# CORRECTIONAL MANAGED HEALTH CARE

# COMMITTEE

# AGENDA

December 4, 2007

9:00 a.m.

Love Field Main Terminal
Conference Room A
8008 Cedar Springs Road
Dallas, Texas

# CORRECTIONAL MANAGED HEALTH CARE COMMITTEE

December 4, 2007
9:00 a.m.

Love Field Main Terminal Conference Room A
8008 Cedar Springs Road
Dallas, Texas

I. Call to Order

II. Recognitions and Introductions

III. Approval Excused Absence

IV. Consent Items

1. Approval of Minutes, September 25, 2007

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. Performance and Financial Status Dashboard

VII. Summary of Critical Correctional Health Care Personnel Vacancies

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

VIII. 24-Hour Staffing Review

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EACH ITEM ABOVE INCLUDES DISCUSSION AND ACTION AS NECESSARY

IX. Medical Director's Updates

1. Texas Department of Criminal Justice

2. Texas Tech University Health Sciences Center

3. The University of Texas Medical Branch
   - Hospital Galveston Update
   - Overview of Mental Health Services

X. Report: Organ Transplants in Correctional Health Care Systems

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

XII. Presentation from Joint Work Group: System Leadership Council

XIII. Updates to Hepatitis Policy

1. B-14.13: Hepatitis Policy
2. B-14.13TR: Technical Reference for Hepatitis Policy

XIV. Financial Reports

1. FY 2007 Fourth Quarter and Monthly Financial Report
2. Financial Monitoring Update

XV. Public Comment

XVI. Date / Location of Next CMHCC Meeting

XVII. Adjourn

# Consent Item 1

Approval of Minutes, September 25, 2007

**MINUTES**

**CORRECTIONAL MANAGED HEALTH CARE COMMITTEE**
**September 25, 2007**

**Chairperson:** James D. Griffin, M.D.

**CMHCC Members Present:** Elmo Cavin, Cynthia Jumper, M.D., Lannette Linthicum, M.D., Ben G. Raimer, M.D.

**CMHCC Members Absent:** Jeannie Frazier, Larry Revill, Desmar Walkes, M.D.

**Partner Agency Staff Present:** Owen Murray, D. O, John Allen, Steve Alderman, The University of Texas Medical Branch; Gary Tonniges, Nancy Spain (Retired) Texas Tech University Health Sciences Center; Dee Wilson, Nathaniel Quarterman, Jerry McGinty, George Crippen, R.N., Cathy Martinez, Rebecca Berner, Texas Department of Criminal Justice; Allen Hightower, Allen Sapp, Tati Buentello, CMHCC Staff, Lynn Webb future CMHCC Staff.

**Others Present:** Martha Ann Dafft, Representing Self

**Location:** Love Field Main Terminal Conference Room A, 8008 Cedar Springs Road, Dallas, Texas

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| **I. Call to Order**<br><br>**- James D. Griffin, M.D.** | Dr. Griffin called the CMHCC meeting to order at 9:00 a.m. in accordance with Chapter 551 of the Texas Government Code, the Open Meetings Act. He noted that a quorum was present then thanked everyone for attending. | | |
| **II. Recognitions and Introductions**<br><br>**- James D. Griffin, M.D.** | Announcement of new CMHCC Member:<br><br>Dr. Griffin announced that Mr. Brad Livingston, Executive Director, appointed Mr. Bryan Collier to be the non-physician member representing TDCJ. Mr. Collier is filling in the position vacated by Mr. Ed Owens. Dr. Griffin further noted that Mr. Collier was unable to attend this meeting due to prior commitments but will be officially introduced and welcomed at the next meeting.<br><br>Dr. Griffin next introduced Mr. Lynn Webb who has been selected to serve as the CMHCC Finance Manager who will be joining the staff formally in October. Dr. Griffin stated that Mr. Webb has more than 28 years of hospital finance experience and most recently served as controller and chief financial officer at Healthsouth Rehabilitation Hospital in Beaumont. He further noted | | |

