

Agenda Topic / Presenter	Presentation	Discussion	Action
<p>II. Recognitions and Introductions (Cont.) - Margarita de la Garza-Graham</p> <p>III. Approval of Consent Items</p> <p>Dr. de la Garza-Graham</p> <ul style="list-style-type: none"> - Approval of Excused Absences - Approval of CMHCC Meeting Minutes – March 20, 2018 - Approval of TDCJ Health Services Monitoring Report 	<p>Dr. de la Garza-Graham stated that there are two new members who are not present: Dr. John Burruss and Ms. Erin Wyrick. Dr. de la Garza-Graham noted that both had completed their required training and would be present at the next CMHCC meeting.</p> <p>Dr. de la Garza-Graham next recognized Dr. Cynthia Jumper, who was bestowed the honor of “Master” by the American College of Physicians (ACP).</p> <p>Dr. de la Garza-Graham then moved onto agenda item III approval of consent items.</p> <p>Dr. de la Garza-Graham stated that the following five consent items would be voted on as a single action:</p> <p>The first consent item was the approval of excused absences from the March 20, 2018 meeting, which include; Elizabeth Anne Linder, Mary Annette Gary, Cynthia Jumper, Tamela Griffin and Margarita de la Garza-Graham.</p> <p>The second consent item was the approval of the CMHCC meeting minutes from the March 20, 2018 meeting. Dr. de la Garza-Graham asked if there were any corrections, deletions or comments-hearing none; Dr. de la Garza-Graham moved onto the third consent item.</p> <p>The third consent item was the approval of TDCJ Health Services Monitoring Report and there were no comments or discussion of these reports.</p>	<p>Dr. Linthicum noted that Ms. Garcia participated in the 2013 Sunset review of the Correctional Managed Health Care Committee.</p> <p>Dr. Linthicum shared that the American College of Physicians is a national organization. There are very few female Masters and it is the highest honor bestowed by the ACP.</p> <p>Dr. Linthicum next recognized Dr. Olugbenga Ojo who was bestowed the honor of “Fellow” by the ACP at their national meeting in New Orleans in May.</p>	

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<p>III. Approval of Consent Items (Cont.)</p> <ul style="list-style-type: none"> - University Medical Directors Reports <ul style="list-style-type: none"> - TTUHSC - UTMB - Summaries of CMHCC Joint Committee/ Work Groups Activities <p>IV. Update on Financial Reports</p> <ul style="list-style-type: none"> - Ron Steffa 	<p>The fourth consent item was the approval of the University Medical Directors Report. There were no comments or discussion of these reports.</p> <p>The fifth consent item was the approval of the summaries of CMHCC Joint Committee/Work Groups Activities. There were no comments or discussion of these reports.</p> <p>Dr. de la Garza-Graham then called for a motion to approve the consent items.</p> <p>Dr. de la Garza-Graham next called on Mr. Ron Steffa to present the financial report.</p> <p>Mr. Steffa reported on statistics for the Second Quarter of Fiscal Year (FY) 2018, as submitted to the Legislative Budget Board (LBB). The report was submitted in accordance with the General Appropriations Act, Article V, Rider 47.</p> <p>Mr. Steffa reported that the overall offender service population has increased 1.5% from FY 2017. The offender population age 55 and over had a 6.4% increase with an average daily census of 17,488 through the Second Quarter of FY 2017 compared to 18,600 through the Second Quarter of FY 2018.</p> <p>Unit and psychiatric care expenses represent the majority of health care cost at \$180.8 million or 52.6 percent of total expenses. Hospital and clinical care accounted for \$128.1 million or 37.2 percent. Pharmacy services were at \$34.9 million or 10.2 percent of the total expenses.</p> <p>Mr. Steffa reported on unit and psychiatric care revenues of \$180.4 million and expenditures of \$180.8 million, which for the Second Quarter of FY 2018 resulted in a \$462 thousand shortfall in this strategy.</p>		<p>Dr. Berenzweig made a motion to approve all consent items, and Dr. Jumper seconded the motion which prevailed by unanimous vote.</p>

