0.00	$0.00	$0.00
Travel	$14,064	$4,677	$18,741	$0.00	$0.00	$0.00
Subtotal Pharmacy Health Expenses	$18,434,646	$5,004,244	$23,438,890	$0.86	$0.90	$0.87
Indirect Expenses	$0	$201,218	$201,218	$0.00	$0.04	$0.01
Total Pharmacy Expenses	**$18,434,646**	**$5,205,462**	**$23,640,108**	**$0.86**	**$0.93**	**$0.88**
Operating Income (Loss) for C.1.9	**$2,959,714**	**$22,135**	**$2,981,849**	**$0.14**	**$0.00**	**$0.11**

All Health Care Summary

	All Health Care Services			Cost Per Offender Per Day		
	UTMB	TTUHSC	TOTAL	UTMB	TTUHSC	TOTAL
Unit & Mental Health Services	$112,342,807	$30,205,255	$142,548,062	$5.26	$5.41	$5.29
Hospital & Clinic Services	$54,556,318	$13,290,201	$67,846,519	$2.55	$2.38	$2.52
Pharmacy Health Services	$21,394,360	$5,227,597	$26,621,957	$1.00	$0.94	$0.99
Total Revenue	**$188,293,485**	**$48,723,053**	**$237,016,538**	**$8.82**	**$8.73**	**$8.80**
Unit & Mental Health Services	$112,460,447	$28,657,063	$141,117,510	$5.27	$5.14	$5.24
Hospital & Clinic Services	$70,360,767	$14,208,927	$84,569,694	$3.29	$2.55	$3.14
Pharmacy Health Services	$18,434,646	$5,205,462	$23,640,108	$0.86	$0.93	$0.88
Total Expenses	**$201,255,861**	**$48,071,452**	**$249,327,312**	**$9.42**	**$8.62**	**$9.26**
Operating Income (Loss)	**($12,962,375)**	**$651,601**	**($12,310,773)**	**($0.60)**	**$0.11**	**($0.46)**

Table 4
FY 2013 2nd Quarter
UTMB/TTUHSC EXPENSE SUMMARY

Category	Expense	Percent of Total
Onsite Services	**$113,811,358**	**45.65%**
Salaries	$72,520,781	
Benefits	$21,856,974	
Operating	$19,433,603	
Pharmacy Services	**$23,438,890**	**9.40%**
Salaries	$3,727,207	
Benefits	$965,949	
Operating	$813,874	
Drug Purchases	$17,931,860	
Offsite Services	**$84,074,434**	**33.72%**
Univ. Professional Svcs.	$9,076,158	
Freeworld Provider Svcs.	$19,665,720	
Univ. Hospital Svcs.	$49,239,182	
Est. IBNR	$6,093,374	
Mental Health Services	**$21,131,352**	**8.48%**
Salaries	$16,520,240	
Benefits	$4,161,860	
Operating	$449,252	
Indirect Expense	**$6,871,279**	**2.76%**
Total Expenses	**$249,327,312**	**100.00%**

Chart 3: Total Health Care by Category

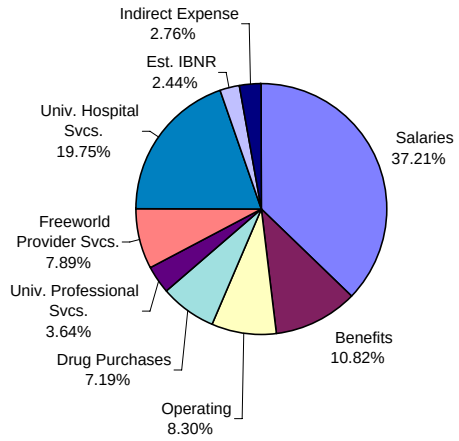


Chart 4: Onsite Services

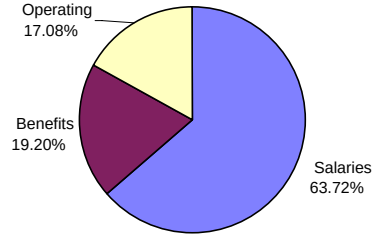


Chart 5: Pharmacy Services

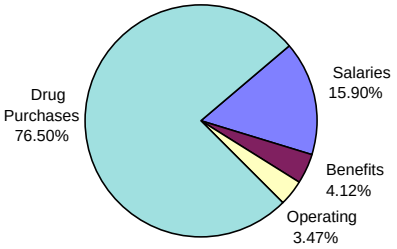


Chart 6: Offsite Services

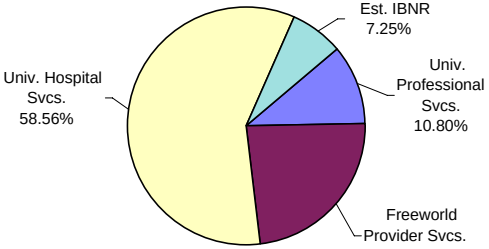


Chart 7: Mental Health Services

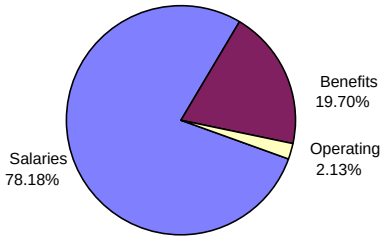


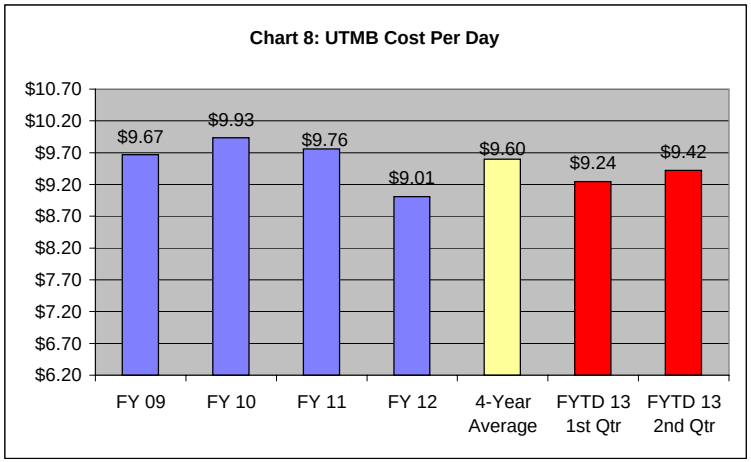
Table 4a
FY 2013 2nd Quarter
UTMB/TTUHSC EXPENSE SUMMARY

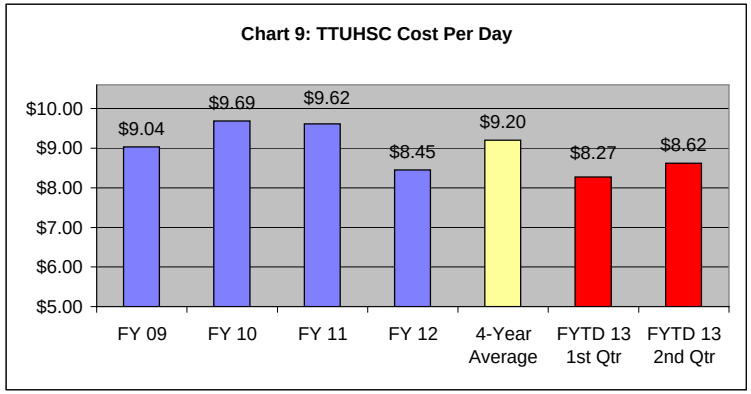
Category	Total Expense	UTMB	TTUHSC	% UTMB
Onsite Services	**$113,811,358**	**$92,482,628**	**$21,328,730**	**81.26%**
Salaries	$72,520,781	$63,538,257	$8,982,524	
Benefits	$21,856,974	$19,609,143	$2,247,831	
Operating	$19,433,603	$9,335,228	$10,098,375	
Pharmacy Services	**$23,438,890**	**$18,434,646**	**$5,004,244**	**78.65%**
Salaries	$3,727,207	$2,812,723	$914,484	
Benefits	$965,949	$932,659	$33,290	
Operating	$813,874	$673,608	$140,266	
Drug Purchases	$17,931,860	$14,015,656	$3,916,204	
Offsite Services	**$84,074,434**	**$70,360,767**	**$13,713,667**	**83.69%**
Univ. Professional Svcs.	$9,076,158	$8,657,067	$419,091	
Freeworld Provider Svcs.	$19,665,720	$12,588,727	$7,076,993	
Univ. Hospital Svcs.	$49,239,182	$43,982,740	$5,256,442	
Est. IBNR	$6,093,374	$5,132,233	$961,141	
Mental Health Services	**$21,131,352**	**$14,670,103**	**$6,461,249**	**69.42%**
Salaries	$16,520,240	$11,478,915	$5,041,325	
Benefits	$4,161,860	$2,905,617	$1,256,243	
Operating	$449,252	$285,571	$163,681	
Indirect Expense	**$6,871,279**	**$5,307,717**	**$1,563,562**	**77.24%**
Total Expenses	**$249,327,312**	**$201,255,860**	**$48,071,452**	**80.72%**

Table 5
Comparison of Total Health Care Costs

	FY 09	FY 10	FY 11	FY 12	4-Year Average	FYTD 13 1st Qtr	FYTD 13 2nd Qtr
Population							
UTMB	119,952	120,177	121,417	120,557	120,526	118,040	118,008
TTUHSC	30,616	31,048	31,419	31,491	31,144	31,296	30,821
Total	150,568	151,225	152,836	152,048	151,669	149,336	148,829
Expenses							
UTMB	423,338,812	435,710,000	432,371,801	$397,606,713	422,256,832	99,296,587	201,255,861
TTUHSC	100,980,726	109,767,882	110,272,668	$97,426,964	104,612,060	23,566,280	48,071,452
Total	524,319,538	545,477,882	542,644,469	$495,033,677	526,868,892	122,862,867	249,327,313
Cost/Day							
UTMB	$9.67	$9.93	$9.76	$9.01	$9.60	$9.24	$9.42
TTUHSC	$9.04	$9.69	$9.62	$8.45	$9.20	$8.27	$8.62
Total	**$9.54**	**$9.88**	**$9.73**	**$8.90**	**$9.51**	**$9.04**	**$9.26**