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| **II. Recognitions and Introductions (Cont.)** | that Mr. Webb also has experience as both a Medicare auditor and an auditor for Blue Cross. Dr. Griffin on behalf of the committee then welcomed Mr. Webb to the staff.<br><br>Dr. Griffin next introduced Mr. Jerry McGinty who was recently named as the Deputy Chief Financial Officer for TDCJ and welcomed him to the meeting.<br><br>Dr. Griffin then called on Mr. Sapp, Dr. Linthicum and Dr. DeShields to present the certificate of appreciation to Ms. Nancy Hurt-Spain for her dedicated and key leadership role with TTUHSC and the correctional healthcare program.<br><br>Dr. Griffin stated that he would entertain a motion to adopt the Resolution as provided by Mr. Sapp. | Mr. Sapp noted that Ms. Spain quietly retired several months ago from her position as the Administrator, Office of Standards / Compliance and as Institutional Deputy Compliance Officer for TTUHSC, but all the partner agencies wanted to properly recognize her for her outstanding service to the Texas correctional health care program. He then read and asked that the committee adopt the Resolution of Appreciation being presented to Ms. Spain. (copy provided at Attachment 1).<br><br>Dr. Linthicum next acknowledged Ms. Spain for her tireless service, for steering the nursing policies for the correctional health care program and for always exhibiting her West Texas can-do attitude.<br><br>Dr. DeShields also noted that Ms. Spain was a staunch nursing and patient advocate which are two of the most admirable attributes in this profession and applauded all of her accomplishments. | Mr. Elmo Cavin moved that the committee adopt the Resolution of Appreciation to Ms. Spain as presented by Mr. Sapp.<br><br>Dr. Ben Raimer seconded the motion, which prevailed by a unanimous vote. |

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| | | Ms. Spain thanked the committee for the recognition but stated that whatever achievement she had could not have been accomplished alone and credited her magnificent support team and nursing staff, then thanked her mentors who taught her to treat each patient's health care needs without taking away their dignity. | |
| **III. Approval of Excused Absence**<br><br>- **James D. Griffin, M.D.** | Dr. Griffin next noted that Dr. Ben Raimer and Dr. Desmar Walkes were absent from the June 26, 2007 CMHCC meeting due to scheduling conflicts then stated that he would entertain a motion to excuse their absence. | | Mr. Cavin moved that Dr. Raimer and Dr. Walkes absence from the June 26, 2007 CMHCC meeting be excused.<br><br>Dr. Jumper seconded the motion. Motion passed by unanimous vote. |
| **IV. Consent Items**<br><br>- **James D. Griffin, M.D.** | Dr. Griffin then stated next on the agenda was the approval of the consent items to include approval of the Minutes from the June 26, 2007 CMHCC meeting; the TDCJ Health Services Monitoring Report; both UTMB and TTUHSC Medical Director's report and the Summary of Joint Committee Activities.<br><br>He asked if any of the members had any specific consent item(s) to pull out for separate discussion? Hearing none, stated that he would entertain a motion. | | Dr. Jumper moved to approve the consent items as presented in the agenda packet.<br><br>Dr. Linthicum seconded the motion. Motion passed by unanimous vote. |
| **V. Executive Director's Report**<br><br>- **Allen Sapp** | Dr. Griffin next called on Mr. Sapp to present the Executive Director's Report on behalf of Mr. Hightower who was recovering from a recent medical procedure.<br><br>Mr. Sapp thanked the Chairman and noted that the Executive Director's Report is provided on page 73 of the agenda packet. He then stated that he would briefly summarize the significant activities relating to the correctional health care program since the last meeting. | | |

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| - FY 06-07 Supplemental Appropriations | Mr. Sapp reported that the contract amendments authorized as a result of the FY 2006-2007 supplemental appropriations to UTMB and TTUHSC were executed following the approval by the committee at the last meeting. Those payments were completed in August and as required by the committee's motion, each invoice was accompanied by a certification from the university Chief Financial Officer that outlined the projected losses. | | |
| - Contract Amendment Pandemic Flu Medication | Mr. Sapp also recalled that at the last meeting, the committee authorized a contract amendment be executed for the purchase of pandemic flu medication made available at a subsidized rate by the Texas Department of State Health Services. A total of $230,000 was identified as available for the purpose of providing a contingency stock of the pandemic flu medication. In the event of a pandemic flu outbreak, he noted that UTMB would distribute this medication statewide as directed by the Joint Infection Control Committee. | | |
| - FY 08-09 Contract | Mr. Sapp again noted that at the last CMHCC meeting, the Committee approved the budget allocations and were provided a summary of key changes to the proposed new contracts for the upcoming budget cycle. Since that meeting, all three master contracts for the FY 2008-2009 biennium were completed and fully executed in a timely manner. He then expressed his appreciation to all those involved for their cooperation and assistance throughout the contract renewal cycle. | | |
| - CMHCC Finance Manager Position | Mr. Sapp next reported that Ms. Colleen Shelton submitted her resignation effective July 27th from her position as the CMHCC Finance Manager in order to accept a regional financial management position with a private hospital corporation. He then stated that while Ms. Shelton will be missed as a member of the CMHCC staff team, the committee is looking forward to Mr. Lynn Webb joining the team and picking up those duties as noted earlier by Chairman Griffin.<br><br>Mr. Sapp concluded by stating on a personal note that after careful consideration and with mixed emotions he had reached the decision to retire from the correctional health care program in November of this year. | Dr. Griffin stated that he would entice Mr. Sapp to attend the next meeting so that he can be formally recognized on the record for his services to the State of Texas. | |