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<p>IV. Update on Financial Reports (Cont.) - Ron Steffa</p>	<p>Mr. Steffa reported on hospital and clinical care revenues of \$95 million and expenditures of \$128.1 million leaving a shortfall of \$33.1 million in this strategy.</p> <p>Managed health care pharmacy revenues of \$313 million and expenditures of \$34.9 million leaving a shortfall of \$3.7 million in this strategy.</p> <p>Mr. Steffa next reported on the Second Quarter FY 2018 combined summary for both universities. The combined total reflects a shortfall of \$44.7 million for Second Quarter FY 2018. The Annual Projection reflects an estimated \$86.5 million shortfall. Mr. Steffa noted that at the end of May the agency submitted a request to the Legislative Budget Board for their approval to transfer funds between and within strategies. TDCJ each year looks within the agency budget for funds to reduce shortfalls. Approximately \$7 million has been identified in the Commissary and in the Texas Correctional Industries. To cover the remaining shortfall of 79.5 million, a spend-forward has been requested. This will allow the agency to transfer FY 2019 funds to FY 2018 to finish out the year and cover the shortfall.</p>	<p>Dr. Linthicum asked Mr. Steffa if he could speak about what the driving force is in the Pharmacy shortfall.</p> <p>Mr. Steffa said that he would need to defer to the universities for the specifics.</p> <p>Dr. Murray stated that HIV care has expanded and the patient population is an experienced population. Unfortunately, with some of the discharge and compliance issues, when offenders return to incarceration some of those regimens that are less expensive are not necessarily regimens that work for the offenders anymore. Hepatitis treatment and mental health are other areas where we are experiencing expansion.</p>	

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<p>IV. Update on Financial Reports (Cont.) - Ron Steffa</p>		<p>Dr. Linthicum asked if increasing to a 30 day supply from a 10 day supply of medication to discharging offenders has had an impact. Although, she noted, there was some additional funding to cover this.</p> <p>Dr. Murray stated that that is not necessarily a driving force.</p> <p>Dr. DeShields noted that the cost of specialty drugs and an aging population are contributors.</p> <p>Dr. Linthicum also noted that cancer alternates with cardiovascular disease as our top mortality and cancer related medications are very expensive.</p> <p>Dr. Roberts stated that Hep C and HIV are probably two of the largest contributors as well as specialty drugs and oncology drugs. Dialysis is also a large expense, probably the fourth largest cost center.</p> <p>Mr. Connaughton stated that in the strategy last year there was a deficit of \$5 million. Effectively we did not start out at baseline. And, funding for FY 2018 actually went down.</p> <p>Mr. Steffa concurred and explained that part of the contributing factor to deficits larger than we have seen in the past is that part of the exceptional item to maintain the base services was not funded which gave us a structural deficit coming into the biennium that is adding to these numbers we see this year and will see next year. In fact, next year we will also see the spend-forward which will start FY 2019 with sort of a double hit.</p>	

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<p>IV. Update on Financial Reports (Cont.) - Ron Steffa</p> <p>V. Summaries of Critical Correctional Health Care Personnel Vacancies</p> <p>- Dr. Lannette Linthicum</p>	<p>Dr. de la Garza-Graham thanked Mr. Steffa and then called on Dr. Linthicum to begin the presentation of the TDCJ's Critical Correctional Health Care Personnel Vacancies.</p> <p>Dr. Linthicum reported that the Deputy Division Director position is currently posted. The job description was rewritten and then the position was reposted.</p> <p>The Director II position in the Office of Public Health is on hold.</p> <p>Dr. Linthicum reported that there is a vacant Health Specialist V position in the Office of Mental Health Monitoring and Liaison. This position posted on May 22, 2018 and was extended to expand the applicant pool.</p> <p>Dr. Linthicum reported that there is an Investigator II position vacancy in the Patient Liaison Program at the Hilltop Unit. The posting closed on May 31, 2018 and interviews are being scheduled.</p> <p>There is also an Investigator II position vacancy in the Patient Liaison Program at the Stiles Unit. This position posting closed on June 1, 2018 and interviews are being scheduled.</p> <p>Dr. Linthicum reported that there is an Investigator III position vacancy in Step Two Medical Grievance. This position closed and interviews are being scheduled.</p> <p>There is a Nurse II vacancy in the Office of Health Services Monitoring. This position posting was reposted on May 22, 2018 and will be extended to expand the applicant pool.</p>	<p>Dr. de la Garza-Graham noted that she sits on an ERS advisory committee and their overview shows the same thing: higher costs due to an aging population and biologics.</p>	