* Expenses include all health care costs, including medical, mental health, and benefit costs.
NOTE: The FY12 calculation has been adjusted from previous reports to correctly account for leap year





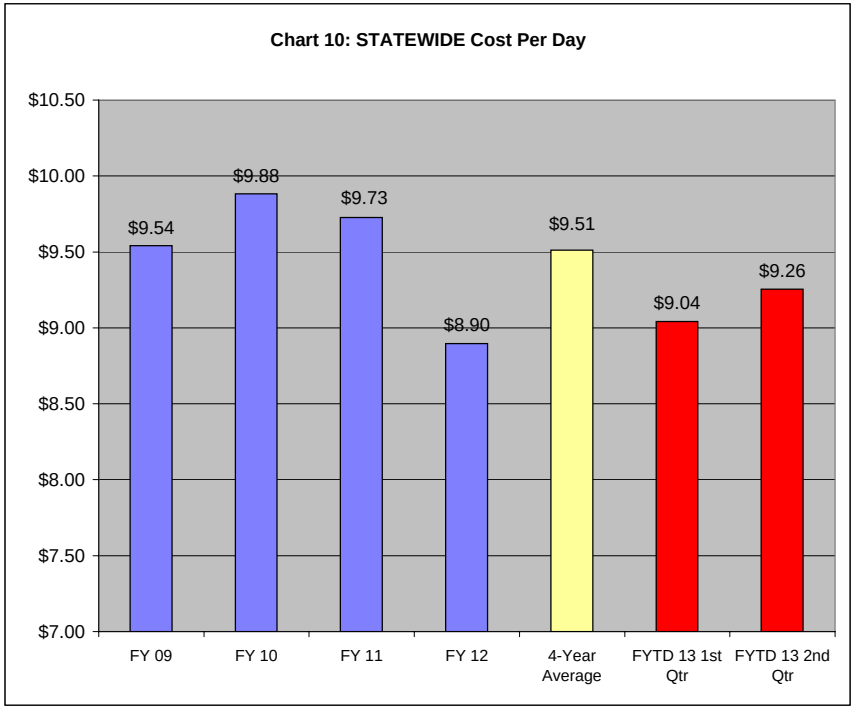


Table 6
Medical Encounter Statistics* by Age Grouping

6

Month	Encounters			Population			Encounters Per Offender		
	Age 55 and Over	Under Age 55	Total	Age 55 and Over	Under Age 55	Total	Age 55 and Over	Under Age 55	Total
Sep-12	14,993	109,296	124,289	11,474	106,583	118,057	1.31	1.03	1.05
Oct-12	17,049	126,705	143,754	11,519	106,402	117,921	1.48	1.19	1.22
Nov-12	15,793	115,612	131,405	11,603	106,537	118,140	1.36	1.09	1.11
Dec-12	14,342	101,684	116,026	11,628	106,576	118,204	1.23	0.95	0.00
Jan-13	17,081	123,976	141,057	11,734	106,060	117,794	1.46	1.17	0.00
Feb-13	15,068	113,744	128,812	11,809	106,122	117,931	1.28	1.07	0.00
Average	15,721	115,170	130,891	11,628	106,380	118,008	1.35	1.08	1.11

*Detailed data available for **UTMB** Sector only (representing approx. 79% of total population). Includes all medical and dental onsite visits. Excludes mental health visits.
Note: Previous calculations of Age 55 and Over Encounters were incorrect using 50 and older stats as well as Texas Tech encounter data

Chart 11
Encounters Per Offender By Age Grouping

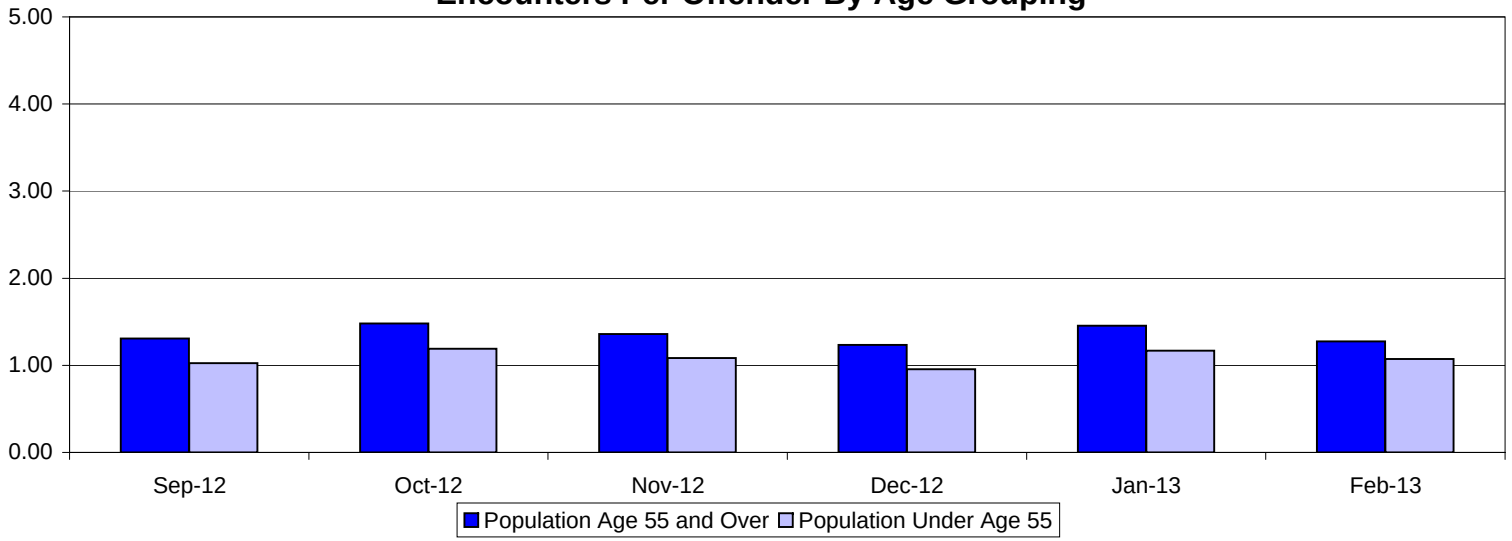


Table 7
FY 2013 2nd Quarter
Offsite Costs* To Date by Age Grouping

Age Grouping	Cost Data	Total Population	Total Cost Per Offender
Age 55 and Over	$26,433,686	14,010	$1,886.75
Under Age 55	$44,287,978	134,819	$328.50
Total	**$70,721,664**	**148,829**	**$475.19**

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

Chart 12
Hospital Costs to Date Per Offender
by Age Grouping

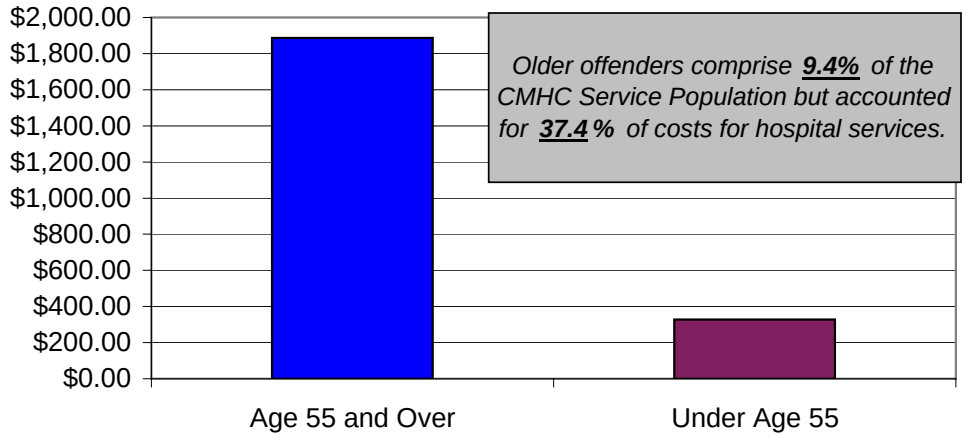
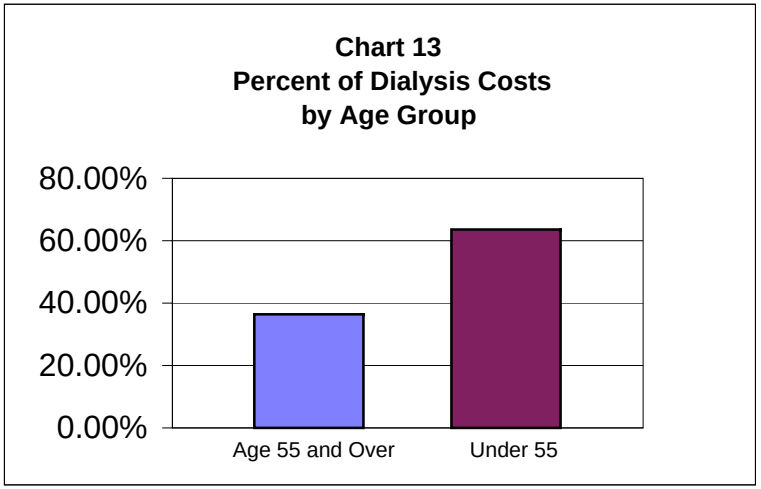


Table 8
Through FY 2013 2nd Quarter
Dialysis Costs by Age Grouping

Age Group	Dialysis Costs	Percent of Costs	Average Population	Percent of Population	Avg Number of Dialysis Patients	Percent of Dialysis Patients in Population
Age 55 and Over	$915,923	36.38%	14,010	9.41%	79	0.57%
Under Age 55	$1,601,574	63.62%	134,819	90.59%	139	0.10%
Total	**$2,517,497**	**100.00%**	**148,829**	**100.00%**	**218**	**0.15%**