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| **VI. Performance and Financial Status Update**<br><br>- Allen Sapp | Dr. Griffin next asked that Mr. Sapp provide the performance and financial status update.<br><br>Mr. Sapp reported that over the course of the FY 2006-2007 biennium approached the anticipated average service population of 151,700.<br><br>Mr. Sapp noted that the aging offenders continue to rise at a steady rate. In May 2007, for the first time in TDCJ history, the number of offenders aged 55+ and older topped 10,000 as reported at the last meeting. This number has leveled off in June but will be back above that mark in July.<br><br>The psychiatric inpatient census averaged pretty consistently at 2,000 and the psychiatric outpatient census has remained consistently between 19,000 – 21,000. Again, both the psychiatric inpatient and outpatient census are over the expected budgeted levels.<br><br>The access to care indicators which shows the percent of compliance through the biennium overall are averaging in the 98 percentile. The medical indicator number nine which is the follow-up review appointment was averaging at 96%. Mr. Sapp noted that the ups and downs leveling off in the last six month period is probably indicative of the vacancy situation being addressed.<br><br>Mr. Sapp then reported that mental health access to care is consistently between the 98% - 99% range; and the dental access to care has improved in the area of follow-up care as noted in the chart provided at page 82 of the agenda packet. | | |

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| - Performance and Financial Status Update (Cont.) | The UTMB position vacancy chart on page 83 shows the seven quarters of the fiscal biennium which ranges from 10% - 15% across the provider categories except the dental vacancy rates which are considerably lower.<br><br>TTUHSC vacancy rates have been historically higher as they are affected by the challenges of recruiting staff in some of their more remote geographic locations in Texas. Their nursing staff vacancy rates are at 15% or higher but Mr. Sapp again cautioned that the psychiatric vacancy numbers can look deceivingly higher because of the lower number of the total psychiatric positions.<br><br>Mr. Sapp further noted that the timeliness of medical summaries for the Medically Recommended Intensive Supervision Program (MRIS) have remained consistent.<br><br>In terms of financial indicators, TTUHSC's expenses have been exceeding their revenues throughout the fiscal year as had been projected. On a month by month basis, TTUHSC has been at a loss each month and accumulatively at the end of June was approximately $4.8M in the red. Mr. Sapp then noted that this amount is prior to the consideration of the supplemental appropriation funding.<br><br>UTMB data shows that the revenues exceeded the expenses in some months and vice-versa. Mr. Sapp stated that those are again dictated to some degree by the bi-weekly payroll schedule and that scheduling of transactions impact this more than anything else. Cumulatively at the end of June, UTMB was $0.4M in the red.<br><br>Mr. Sapp concluded by stating that as he noted in the Executive Director's Report earlier, the supplemental appropriations payments were completed in August and both universities provided invoices accompanied by a certification from the university that outlined the projected losses. | Dr. Linthicum asked what the amount of the supplemental appropriations were for both universities?<br><br>Mr. Sapp responded approximately to $5.1M for UTMB and $7.8M for TTUHSC. | |

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| **VII. CMHCC Critical Vacancy Updates**<br><br>**- Allen Sapp** | Dr. Griffin then noted that at the June meeting, he had asked for an update to be provided as a permanent agenda item relating to critical vacancy positions that would potentially impact the healthcare services being provided. He then called on Mr. Sapp to provide the initial update.<br><br>Mr. Sapp noted that the critical vacancy position listing for all three partner agencies is provided at page 93 of the agenda packet. He further stated that he basically set up a format then asked the three Medical Directors to submit the position vacancies. Mr. Sapp then stated that the definition as to what constitutes a critical vacancy is continuing to be looked at but the information presented provides a sample of what positions are currently unfilled and the action(s) being taken to date in working towards filling those position. | Dr. Griffin then asked each of the three medical directors to comment on those vacancies in their sector.<br><br>Dr. Murray stated that the biggest concern that both he and Dr. DeShields have faced collectively for the physicians and mid-level practitioners is the need for those salaries to be comparable to the market levels in order to attract and recruit qualified professionals. The mental health director for example took close to three years to fill. Dr. Murray further stated that the salary ranges were competitive at one time but had fallen behind for the last 24 months and now they need to entertain new and innovative strategies such as a loan repayment program that may help recruit applicants.<br><br>Dr. Linthicum agreed and also added that there is a constant competition between the three partner agencies recruiting staff away from one another. She recommended that a strategy be looked at in terms of an equalization of salaries across the board for the three agencies that are comparable to the market level.<br><br>Dr. DeShields stated that being situated in rural locations and being so dispersed throughout West Texas makes it even more challenging to recruit applicants. TTUHSC is also looking for new innovative strategies such as sending out information to the post graduate programs with the available job postings. She did note that the legislative increases | |