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<p>V. Summaries of Critical Correctional Health Care Personnel Vacancies (Cont.)</p> <ul style="list-style-type: none"> - Dr. Lannette Linthicum <ul style="list-style-type: none"> - Dr. DeShields - Dr. Owen Murray <p>VI. Medical Director's Updates</p> <ul style="list-style-type: none"> - TDCJ – Health Services Division FY 2018 Second Quarter Report -Dr. Lannette Linthicum 	<p>Dr. Linthicum reported on the Manager IV vacancy in the Mental Health Services Liaison office. This position posted on March 29, 2018 and has been extended several times to expand the applicant pool.</p> <p>There is also a Manager III vacancy in the Office of Mental Health Monitoring and Liaison. This position closed on June 18, 2018 and the applicants are in the screening process.</p> <p>Dr. Linthicum next reported that the Executive Assistant I position in the Division Director's Office is vacant. This position posting closed June 15, 2018 and the applicants are in the screening process.</p> <p>Dr. DeShields reported that there is a Correctional Unit Dentist position vacancy at the Wallace Unit. The vacancy is currently being covered by rotation and locums.</p> <p>Dr. Murray reported that UTMB has 13 Physician I-II, 5 Mid-Level Practitioners (PA and FNP) and 6 Psychiatrist position vacancies. Dr. Murray explained that tele-health is used to assist with maintaining access to care. UTMB-CMC will be requesting additional information technology funding in their legislative appropriations request to support tele-health.</p> <p>Dr. de la Garza-Graham then called on Dr. Linthicum to present the TDCJ Medical Director's Report.</p> <p>Dr. Linthicum began by explaining that the TDCJ Medical Director's report focuses on the Second Quarter of Fiscal Year (FY) 2018 (December, January and February). During this quarter, Operational Review Audits (ORAs) were conducted at the following 9 facilities: Baten Intermediate Sanction Facility (ISF), Estelle General Population (GP), Extended Cell Block (ECB), Regional Medical Facility (RMF) and Substance Abuse Felony Punishment (SAFP), Jordan, Kegans, Rudd, Ramsey, Stiles, Stringfellow and Vance. Dr. Linthicum referenced the 12 items found to be most frequently below the 80 percent compliance, and noted that corrective actions have been requested on all of these items.</p>		

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<p>VI. Medical Director's Updates (Cont.)</p> <ul style="list-style-type: none"> - Dr. Lannette Linthicum - Office of Public Health 	<p>Dr. Linthicum reported that there was an average of 21 Tuberculosis (TB) cases under active management for the Second Quarter FY 2018.</p> <p>Dr. Linthicum next reported that the Office of Public Health employs a Sexual Assault Nurse Examiner (SANE) Coordinator who collaborates with the Safe Prisons Program and is trained and certified by the Texas Attorney General's Office. This person provides in-service training to facility staff in the performance of medical examinations, evidence collection and documentation and use of the sexual assault kits. This position also audits the documentation and services provided by medical unit personnel for each sexual assault reported. During the Second Quarter FY 2018, there were 182 chart reviews of alleged sexual assaults. There were 51 deficiencies found this quarter and corrective actions have been requested. 50 blood-borne exposure baseline labs were drawn on exposed offenders. To date, no offenders have tested positive for HIV in baseline labs routinely obtained after the report of sexual assault.</p> <p>Dr. Linthicum reported that during the Second Quarter FY 2018, 1 unit received a 3 day training which included the Wall Talk Training in the Peer Education Program and 1 unit received a 3 day training which included the Somebody Cares Training. As of the close of the Second Quarter of FY 2018, 99 of the 104 facilities housing Correctional Institutions Division (CID) offenders had active peer education programs. During this quarter, 121 offenders were trained to become peer educators, and 19,234 offenders attended the classes presented by peer educators.</p>	<p>Ms. Black-Edwards stated that she has good news to share regarding this very successful peer education program. The Wall Talk Training has not been revised for many years and there have been copy write issues. Ms. Black-Edwards explained that they have been working with Aids Foundation Houston to find a funding source to review and revise the curriculum and the University of Texas Houston has been identified as a possible funding source to update the curriculum.</p>	