Projected Avg Cost Per Dialysis Patient Per Year: $23,131



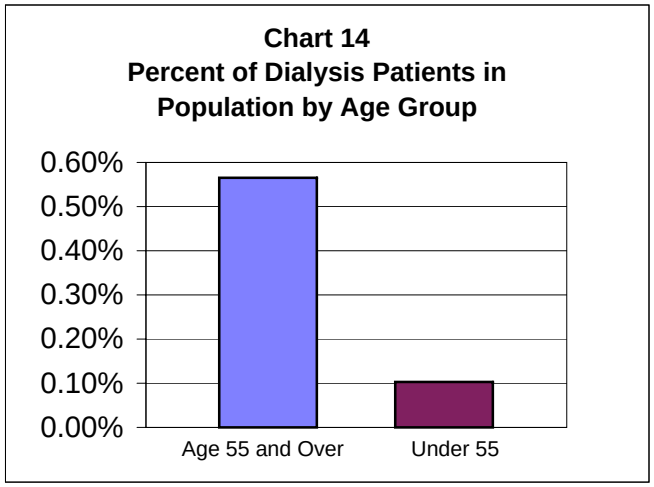


Table 9
Selected Drug Costs FY 2013

Category	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Total Year-to-Date
Total Drug Costs	$3,326,275	$3,285,979	$3,116,225	$2,329,065	$3,183,026	$2,155,248	$17,395,818
HIV Medications							
HIV Drug Cost	$1,492,551	$1,699,668	$1,606,214	$1,035,921	$1,678,290	$866,702	$8,379,346
HIV Percent of Cost	44.87%	51.72%	51.54%	44.48%	52.73%	40.21%	48.17%
Psychiatric Medications							
Psych Drug Cost	$219,039	$199,757	$182,056	$158,438	$236,452	$173,717	$1,169,458
Psych Percent of Cost	6.59%	6.08%	5.84%	6.80%	7.43%	8.06%	6.72%
Hepatitis C Medications							
Hep C Drug Cost	$162,080	$95,155	$81,288	$95,712	$82,278	$127,707	$644,221
Hep C Percent of Cost	4.87%	2.90%	2.61%	4.11%	2.58%	5.93%	3.70%
All Other Drug Costs	$1,452,605	$1,291,398	$1,246,667	$1,038,994	$1,186,006	$987,123	$7,202,794

Chart 15
Drug Costs by Selected Categories

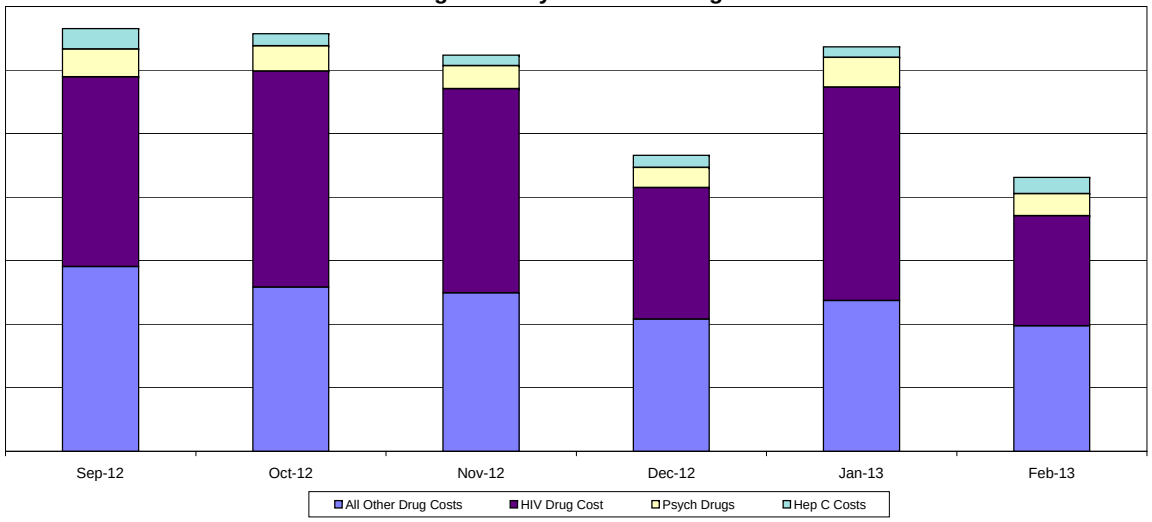


Table 10
Ending Balances 2nd Quarter FY 2013

	Beginning Balance September 1, 2012	Net Activity FY 2013	Ending Balance February 28, 2013
CMHCC Operating Funds	$79,991.45	$75,153.25	$155,144.70
CMHCC Unit & Mental Health S	Balances Maintained by TDCJ		Balances Maintained by TDCJ
CMHCC Hospital & Clinic Serv	Balances Maintained by TDCJ		Balances Maintained by TDCJ
CMHCC Pharmacy Health	Balances Maintained by TDCJ		Balances Maintained by TDCJ
Ending Balance All Funds	**$79,991.45**	**$75,153.25**	**$155,144.70**
Funds Lapsed to TDCJ Strategy C.1.7, 12/31	($79,991.45)		($79,991.45)
Funds After Lapse	**$0.00**	**$75,153.25**	**$75,153.25**

SUPPORTING DETAIL

CMHCC Operating Account	
Beginning Balance	$79,991.45
FY 2012 Funds Lapsed to TDCJ	($79,991.45)
Revenue Received	
1st Qtr Payment	$118,516.00
2nd Qtr Payment	$118,516.00
3rd Qtr Payment	$118,515.00
Interest Earned	$25.61
Subtotal Revenue	$355,572.61
Expenses	
Salary & Benefits	($178,467.34)
Operating Expenses	($101,952.02)
Subtotal Expenses	**($280,419.36)**
Net Activity thru this Qtr	**$75,153.25**
Total Fund Balance CMHCC Operating	**$155,144.70**

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

As of June 2013

Title of Position	CMHCC Partner Agency	Vacant Since (mm/yyyy)	Actions Taken to Fill Position
Director III-Office of Mental Health Monitoring & Liaison	TDCJ	5/31/12	Interviewed 1 qualified applicant; awaiting decision
Licensed Vocational Nurse III-Office of Professional Standards	TDCJ	4/1/13	DM submitted to request approval to fill
Investigator II-Patient Liaison Program Stiles Unit	TDCJ	4/1/13	Interviewed; selected applicant in clearance
Investigator II-Patient Liaison Program Jester IV Unit	TDCJ	4/16/13	DM submitted for approval to relocate the position from Garza to Jester IV
PAMIO Medical Director	TTUHSC	02/2009	Continued advertisement in local and national publications; Expanded Recruiting Agency utilization.
Staff Psychiatrists	TTUHSC	09/2010	Continued advertisement in local and national publications; Expanded Recruiting Agency utilization.
Medical Director	TTUHSC	07/2012	Continued advertisement in local and national publications; Expanded Recruiting Agency utilization.
Physician I-III	UTMB	12/1/2012	Local and National Advertising, Conferences, Timeline National Recruiting and other agency
Mid Level Practitioners (PA and FNP)	UTMB	12/1/2012	Local and National Advertising, Career Fairs, Conferences, Intern programs with numerous PA schools
Dentists	UTMB	12/1/2012	Local and National Advertising, Star of the South Conference

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TEXAS DEPARTMENT OF CRIMINAL JUSTICE

HEALTH SERVICES DIVISION MEDICAL DIRECTORS' REPORT

Second Quarter FY-2013

Lannette Linthicum, MD, CCHP-A, FACP

TDCJ Medical Directors' Report

Office of Health Services Monitoring (OHSM)

Operational Review Audit (ORA)

- During the Second Quarter of FY-2013 (December 2012, January and, February 2013), **10** Operational Review Audits (ORAs) were conducted at the following facilities: Briscoe, Choice Moore, Cole State Jail, Cotulla, Gurney, Kegans State Jail, Lockhart, Lychner State Jail, Michael, and Skyview.

- During the Second Quarter of FY-2013, **12** ORAs were closed for the following facilities: Briscoe, Byrd, Cotulla, Goree, Halbert, Jester I, Jester III, Jester IV, Mineral Well Private PPT, Plane State Jail, South Texas Intermediate Sanction Facility, and Wynne.

- The following is a summary of the 8 items found to be most frequently below 80 percent compliance in the 10 ORAs conducted in the Second Quarter FY-2013.

1. Item **6.040** requires offenders receiving anti-tuberculosis medication at the facility have a Tuberculosis Patient Monitoring Record (HSM-19) completed. Nine of the ten facilities were not in compliance with this requirement. The nine facilities out of compliance were: Briscoe, Cole State Jail, Cotulla, Gurney, Kegans State Jail, Lockhart, Lychner State Jail, Michael, and Skyview. Corrective actions were requested from the nine facilities. At the time of this report, two facilities have returned their corrective action plan: Briscoe and Cotulla. Seven facilities are preparing facility-specific corrective actions to ensure future compliance: Cole State Jail, Gurney, Kegans State Jail, Lockhart, Lychner State Jail, Michael, and Skyview.

2. Item **6.380** requires the pneumococcal vaccine be offered to offenders with certain chronic diseases and conditions*, and all offenders 65 years of age or older. Vaccinations are to be documented on the Abstract of Immunizations Form (HSM-2) when administered. If the vaccination is refused, the refusal should be documented with a signed Refusal of Treatment Form (HSM-82). Seven of the ten facilities were not in compliance with this requirement. The seven facilities out of compliance were: Briscoe, Choice Moore, Cole State Jail, Cotulla, Gurney, Lockhart, and Lychner State Jail. Corrective actions were requested from the seven facilities. At the time of this report, two facilities have returned their corrective action plan: Briscoe and Cotulla. Five facilities are preparing facility-specific corrective actions to ensure future compliance: Choice Moore, Cole State Jail, Gurney, Lockhart, and Lychner State Jail.

Diseases and conditions for which the pneumococcal vaccine is indicated: heart disease, Emphysema, Chronic Obstructive Pulmonary Disease (COPD), Diabetes, Splenic Dysfunction, Anatomic Asplenia, Human Immunodeficiency Virus infection, most cancers, Sickle Cell Disorder, Cirrhosis, alcoholism, Renal Failure, and Cerebral Spinal Fluid leaks. (Note:** Asthma is not included unless it is associated with COPD, Emphysema or long-term systemic steroid use).*

3. Item **6.020** 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. Seven of the ten facilities were not in compliance with this requirement. The seven facilities out of compliance were: Cole State Jail, Cotulla, Gurney, Kegans State Jail, Lockhart, Lychner State Jail, and Skyview. Corrective actions were requested from the seven facilities. At the time of this report, one facility has returned their corrective action plan: Cotulla. Six facilities are preparing facility-specific corrective actions to ensure future compliance: Cole State Jail, Gurney, Kegans State Jail, Lockhart, Lychner State Jail, and Skyview.