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| | Dr. Griffin remarked that this is a good example of the kinds of issues concerning the CMHCC program that the state leadership should be made aware of. He then thanked Mr. Sapp for formatting the critical position vacancy update information and for the comments presented by the three Medical Directors. | approved during the last session have helped but are still around 25% below the salaries being offered at the Federal Correctional Systems. | |
| **VII. TDCJ Medical Director's Report**<br><br>- Lannette Linthicum, M.D.<br><br>- Office of Professional Standards<br><br>- Capital Assets Contract Monitoring<br><br>- Preventive Medicine Program | Dr. Griffin hearing no further discussions, called on Dr. Linthicum to provide the TDCJ Medical Director's Report.<br><br>Dr. Linthicum noted that the TDCJ Medical Director's Report starts on page 95 of the agenda packet.<br><br>During the third quarter of FY 2007, Dr. Linthicum reported that ten operational review audits were conducted. The Office of Professional Standards received a total of 3,137 correspondences of which 251 action requests were generated. Patient Liaison Program received 1,435 correspondences and of those 105 action requests were generated. Step II Grievances received 1,702 correspondences and generated 146 action requests.<br><br>Dr. Linthicum further reported that 50 access to care audits were conducted with a total of 450 indicators reviewed. Of those 450 indicators, 83 or 18% fell below the 80 percent compliance rate.<br><br>The Capital Assets Contract Monitoring Office audited 9 units and those audits are conducted to determine compliance with the Health Services Policy and State Property Accounting inventory procedures.<br><br>Dr. Linthicum next reported that the Preventive Medicine Program monitors the incidence of infectious diseases within TDCJ. For the third quarter of FY 2007, there were 171 reports of suspected syphilis; 18,476 HIV screens were conducted; and 9,385 offenders identified for pre-release HIV tests for a total of 27,861 tests performed. She then noted that 140 new cases of HIV and 20 new AIDS cases were identified; and 7 offenders have been found to be HIV positive in pre-release testing. | | |

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| - Preventive Medicine Program (Cont.) | Dr. Linthicum recalled at the June meeting, the committee adopted and approved the new HIV policy that was consistent with HB 453 that requires HIV testing and reported that this was implemented on July 1, 2007.<br><br>Dr. Linthicum next reported that 881 MRSA cases were identified during this quarter compared to 956 during the same quarter of FY 2006. There was an average of 18 TB cases under management versus an average of 20 per month during the same period of the previous fiscal year.<br><br>The Sexual Assault Nurse Examiner (SANE) Coordinator whose position is funded through the Safe Prisons Program is trained in the performance of medical examination, evidence collection and documentation, and for the use of sexual assault kits. The position audits the documentation and services provided by medical personnel for each sexual assaults reported. Out of 17 facilities, 116 staff members participated in the sexual assault in-service training so far this year and 140 chart reviews for victims were performed from January through May 2007. | Dr. Griffin asked if the HIV numbers reported were pre-mandatory testing then asked if there are any projections as to what those numbers will become or if they would stay the same?<br><br>Dr. Linthicum responded that the numbers were for pre-mandatory testing. She further stated that Dr. Michael Kelley, Director of Preventive Medicine looked at this and noted they were already capturing 80% of the intake population.<br><br>Mr. Sapp agreed stating that the numbers would not go up much higher as the majority of the population have already been captured<br><br>Dr. Griffin then asked if the legislative intent was to protect the general population by releasing the information gathered by TDCJ?<br><br>Dr. Linthicum responded that there has always been public perceptions that prisons were the breeding ground for HIV transmission. With this, there will be data on the status at intake and also the status upon discharge. This data then provides information on sero-prevalence transmission within the prison system. She further noted that the emphasis is on knowing the status and how to take care of one-self by getting treatment early so that it does not progress in to AIDS. She then stated that the State Department of Health has the responsibility for partner notifications. | |
| - Mortality and Morbidity | The Mortality and Morbidity Committee reviewed 107 deaths. Of these, ten cases were referred to peer review committees. Breakout of those cases are provided on page 98. | | |
| - Mental Health Services Monitoring | The summary of the Mental Health Services Monitoring and Liaison is provided on page 98 of the agenda packet. | | |
| - Clinical Administration | During the third quarter of FY 2007, 10 percent of the combined UTMB and TTUHSC hospital (2,832) and infirmary (603) discharges were audited. The breakdown of the hospital and infirmary discharges, the accreditation data and the administrative segregation audit information are also provided on page 98. | | |