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<p>VI. Medical Director's Updates (Cont.)</p> <ul style="list-style-type: none"> - Dr. Lannette Linthicum - Office of the Mental Health Services Liaison - Accreditation - Biomedical Research Projects 	<p>Dr. Linthicum noted that on average TDCJ has approximately 70,000 new intakes each year. Audits were conducted at 26 intake facilities and 25 facilities identified incoming offenders in need of Mental Health Evaluations. At the Kyle Unit there were no offenders identified as applicable to the audit. 17 of the 25 facilities met or exceeded the 80 percent compliance for completing Mental Health Evaluations within 14 days of identified need and corrective action plans have been requested for those who did not.</p> <p>Dr. Linthicum reported that the Office of Mental Health Services Liaison (MHSL) conducted a random audit of 10 percent of electronic health records (EHRs) of offenders discharged from hospitals and infirmaries in the TTUHSC and the UTMB sectors. In Second Quarter of FY 2018, the Office of Mental Health Services Liaison conducted 227 hospital and 40 infirmary discharge audits. UTMB had 61 deficiencies identified and TTUHSC had 8 deficiencies identified for the hospital discharge audits. UTMB had 11 deficiencies identified and TTUHSC had 5 deficiencies identified for the infirmary discharge audits. Corrective action has been requested to address deficiencies.</p> <p>Dr. Linthicum reported that the ACA Winter Conference was held in Orlando Florida on January 4-9, 2018. During this conference, the following facilities were represented: Polunsky, Briscoe, Cotulla, Cole, Moore, Gist, LeBlanc, Goodman, Woodman, Stiles, Beto, Torres/Ney, Jordan/Baten, Lopez/Segovia, Luther and Holliday. Dr. Linthicum stated that Texas is a Golden Eagle State which is an award presented to criminal justice agencies that have achieved accreditation on all aspects of agency operations, to include accreditation of every facility under its jurisdiction.</p> <p>Dr. Linthicum reported on the summary of active and pending biomedical research projects as reported by the TDCJ Executive Services. The CID has 26 active and 7 pending biomedical research projects. The Health Services Division has 9 active and 3 pending biomedical research projects.</p>		

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<p>VI. Medical Director's Updates (Cont.)</p> <ul style="list-style-type: none"> - Dr. Lannette Linthicum - Texas Tech University Health Sciences Center - Dr. Dr. Denise DeShields - University of Texas Medical Branch - Dr. Owen Murray <p>VII. Hepatitis C Policy and Program</p> <ul style="list-style-type: none"> - Dr. Melanie Roberts 	<p>Dr. Linthicum noted that while the Deputy Director position remains vacant, some research projects are being curtailed until that position is filled.</p> <p>Dr. de la Garza-Graham thanked Dr. Linthicum and then called on Dr. DeShields to present the report for TTUHSC.</p> <p>Dr. DeShields reported that there were no further updates.</p> <p>Dr. de la Garza-Graham thanked Dr. DeShields and then called on Dr. Murray to present the report for UTMB.</p> <p>Dr. Murray reported that there were no further updates.</p> <p>Dr. de la Garza-Graham thanked Dr. Murray and then called on Dr. Melanie Roberts, PharmD, Director of Pharmacy Services, UTMB Pharmacy to present Hepatitis C Policy and Program.</p> <p>Dr. Roberts began by stating that she would be giving the committee the rationale for treatment of Hepatitis C and providing the updated recommendation being made to revise the policy. Dr. Roberts reported that she would also provide some updates on related costs and outcomes for Hepatitis C since the December 2017 meeting. The membership of the Hepatitis C workgroup has not changed since the December 2017 meeting. The workgroup met in February 2018 and a few revisions were recommended. These revisions were presented to the Correctional Managed Health Care (CMHC) Pharmacy and Therapeutics Committee as well as the Joint Infection Control Committee and the Joint Medical Directors.</p> <p>Dr. Roberts explained that the standard of care for Hepatitis C has changed dramatically in the past few years and continues to evolve. Hepatitis C is a significant issue nationally. There is a disproportionately high number in the prison system. National prevalence is approximately 1.5% while it is as high as 12.9% and maybe even higher in the prison population.</p>	<p>Dr. Linthicum explained that the numbers reflect diagnosed prevalence. Hepatitis C is not a universal intake test.</p>	