Operational Review Audit (ORA) Continued

4. Item **1.100** requires interpreter services to be arranged and documented in the medical records for monolingual Spanish-speaking offenders. Six of the ten facilities were not in compliance with this requirement. The six facilities out of compliance were: Briscoe, Gurney, Kegans State Jail, Lychner State Jail, Michael, and Skyview. Corrective actions were requested from the six facilities. At the time of this report, one facility has returned their corrective action plan: Briscoe. Five facilities are preparing facility-specific corrective actions to ensure future compliance: Gurney, Kegans State Jail, Lychner State Jail, Michael, and Skyview.

5. Item **5.151** requires intra-system medical transfers returning to the facility from an inpatient infirmary, hospital or emergency room to have a physician or mid-level practitioner review and sign the HSN-1 within 48 hours Sunday through Thursday and 72 hours Friday through Saturday for returning offenders for whom there were changes in medication orders, treatment plan, housing assignment or disciplinary restrictions. Six of the ten facilities were not in compliance with this requirement. The six facilities out of compliance were: Briscoe, Gurney, Lockhart, Lychner State Jail, Michael, and Skyview. Corrective actions were requested from the six facilities. At the time of this report, one facility has returned their corrective action plan: Briscoe. Five facilities are preparing facility-specific corrective actions to ensure future compliance: Gurney, Lockhart, Lychner State Jail, Michael, and Skyview.

6. Item **5.170** requires intra-system medical transfers returning to the facility to have a Health Information Classification form (HSM-18) updated whenever an offender returns from an offsite specialty clinic, infirmary, or hospital for whom there are changes in medication orders, treatment plan, housing assignment, or disciplinary restrictions. Six of the ten facilities were not in compliance with this requirement. The six facilities out of compliance were: Cotulla, Gurney, Lockhart, Lychner State Jail, Michael, and Skyview. Corrective actions were requested from the six facilities. At the time of this report, one facility has returned their corrective action plan: Cotulla. Five facilities are preparing facility-specific corrective actions to ensure future compliance: Gurney, Lockhart, Lychner State Jail, Michael, and Skyview.

7. Item **6.330** requires the initial evaluations of offenders diagnosed with Hepatitis C be completed by a physician or mid-level provider. Six of the ten facilities were not in compliance with this requirement. The six facilities out of compliance were: Choice Moore, Gurney, Kegans State Jail, Lychner State Jail, Michael, and Skyview. Corrective actions were requested from the six facilities. Six facilities are preparing facility-specific corrective actions to ensure future compliance: Choice Moore, Gurney, Kegans State Jail, Lychner State Jail, Michael, and Skyview.

8. Item **6.370** requires seasonal influenza vaccine offered annually to offenders. Six of the ten facilities were not in compliance with this requirement. The six facilities out of compliance were: Briscoe, Choice Moore, Cole State Jail, Cotulla, Gurney, and Lychner State Jail. Corrective actions were requested from the six facilities. At the time of this report, two facilities have returned their corrective action plan: Briscoe and Cotulla. Four facilities are preparing facility-specific corrective actions to ensure future compliance: Choice Moore, Cole State Jail, Gurney, and Lychner State Jail.

Capital Assets Monitoring

The Fixed Assets Contract Monitoring officer audited the same ten units listed above for operational review audits during the Second Quarter of FY-2013. These audits are conducted to monitor compliance with the Health Services Policy and State Property Accounting (SPA) policy regarding inventory procedures. All 10 units were within the required compliance range.

Dental Quality Review Audit

During the Second Quarter of FY-2013 (December 2012, January and, February 2013), Dental Quality Review audits were conducted at the following sixteen facilities: Beto, Cleveland, Coffield, Dawson, Estelle, Estes, Ferguson, Glossbrenner, Gurney, Huntsville, Hutchins, Lopez, Michael, Powledge, Segovia, and Willacy. The following is a summary of the items found to be most frequently below 80 percent.

- **Item 1** assesses if patients presenting with signs and/or symptoms consistent with an urgent dental need received definitive care within fourteen days of receipt of the Sick Call Exam (SCE). See Attachment 1. Three of the sixteen facilities were not in compliance with this requirement. The three facilities out of compliance were: Dawson (60%), Estelle (75%), and Willacy (70%). Corrective Action Requests are pending with all facilities.
- **Item 2** assesses if charts of incoming (Chain-in) intra-system offender transfers are reviewed by the facility dental department within seven days of arrival. The following four facilities were out of compliance: Dawson (23%), Estelle (0%), Powledge (70%), and Willacy (40%). Corrective Action Requests are pending with all facilities.
- **Item 4** assesses if the highest (most urgent) priority was documented in the dental in-processing (intake) exam. The following two facilities were out of compliance: Glossbrenner (62%) and Hutchins (0%). Corrective Action Requests are pending with all facilities.
- **Item 20** assesses if the Ending Priority on the Comprehensive Treatment Plan (CTP) is consistent with the objective findings and assessment. Four of the sixteen facilities audited were less than 80% consistent with this requirement. The four facilities out of compliance were: Estelle (75%), Ferguson (77%), Michael (73%), and Segovia (67%). Corrective Action Requests are pending with all facilities.
- **Item 25** assesses whether or not the dental department had a functioning and readily accessible eye wash station. Two of the sixteen facilities audited were less than 80% consistent with this requirement. The two facilities out of compliance were: Estelle (GP, HS, & RMF clinics) and Beto. Corrective Action Requests are pending with all facilities.
- **Item 31** assesses whether or not the air-conditioner/air exchange was adequate for the treatment area. Two of the sixteen facilities audited were less than 80% consistent with this requirement. The two facilities out of compliance were: Estelle (HS) and Lopez. Corrective Action Requests are pending with all facilities.

Grievances and Patient Liaison Correspondence

During the Second Quarter of FY-2013 (December 2012, January and, February 2013), the Patient Liaison Program (PLP) and the Step II Grievance Program received **3,211** correspondences: The PLP received **1,653** correspondences and Step II Grievance received **1,558** grievances. There were **352** Action Requests generated by the Patient Liaison and the Step II Grievance Programs.

The University of Texas Medical Branch (UTMB) and Texas Tech University Health Sciences Center (TTUHSC) *overall* combined percentage of sustained offender grievances closed in the First Quarter FY-2013, for the Step II medical grievances was nine percent. Performance measure expectation is **six** percent or less (Article IX, Correctional Managed Health Care contract). The percentage of sustained Step II medical grievances from UTMB was **9** percent and **9** percent for TTUHSC.

Action Requests are generated to address Quality of Care issues, (i.e., clinical decisions, complaints about medical personnel and staff practice issues). Action Requests are also generated to address policy and documentation issues.

Quality Improvement (QI) Access to Care Audit

The frequency of the Sick Call Request Verification Audits (SCRVA) was changed in the Fourth Quarter of FY-2011. Units with an average composite score of 80 percent or above in each discipline will be audited one time per fiscal year. Those with average composite scores less than 80 percent in a discipline(s) or less than a two year history of scores will have that discipline(s) audited quarterly.

Quality Improvement (QI) Access to Care Audit (Continued)

During the Second Quarter of FY-2013 (December 2012, January and, February 2013), the Patient Liaison Program nurses and investigators performed 34 Sick Call Request Verification audits on 33 facilities. At some units, Expansion Cell Block areas were counted as a separate audit. This audit was formerly known as Access to Care (ATC) audits.

The SCRVA examines and verifies the facility methodology for reporting Access to Care. A random sample of Sick Call Requests was also audited by the Office of Professional Standards (OPS) staff. A total of 216 indicators were reviewed at the **33 facilities and 8 of the indicators fell below the 80 percent** compliance threshold representing five percent. The discipline composite score (medical/nursing, dental, and mental health) is an overall assessment of compliance with the sick call process of the 33 facilities audited. There were **7** facilities with one or more discipline composite scores **below** 80. The facilities out of compliance were Beto, East Texas Treatment Facility, Eastham, Estelle Expansion Cell Block, McConnell, Polunsky, Smith Expansion Cell Block. Corrective action has been requested from these facilities. At each unit OPS staff continued educating the medical staff.

Office of Public Health

- The Public Health Program monitors cases of infectious diseases in newly incarcerated offenders as well as new cases that occur in the offenders within TDCJ population. The data is reported by the facilities for 11 infectious conditions including Syphilis, Hepatitis C Virus (HCV), Human Immunodeficiency Virus (HIV), and Tuberculosis (TB) as well as the data for occupational exposures to bloodborne pathogens. Year-to-date figures for a disease may differ from the monthly reports totals due to late reporting or to a determination that some previously reported cases fail to meet the criteria to be considered new cases.

  There were 706 cases of Hepatitis C identified for the Second Quarter FY-2013, compared to 740 cases identified during the First Quarter. The reporting mechanism for HIV tests was changed effective February 1, 2010. HIV tests are now to be classified as belonging to one of four categories: intake, offender-requested, provider-requested, or pre-release. HIV test became mandatory at intake in July 2007. However, offenders who are already known to be HIV positive are not required to be retested at intake. Instead, they are offered laboratory testing to assess the severity of their infections. HIV testing became mandatory for pre-release in September 2005 (HB43). Pre-release testing generally occurs during the last six months of incarceration. 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. During the Second Quarter FY-2013, 18,012 offenders had intake tests, and 110 are newly identified as having HIV infections. For the First Quarter FY-2013, 18,069 offenders had intake tests, and 148 were HIV positive. During the Second Quarter FY-2013, 11,578 offenders had pre-release tests; three were HIV positive compared to seven in the First Quarter FY-2013. 14 new AIDS cases were identified during the Second Quarter FY-2013, compared to 23 new AIDS cases in the First Quarter FY-2013.

- **204 cases of suspected Syphilis** were reported in the Second Quarter FY-2013, compared to **230** in the First Quarter in FY-2013. **21 required treatment or retreatment c**ompared to **15** in the First Quarter FY-2013. Syphilis can take months to identify, these figures represent an overestimation of actual number of cases. Some of the suspected cases will later be reclassified as resolved prior infections.

- **177 Methicillin-Resistant Staphylococcus Aureus (MRSA)** cases were reported for the Second Quarter FY-2013, compared to 186 during the First Quarter of FY-2012. 204 Methicillin-Sensitive Staphylococcus Aureus (MSSA) cases were reported compared to 123 for the First Quarter of FY-2013. Numbers of both MRSA and MSSA have been decreasing for the last few years.