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<p>VII. Hepatitis C Policy and Program (Cont.) - Dr. Melanie Roberts</p>	<p>Dr. Roberts next discussed the cost of Hepatitis C Virus (HCV) drugs. Over the past two fiscal years the cost has almost doubled. This is due to the use of the newer agents. It is estimated that for fiscal year 2018 the cost for Hepatitis C treatment will exceed \$8 million which is over 15% of the TDCJ drug budget. Dr. Roberts went on to explain the rationale for treatment. This is primarily based on two reasons which are that treatment may protect the general community at large and achieving a cure has been shown to prevent disease progression, development of Hepatocellular Carcinoma (HCC), deaths and leads to long-term cost savings. The average cost to treat end stage liver disease is roughly \$25-\$30 thousand and the cost for a liver transplant exceeds \$200 thousand. The number of offenders with end stage liver disease in the TDCJ population was 1,191 (as of May 2018). Hepatitis is the 3rd leading cause of death in state prisons. Next to end stage liver disease, liver cancer is the second most costly complication of Hepatitis C and the treatment of liver cancer costs \$25-\$50 thousand per year per patient.</p> <p>Dr. Roberts next reported on recommended policy changes. The first is to modify the criteria for referral to the HCV clinic. This will allow patients with an APRI score > 0.5 to be considered for referral as opposed to a score of > 0.7 which was previously recommended. The rationale for the change includes a recent meta-analysis utilizing a lower APRI cut-off of 0.5 demonstrated moderate diagnostic accuracy for predicting significant fibrosis. Currently, referral requests are being received for patients with an APRI of < 0.7, but meets criteria. There are also increasing requests for patient education, particularly for those patients who are due to release, in order to provide information on the disease and resources in the free world. The HCV clinic has the resources to accommodate the resultant increase in patient volume. The second change requested is to update the HCV Treatment Consent form to include the new preferred agents.</p>		

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<p>VII. Hepatitis C Policy and Program (Cont.) - Dr. Melanie Roberts</p>	<p>Dr. Roberts next explained that there has been a cost drop due to market competition. As of April 2018 the cost of the drug used in about 99% of patients has dropped to \$17,308 per patient/per course of treatment, the cost was \$21,678 per patient/per course of treatment prior to April 2018. The cost in the Texas Tech sector is \$69,930 per patient/per course of treatment.</p> <p>Dr. Roberts went on to share that there are approximately 4,500 patients who meet priority criteria including F3-F4 fibrosis, co-infection and extra-hepatic manifestations and the cost to treat these patients is approximately \$77.9 million versus \$98.7 million in December 2017 and \$121 million in March 2017.</p>	<p>Dr. Linthicum shared that she, Dr. Murray and Dr. Khan were invited to the DSHS to meet with the Commissioner of Health, Dr. Hellerstedt. They were asked to provide a presentation regarding the CMHC policy and how our Hepatitis C population is managed. The DSHS was impressed with the presentation and Dr. Hellerstedt has endorsed what we are doing in TDCJ to manage this population.</p> <p>Dr. Linthicum explained that when patients are identified in the Texas Tech sector they are moved to the UTMB sector to take advantage of the cost savings of the 340B pricing.</p> <p>Dr. Berenzweig asked if there has been any additional thought given as to what will happen if the 340B pricing goes away.</p> <p>Dr. Murray stated that Ryan Micks and Dr. Ben Raimer have recently been out to Washington speaking with federal lobbyist about this issue and it is very much front and center. The cost savings to the agency is about \$100 million per year. Dr. Murray explained that he recently watched a hearing on the issue and the focus is on wanting to know what these covered entities are doing with the savings. Dr. Murray shared that UTMB does not receive any of the savings and that these savings are passed on to the state.</p>	

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<p>VII. Hepatitis C Policy and Program (Cont.) - Dr. Melanie Roberts</p>		<p>Dr. Murray explained that some other covered entities are able to utilize the cost savings between what they purchase the drugs for and what they sell them for. Cost savings are meant to build out more clinic space and provide more care to the underserved. Dr. Murray also noted that if 340B pricing were to go away there would be no phase in or adjustment period.</p> <p>Dr. Linthicum stated that if we had to face that kind of shortfall there could be a constitutional crisis in terms of assuring access to care. As the population ages the acuity is greater. There has been an unprecedented amount of offenders that have required stem cell transplant, a number of patients have been sent out to MD Anderson and even at intake costs are rising.</p> <p>Dr. Berenzweig stated that he thinks that it is important that a plan be articulated to state legislators on what the consequences would be if this program were to go away.</p> <p>Dr. Murray shared that they have received a request from the lead council in the heat related litigation. It is an open records request for our Hepatitis C treatment policies, procedures and practices.</p> <p>Dr. Linthicum stated that we have a very clinically sound policy and we are addressing this illness. Our patients are being monitored and those at highest risk are being treated. If you look at a correctional standard of care across the country our policies line up with the bureau of prisons and all of the larger states. There are not many state departments of corrections that have hired a full time virologist to manage these patients as we have.</p>	

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<p>VII. Hepatitis C Policy and Program (Cont.) - Dr. Melanie Roberts</p> <p>VIII. Data and the Dashboard - Dr. Jane Leonardson</p>	<p>Dr. Roberts next shared some outcomes. During the timeframe of FY2016-FY2017 282 patients began therapy. 221 achieved a sustained viral load (SVR) at week 12 (cure achieved). 61 patients did not achieve a cure or treatment results are unknown. This is a cure or response rate of 87%. So far for FY2018, through May 16, 2018, 235 patients have started on therapy. 60 patients have been on therapy long enough to assess a response. 52 achieved a SVR (cure achieved), 5 paroled out before SVR labs could be drawn and 3 completed therapy but did not achieve SVR (cure not achieved). This translates to an 87% SVR (cure achieved) rate counting the 5 paroled patients and 94% if they are excluded. There are 175 patients midcourse or awaiting 12 week post treatment outcome assessment. The expectation is that about 400 patients will be treated this fiscal year.</p> <p>Dr. de la Garza-Graham thanked Dr. Roberts and then opened the floor to entertain a motion for approval of the revised "CMHC Infection Control Policy B-14.13.3 Hepatitis C Policy".</p> <p>Dr. de la Garza-Graham then called on Dr. Jane Leonardson, UTMB CMC Chief Medical Information Officer to present Data and the Dashboard.</p>	<p>Mr. Williams stated that they did receive legislative funding to increase the patient caseload in the last legislative session. The funding allowed for the hiring of an additional full time physician and a mid-level provider.</p> <p>Dr. Linthicum stated that restoration of unit staff was one of the items in our special appropriation request which we used to add additional resources into the office of clinical virology. In addition, we partnered with DSHS and got a grant to assist the Reentry and Integration Division with patient education.</p>	<p>Dr. Berenzweig made a motion to approve the policy revision, and Dr. Jumper seconded the motion which prevailed by unanimous vote.</p>