- There was an average of **25 Tuberculosis (TB) cases** under management for the Second Quarter FY-2013, compared to an average of 21 **(TB) cases** for the First Quarter of FY-2012. Although TB numbers often fluctuate significantly from year to year, there has been a slight increase in the numbers of offenders with TB.

Office of Public Health (Continued)

- In FY-2006, the Office of Public Health began reporting the activities of the Sexual Assault Nurse Examiner (SANE) Coordinator. This position collaborates with the Safe Prisons Program and is trained and certified as a SANE. Although the SANE Coordinator does not teach the SANE Curriculum because of restrictions imposed by the State Attorney General's Office, this person provides inservice training to facility staff in the performance of medical examination, evidence collection and documentation, and use of the sexual assault kits. During the Second Quarter FY-2013, nine training sessions were held and 163 medical staff received training. This position also audits the documentation and services provided by medical personnel for each sexual assault reported. There have been 205 chart reviews of alleged sexual assaults performed for the Second Quarter FY-2013. There were no deficiencies found this quarter. 46 bloodborne exposure baseline labs were drawn on exposed offenders, and there were zero conversions as a result of sexual assault.

- During the Second Quarter, FY-2013, three of six Eleventh Annual Peer Education Health Conferences were held in the month of February 2013 for offenders to gain more knowledge about infectious diseases that are important in TDCJ and in the communities from which they come. The conferences included peer educators from thirty-two units: Briscoe, Carol Vance, Clemens, Clements, Connally, Cotulla, Dalhart, Darrington, Dominguez, Formby Garza East, Garza West, Gist, Hightower, Jester III, Jordan, LeBlanc, Lopez, Lychner, McConnell, Neal, Ney, Ramsey, Segovia, Scott, Stevenson, Stiles, Stringfellow, Terrell Torres, Tulia, and Wheeler. As of the close of the quarter, 100 of the 111 facilities housing Correctional Institutional Division offenders had active peer education programs. During the Second Quarter of FY-2013, 139 offenders trained to become peer educators. This is an increase from the 95 offenders trained in the First Quarter FY-2013. During the Second Quarter FY-2013 there were 16,516 offenders attended classes presented by educators. This is a decrease from the First Quarter of FY-2013 of 16,813 offenders attended classes presented by educators.

Mortality and Morbidity

There were 125 deaths reviewed by the Mortality and Morbidity Committee during the months of December 2012, January and, February 2013. Of those 125 deaths, 21 were referred to peer review committees.

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

Peer Review Committee	6
Provider & Nursing Peer Review	9
Provider Peer Review	6
Nursing Peer Review	0
Mental Health	**0**
Total	21

Office of Mental Health Services Monitoring & Liaison

The following is a summary of the activities performed by the Office of Mental Health Monitoring & Liaison during the Second Quarter of FY-2013:

- OMH M&L monitors all offenders in Administrative Segregation (Ad Seg) facilities within the TDCJ Correctional Institution Division/State Jails every 6 months. In the Second Quarter, 18 Ad Seg facilities were audited: Bartlett, Coffield, Clemens, Eastham, Estelle, Ferguson, Formby, Gist, Hughes, Lychner, Michael, Murray, Pack, Robertson, Smith ECB, Stiles, Telford and Travis. 4,583 offenders were observed, 1,107 of them were interviewed and 5 offenders were referred to the university providers for further evaluation. Access to Care (ATC) 4 (i.e. timely triage) met 100 percent compliance for the 18 facilities. ATC 5 (i.e. documentation of Sick

Office of Mental Health Services Monitoring & Liaison (Continued)

Call Requests) met 100 percent compliance for the 18 facilities that received Sick Call Requests from offenders in Ad Seg. All 18 facilities were 100 percent compliant for ATC 6 (i.e. referral from triage).

- Four inpatient mental health facilities: Clements, Jester IV, Montford and Skyview were audited to ensure that all incidents of compelled psychoactive medication were documented on the Mental Health Compelled Psychoactive Medication Log and that the medical records contained documentation of the required criteria for all incidents of compelled psychoactive mediation. The facilities were 100 percent compliant for logging all incidents of compelled psychoactive medication identified on the UOF log on the mental health log. All four facilities were 100 percent compliant for documenting the required criteria for compelled psychoactive medication in the medical record.

- All 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. The intake facilities are: Bartlett State Jail, Baten ISF, Bradshaw State Jail, Byrd Unit, Dominguez State Jail, Formby State Jail, Garza Transfer Facility, Gist State Jail, Glossbrenner SAFPF, Gurney Transfer Facility, Halbert SAFPF, Holliday Transfer Facility, Hutchins State Jail, Jester I SAFPF, Johnston SAFPF, Kyle SAFPF, Lindsey State Jail, Lychner State Jail, Middleton Transfer Facility, Plane State Jail, Sanchez State Jail, Sayle SAFPF, Travis State Jail, and Woodman State Jail. 18 facilities met or exceeded the 80 percent compliance for completing mental health evaluations within 14 days. There were 5 facilities that did not meet 80 percent compliance: Bradshaw State Jail, Garza Transfer Facility, Hutchins State Jail, Sanchez State Jail and Woodman State Jail. Detailed written plans for corrective action were requested from these 5 units and have been received. Baten ISF had no charts that were reviewed.

- OMH M&L reviews the mental health records of all pregnant offenders being considered for the Baby and Mother Bonding Initiative (BAMBI) to determine if there are any mental health issues that preclude participation. In the Second Quarter FY-2013, 8 offenders were reviewed and 8 were allowed to participate in BAMBI.

Office of Health Services Liaison

- The Office of Health Services Liaison (HSL) conducts a random audit of 10 percent of electronic medical records (EMR) of offenders discharged from hospitals and infirmaries in the Texas Tech University Health Science Center (TTUHSC) and the University of Texas Medical Branch (UTMB) sectors. In the Second Quarter of FY-2013, **HSL conducted 157 hospital and 52 infirmary discharge audits.**

- Each audit determines if vital signs were recorded on the day the offender left the discharge facility; if the receiving facility had medical services sufficient to meet the offender's current needs; if the medical record was reviewed by a health care member and referred (if applicable) to an appropriate medical provider as required by policy; if the offender required unscheduled medical care related to the admitting diagnosis within the first seven days after discharge and if discharge information was available in the offender's electronic medical record within 24 hours of arriving at the unit.

- Of the 157 hospital discharge audits conducted, 139 were from the UTMB Sector and 18 were from the TTUHSC sector. There were 35 deficiencies identified for UTMB and 3 indentified for TTUHSC. Of the 52 infirmary discharge audits conducted 23 were from the UTMB sector and 29 were from the TTUHSC sector. **There were 10 deficiencies indentified from UTMB and 11 for TTUHSC.**

Accreditation

The ACA Winter Conference - Congress of Corrections was held in Houston, Texas January 25-30, 2013. During this conference, the following units were awarded Reaccreditation by the ACA Panel of Commissioners: Havins, Boyd, Hamilton, Pack, Powledge, Tulia and Neal.

Biomedical Research Projects

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

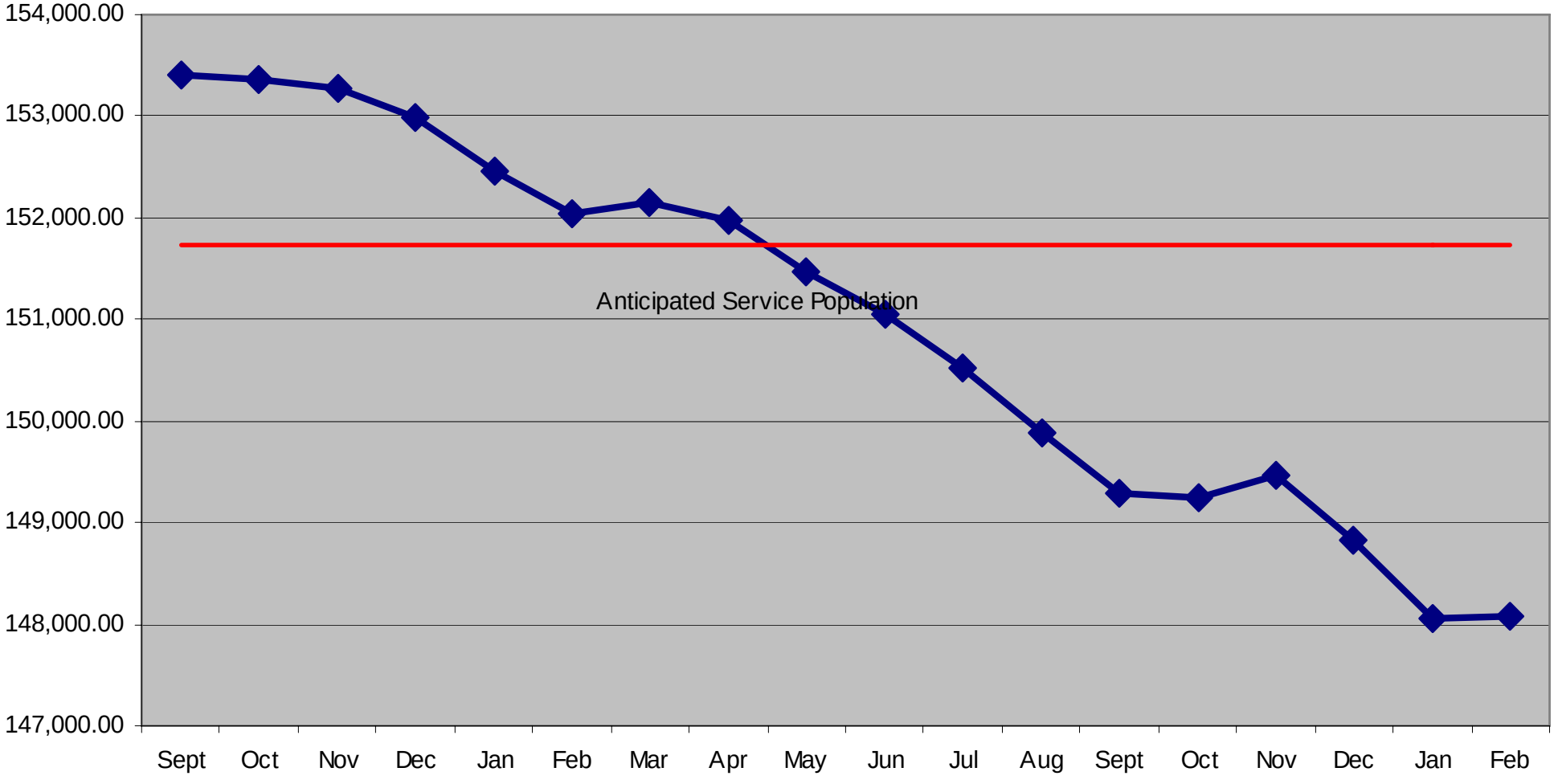
- Correctional Institutions Division Active Monthly Research Projects – 29,
- Correctional Institutions Division Pending Monthly Research Projects – 4,
- Health Services Division Active Monthly Medical Research Projects – 2, and
- Health Services Division Pending Medical Research Projects – 8.