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<p>VIII. Data and the Dashboard (Cont.)</p> <ul style="list-style-type: none"> - Dr. Jane Leonardson 	<p>Dr. Leonardson began with the implementation and background of the Correctional Managed Care (CMC) Dashboard. She stated that in 1999 Correctional Managed Health Care implemented an electronic health record (EHR). The EHR is a comprehensive health record. Between 15-20 years ago CMC purchased the right to modify the code and now have the ability to change the EHR by using in house programmers. There is an automated pharmacy module tying patient information to script data. Data collection within the EHR is very robust and has migrated from scanned documentation, which is not minable, to “discrete” or minable data. The main reason the dashboard was created was to allow for enhanced population health metrics and monitoring.</p> <p>Dr. Leonardson next explained that the current version of the dashboard was developed in 2014. It started in the UTMB sector and Texas Tech came onboard in January 2018. The dashboard is a central repository or a data warehouse of many types of information and is designed to produce population health analytics, specifically for our offender patient population. It pulls information from the EHR, 3 pharmacy databases and the UTMB utilization review database. It organizes data so that trends can be easily identified and gathers data rapidly to allow for rapid, retrospective analysis.</p> <p>Dr. Leonardson stated that the data is used to identify patients who need help and to notify unit level providers of patients needing extra attention. The data is used to identify where we can improve and to measure improvement. We can develop predictive analytics to estimate cost of care for patient populations or to predict outcomes. It sends alerts to unit management teams when standards are not met and it allows the UTMB or TTUHSC Executive Quality Council to identify problem areas and devise solutions.</p> <p>Dr. Leonardson next gave an overview of some of the dashboard functionality. She explained that the dashboard uses Healthcare Effectiveness Data and Information Set (HEDIS) as a measurement for comparison since there is no correctional group for us to compare to.</p>		

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<p>VIII. Data and the Dashboard (Cont.)</p> <ul style="list-style-type: none"> - Dr. Jane Leonardson 	<p>Dr. Leonardson noted that HEDIS is an imperfect comparator as they have more women and children than our population. She next explained the Prevention/Disease Management screen, the Facility Scorecard screen and the Facilities Compliance Map. These screens can be filtered using drop downs for Year/Month and Facility Types and each page has a glossary. The Prevention/Disease Management screen shows a graphic presentation of asthma, diabetes, hypertension, mental health care and coronary artery disease (CAD) goals. The facility scorecard has an additional filter for Unit and a Download to PDF button. The Facilities Compliance Map has two additional filters; View and Future Compliance. The criteria for inclusion in chronic care scores is 1 year in prison and 1 year with diagnosis.</p> <p>Dr. Leonardson next explained the Email Alert function. In the past if a goal was not met a corrective action plan (CAP) was requested, but no instruction or guidance was given on what that corrective action should be. Within the Email Alert there is a section showing what corrective action(s) may be included in the CAP. Predictive analytics are also part of the Email Alert. This forecasts the outcomes without corrective action.</p> <p>Dr. Leonardson shared that the Patient Dashboards provide many useful tools. The patient dashboards allow staff to look at patients individually who are included in the score and take any corrective action as needed per individual patient. Included in the Patient Dashboard is a Multi-Problem Patients screen. This allows users to look at patients with multiple problems, such as diabetes and hypertension. Patients Needing Labs or Procedures is another useful screen that will show users the last lab results, the last lab date and the next lab due date. Lastly, Dr. Leonardson went over the Patients by Facility which is a useful tool for management teams. It allows the user to pull a patients list, export them to Excel and look at a list of all of the patients who are not meeting the target goal.</p> <p>Dr. Leonardson concluded by stating that the dashboard is a powerful tool and they are continuing to expand it.</p>		