Correctional Managed Health Care Committee

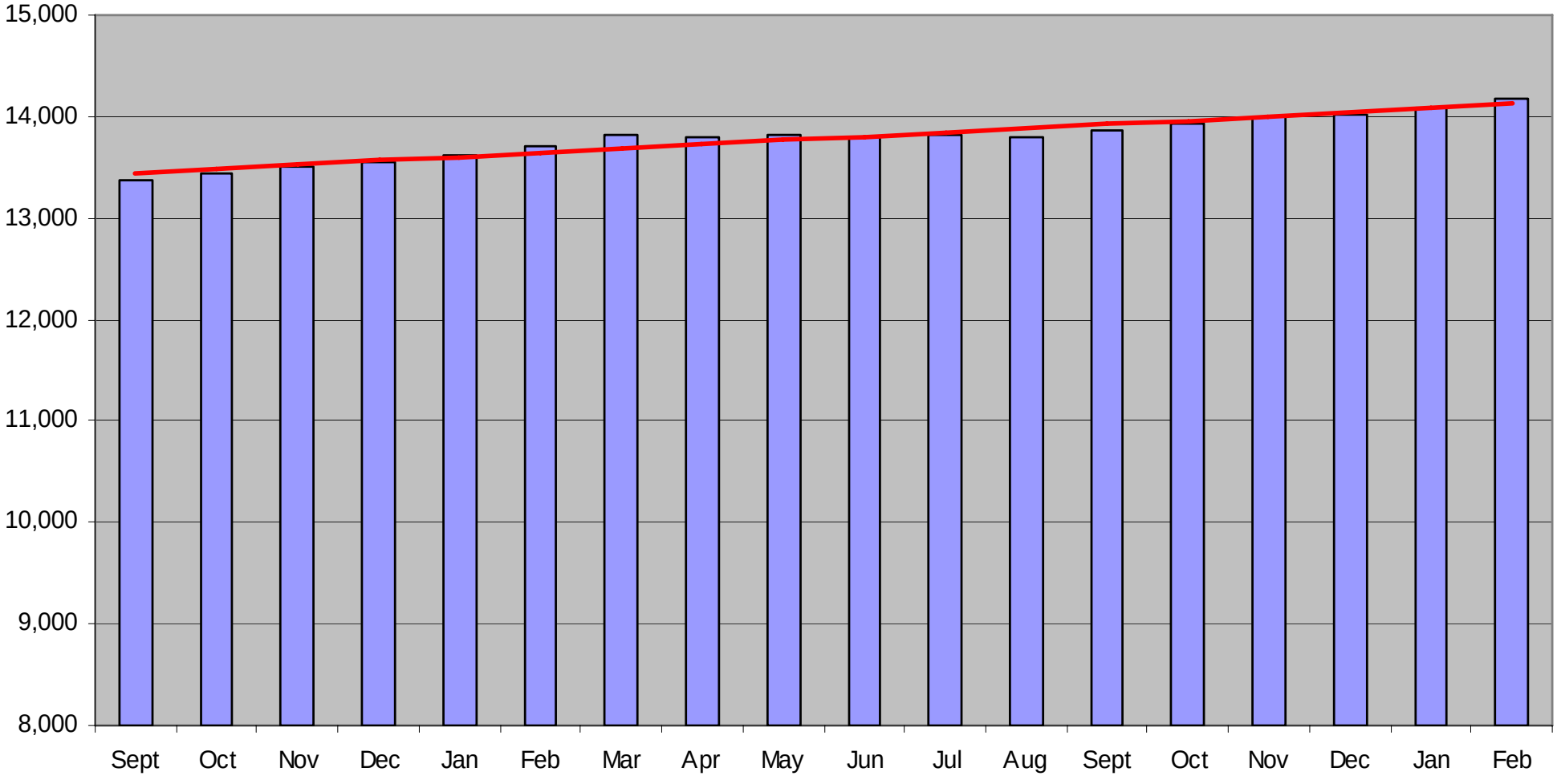
Key Statistics Dashboard

June, 2013

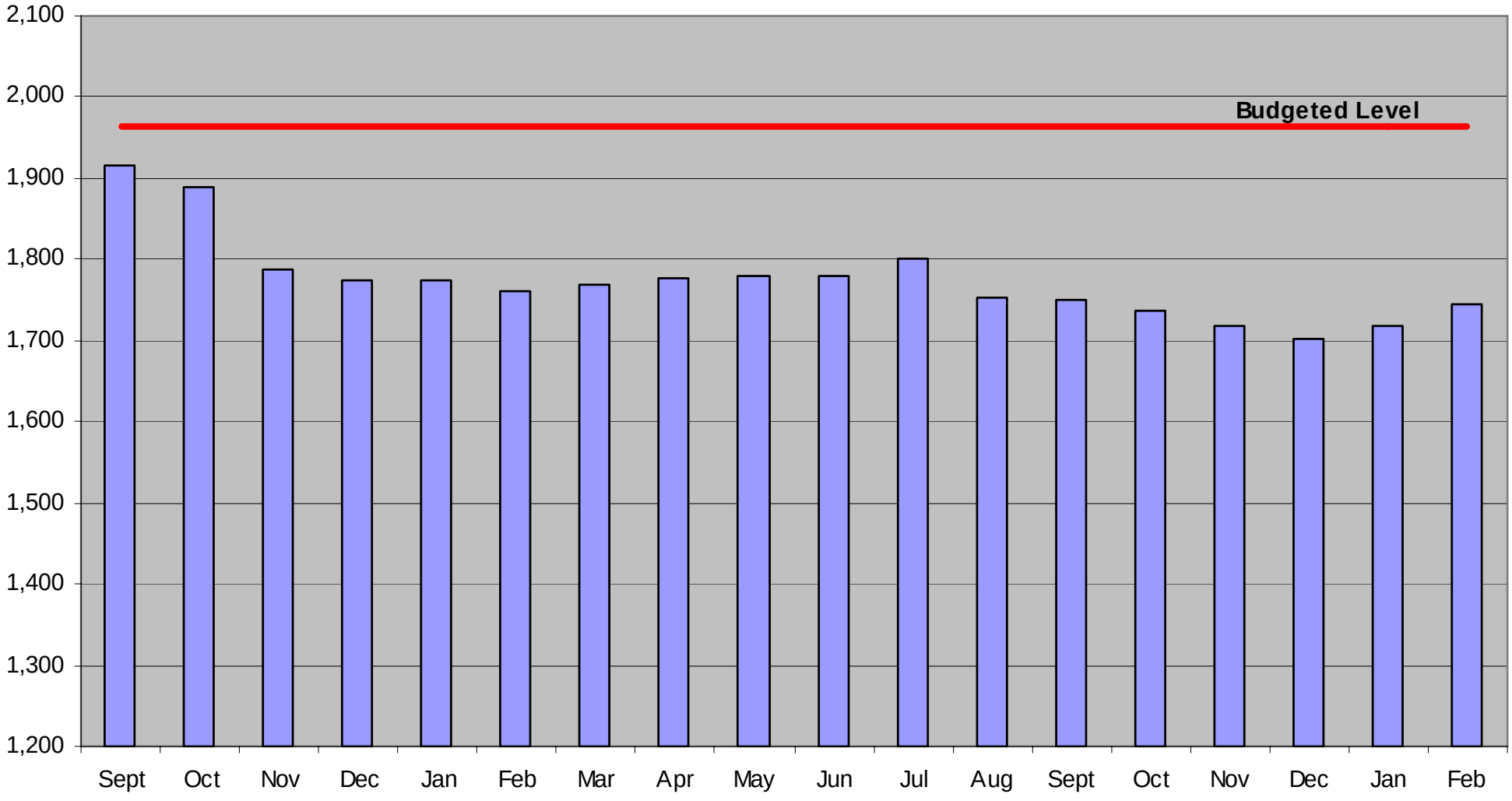
CMHC Service Population
FY 2012-2013 to Date



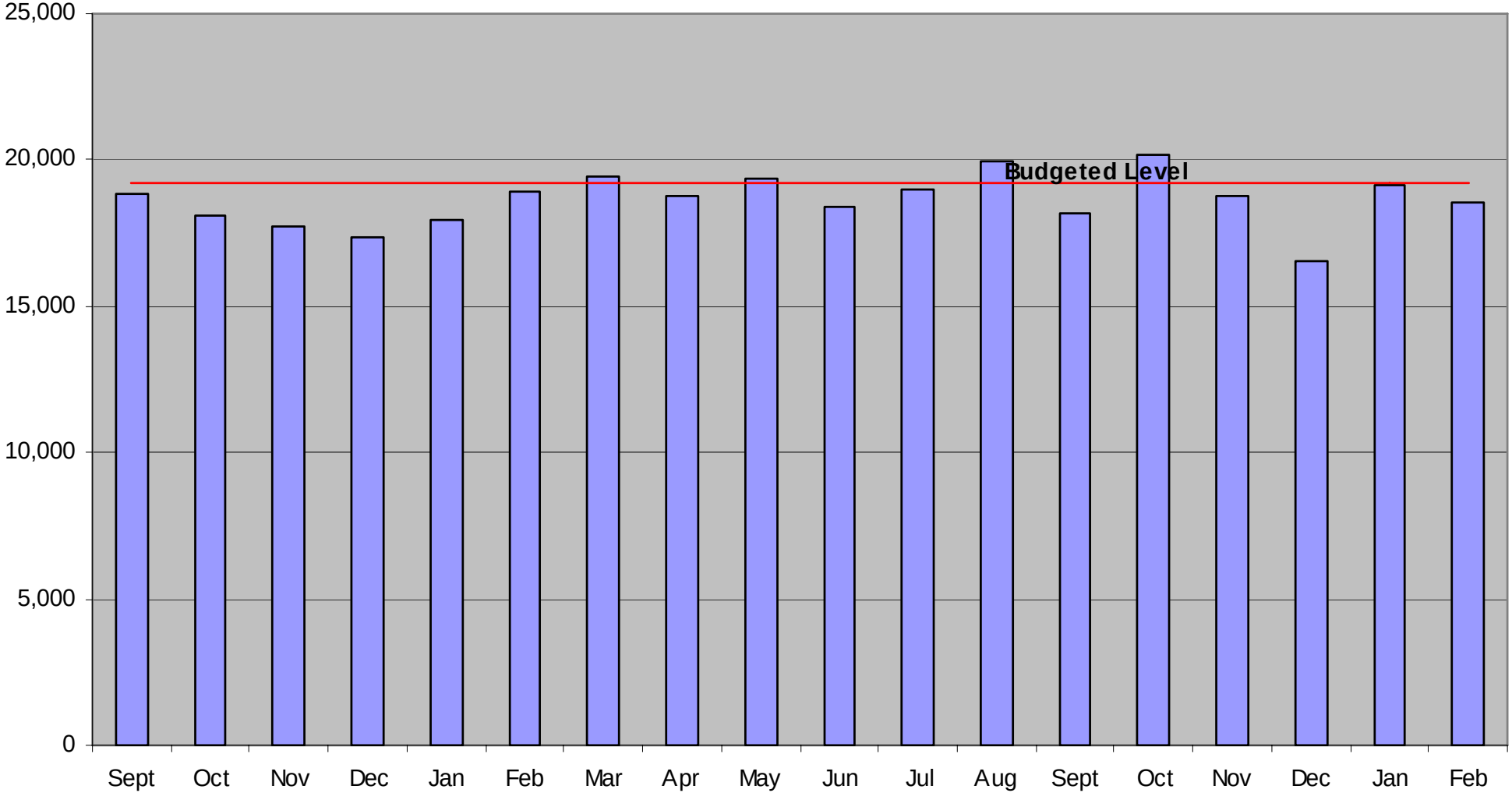
Offenders Age 55+
FY 2012-2013 to Date



Psychiatric Inpatient Census



Psychiatric Outpatient Census



TDCJ MENTAL HEALTH CENSUS BY GENDER

December-13	AVERAGE DAILY POPULATION		UNIQUE ENCOUNTERS	LAST DAY CENSUS	
Facility	Inpatient	Outpatient	MROP	Male	Female
SKYVIEW	531.90			463.00	65.00
JESTER IV	498.42			491.00	8.00
MT. VIEW	14.03				14.00
GATESVILLE (Valley)			98.65		99.00
HODGE			588.32	588.00	
CASELOAD		13,409.00		10,850.00	2,559.00
MONTFORD PSYCHIATRIC	398.00			398.00	
PAMIO	260.00			260.00	
CASELOAD - TTUHSC		3,168.00		3,168.00	
	1,702.35	16,577.00	686.97		

January-13	AVERAGE DAILY POPULATION		UNIQUE ENCOUNTERS	LAST DAY CENSUS	
Facility	Inpatient	Outpatient	MROP	Male	Female
SKYVIEW	526.35			464.00	67.00
JESTER IV	491.68			479.00	8.00
MT. VIEW	15.42				15.00
GATESVILLE (Valley)			99.29		99.00
HODGE			594.35	594.00	
CASELOAD		15,607.00		12,515.00	3,092.00
MONTFORD PSYCHIATRIC	422.00			422.00	
PAMIO	263.00			263.00	
CASELOAD - TTUHSC		3,568.00		3,568.00	
	1,718.45	19,175.00	693.64		

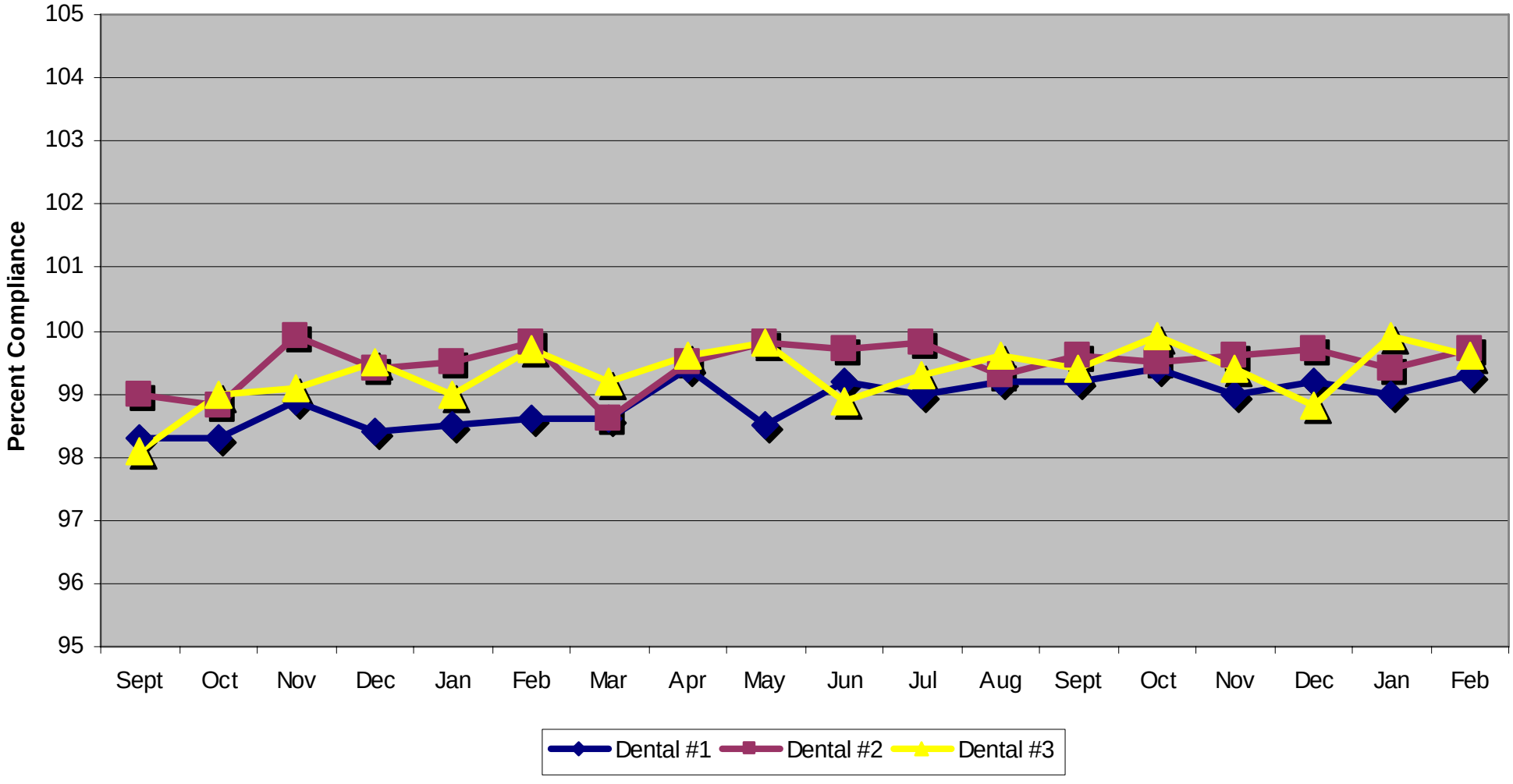
February-13	AVERAGE DAILY POPULATION		UNIQUE ENCOUNTERS	LAST DAY CENSUS	
Facility	Inpatient	Outpatient	MROP	Male	Female
SKYVIEW	532.04			470.00	64.00
JESTER IV	487.68			485.00	7.00
MT. VIEW					16.00
GATESVILLE (Valley)			98.93		99.00
HODGE			600.93	601.00	
CASELOAD		15,078.00		12,002.00	3,076.00
MONTFORD PSYCHIATRIC	426.00			426.00	
PAMIO	282.00			282.00	
CASELOAD - TTUHSC		3,459.00		3,459.00	
	1,727.72	18,537.00	699.86		

Note: Gender Census Report is based on the population on the last day of the month
Outpatient data is obtained from the EMR Unique Encounter Report
Outpatient caseload by Gender includes encounters reported by Gender on EMR