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<p>IX. Public Comments (Cont.)</p>	<p>Ms. Vaughn stated that she wanted to talk about communication, sick call and the grievance process. Invariably some don't get where they are supposed to go because of the sheer volume of offenders, but the number of offenders did not happen overnight so there has been ample time to work toward a better process.</p> <p>Ms. Vaughn stated that an electronic process would be great and if other entities can do this then certainly TDCJ should be able to find a way to implement it. Ms. Vaughn stated that she knows there are security level and cost issues. However, JPay and Securus make money off of giving methods of communication to offenders. Getting them in on the process might be a way to defray some of the cost. In the long run and in such a litigious society, having an electronic system is a better way to go.</p> <p>Regarding the grievance process; if you were to go online and Google Valencia Pollard you would find blogs about the grievance process of getting refunds of the \$100 copay. Ms. Vaughn continued stating that for some people that \$100 is a lot so they go through the grievance process and that can take a minimum of 6 months to be overturned and have funds placed back in their trust fund account, if it is found in their favor. There has to be a better way of tracking things. Ms. Vaughn stated lastly, we all have expectations and then there is what actually happens. Communication is a big issue. She stated that she has read the position description for unit practice managers and it includes the fostering and maintaining of an air of customer service. She stated that as a public servant herself, she understands that it is easy to get jaded. Ms. Vaughn stated that she would encourage reminders be made to practice managers to improve communication and empathy.</p>	<p>Dr. Linthicum thanked Ms. Vaughn for her comments and told her that she would be looking into why it is taking 6 months for the reimbursement of overturned fees. She explained that most health services fees are overturned at the division level if they are not overturned at the unit level and are then appealed to step 2.</p>	

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<p>IX. Public Comments (Cont.)</p>	<p>Ms. Vaughn stated that she would guess that that specifically happens if it goes on to step 2 medical grievance. She stated that she is confused about that process and so she spoke with Ms. Jamison about it to get some background before she spoke on it. Ms. Vaughn noted that she is familiar with the disciplinary grievance process. She stated that Ms. Jamison was under the understanding that if the practice manager upheld their original decision to assess the fee then it would go up to the Regional Director of TDCJ.</p>	<p>Dr. Linthicum stated that if it is determined that a refund is warranted then it goes to the Commissary and Trust Fund staff. Dr. Linthicum noted that Mr. Steffa oversees the Commissary and Trust Fund staff and they will get together and figure out the timeline for those reimbursements.</p> <p>Dr. Linthicum also stated that Marjorie Kovacevich and Tony Williams from UTMB and Will Rodriguez from TTUHSC supervise all of the unit level health care administrators and practice managers and they can reinforce with them that they are the liaisons on the units when family members call with complaints or concerns. We will continue to work with you and other advocates to try to improve the system.</p> <p>Ms. Black-Edwards further explained that practice managers have the authority and ability to reverse charges in the system at the unit level if reimbursement is found to be warranted. She stated that even if it is appealed and overturned at step 2 the reimbursements are done by the practice manager at the unit level after notification by division level staff. Ms. Black-Edwards asked Ms. Vaughn if she could provide specific instances or examples of a refund taking six months to be returned to an offenders account so that she could look into it further.</p> <p>Mr. Williams stated that he would make sure that the process was explained to Ms. Jamison.</p>	

Agenda Topic / Presenter	Presentation	Discussion	Action
<p>IX. Public Comments (Cont.)</p>	<p>Ms. Vaughn stated that perhaps it could be a matter of it getting to the right people. She said that just in the past month she has spoken to a warden at a unit that she respects greatly and he was under the impression that at some point in that grievance process after the practice manager reviews it, it would then go to someone in TDCJ not UTMB.</p>	<p>Dr. Linthicum stated that Ms. Jamison only works on the patient liaison side and does not work on the grievance side. Dr. Linthicum explained that if a health care services fee grievance is denied at step 1, it is appealed up to step 2 in the Health Services Division (HSD). Ms. Black-Edwards oversees the step 2 medical grievance staff in the HSD. If it is overturned in step 2, it then goes back to the unit level for the keying of the refund. Dr. Linthicum requested that Ms. Vaughn forward some specific examples of refunds taking 6 months so that they could look into them and determine why they are taking that long.</p> <p>Dr. Linthicum explained that the Administrative Review and Risk Management (ARRM) Division oversees the offender grievance program. Each unit has a grievance coordinator position. They complete all the administrative work on the offender grievances. If there is a medical issue at step 2, then the ARRM division sends it to the Health Services Division (HSD). After review within the Office of Professional Standards it goes back to the unit grievance coordinator to complete the administrative work. There is an administrative component to it and there is a specific amount of time allowed for that component. Step 2 grievances only come to HSD if they deal with health care. If they deal with another area then the grievance coordinator would get with the warden to determine where to route them. All appealed health care services fee issues are routed to HSD.</p>	