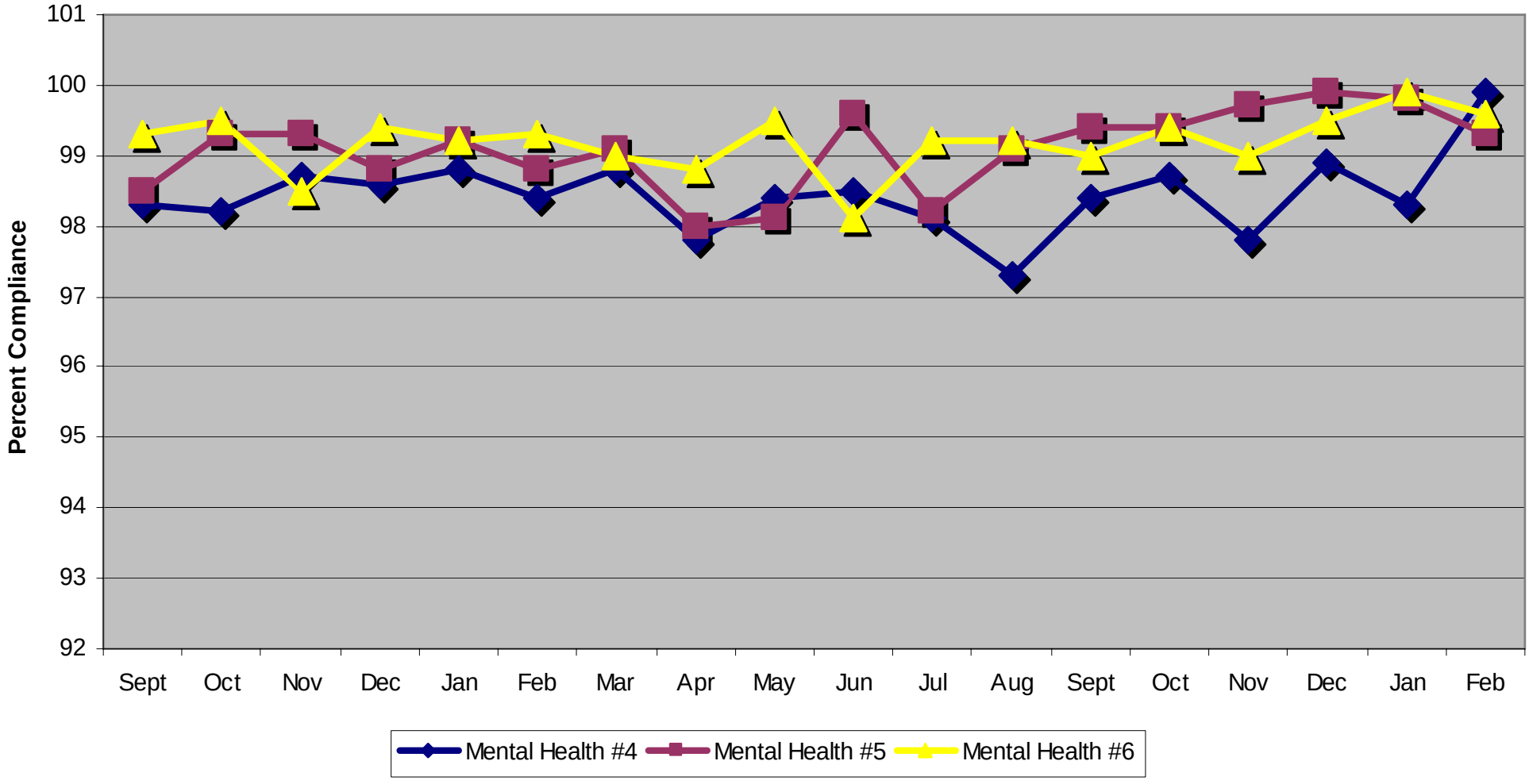
Access to Care Indicators

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

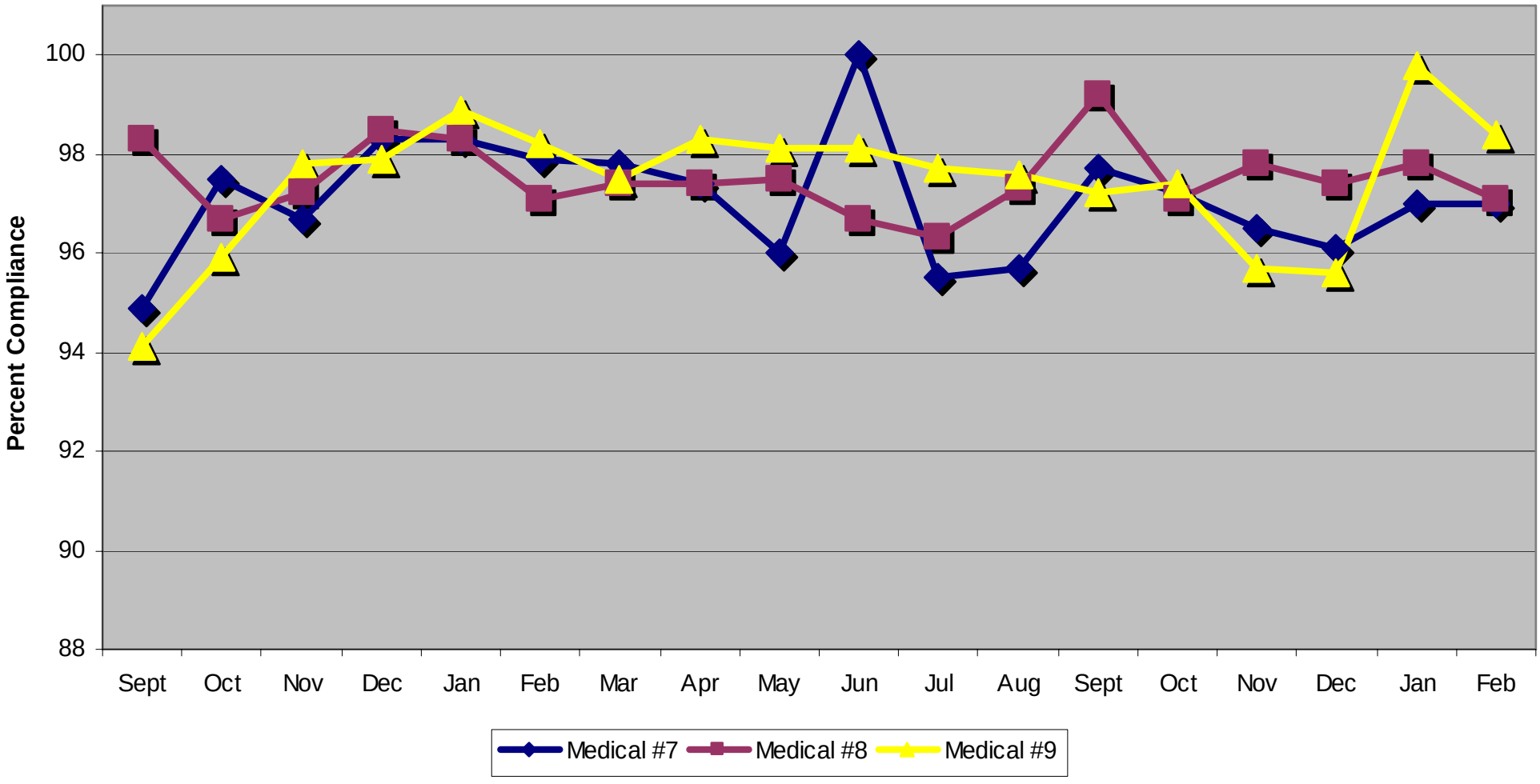
Dental Access to Care
Indicators FY 2012-2013 to Date



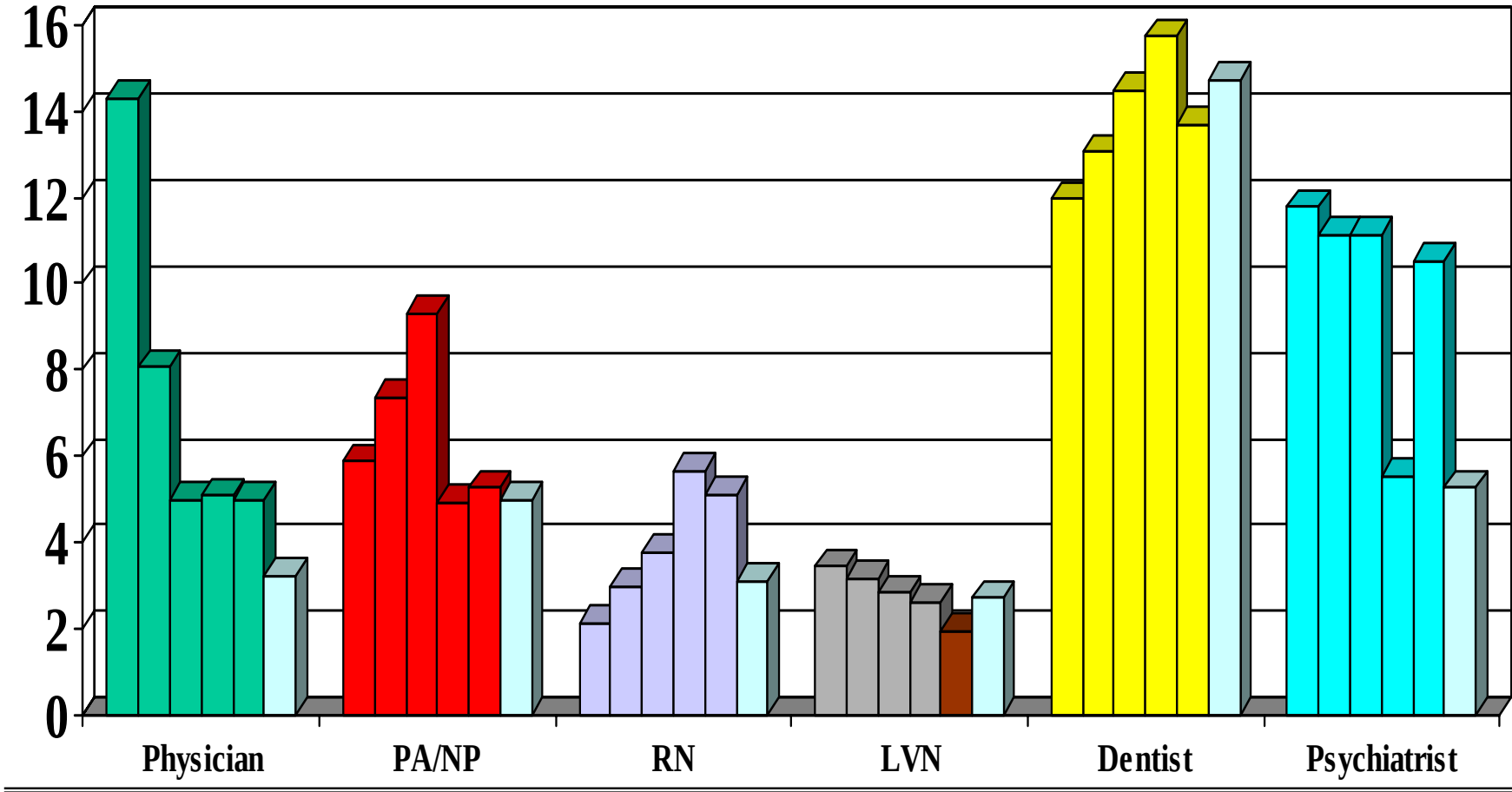
Mental Health Access to Care
Indicators FY 2012-2013 to Date



Medical Access to Care
Indicators FY 2012-2013 to Date



UTMB Vacancy Rates (%) by Quarter FY2012 – FY2013



TTUHSC Vacancy Rates (%)
by Quarter FY 2012 – FY 2013