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| - Accreditation | Dr. Linthicum next reported that the ACA hearings were held at the April 13-17, 2007 Correctional Accreditation Managers Association Conference in Kentucky. A total of 12 TDCJ facilities were presented to the panel of commissioners. Initial accreditations were awarded to 7 of those facilities, reaccreditations were awarded to 5 and noted that the agency now has a total of 64 accredited facilities. | | |
| - Research, Evaluation and Development Group (RED) | Dr. Linthicum next stated that this will be the last report from the Research, Evaluation and Development (RED) Group as it is no longer a division of TDCJ with the recent departure of Ms. Dimitria Pope. This area has been reassigned to the Executive Services Division and Dr. Linthicum noted that she will be working with them on the biomedical research format. She then reported that there were six Health Services Division active monthly medical research projects, seven medical research projects pending approval, and 18 Correctional Institutional Division active monthly medical research projects and the listing of those projects are found under the consent item on pages 50-54 of the agenda packet. | | |
| **VII. Medical Director's Report (UTMB)**<br>- **Owen Murray, D. O**. | Dr. Griffin hearing no further questions, thanked Dr. Linthicum for the report. He then called on Dr. Owen Murray to present the UTMB Medical Director's Report.<br><br>Dr. Murray reported that after close to 3 years of searching for a Mental Health Director, UTMB has hired Dr. Joe Penn who is board certified in forensics, child and adolescence as well as general psychiatry. Dr. Penn is currently a faculty member at Brown University that provides mental health services for the Rhode Island Youth Commission. Dr. Murray further noted that Dr. Penn has extensive experience with the National Commission currently serving on the Board of Directors and is the president-elect of NCCHC. Dr. Penn has a start date of January 2008 but will start doing some work by mail. Dr. Murray stated that Dr. Penn will be attending the March 2008 CMHCC meeting to be formally introduced to the committee. | | |

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| | Dr. Murray also noted that upon the retirement of the mental health director at the Skyview Unit, he was happy to report that they were able to fill that position with an internal candidate.<br><br>Dr. Murray next reported that he and Dr. Linthicum continually sought out different initiatives to promote better relationships and to be more accessible to the public as to how the correctional health care program operates. In that spirit, they have invited the offender advocacy group, CURE to visit UTMB to include the hospital; to meet the divisional teams, and have staff provide brief presentations. This tour is scheduled for Thursday, Sept. 27th. He hoped to continue doing so by inviting other advocacy groups to be part of future tours in both sectors. Dr. Murray concluded by stating that UTMB and TTUHSC together with TDCJ are ready to provide that level of interaction. | | |
| **VII. Medical Director's Report (TTUHSC)**<br><br>**- Denise DeShields, M.D.** | Dr. Griffin asked if there were any questions or further discussion. Hearing none, thanked Dr. Murray for the report then called on Dr. DeShields to present the TTUHSC Medical Director's Report.<br><br>Dr. DeShields stated as noted earlier during the critical vacancy update discussions; position vacancy rates continue to be a problem for TTUHSC. The area of particular concern is the difficulty in recruiting for the psychiatric department. She did however note that the dental vacancy rate improved from her last report. Dr. DeShields hoped to see improvements within the next few months with increases in salaries and shift differential to recruit qualified applicants.<br><br>Dr. DeShield then reported that currently there are 29 offenders housed at the Montford Regional Medical Facility. Of those 29 beds, 21 house long term care patients and eight were for dialysis patients. She concluded by stating they will begin hiring additional staff for those positions still vacant at the facility. | | |

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| **VIII. TCOOMMI Update**<br><br>- **Dee Wilson** | Dr. Griffin thanked Dr. DeShields for the report then called on Ms. Dee Wilson to provide the TCOOMMI update.<br><br>Ms. Wilson began by noting that she is also facing difficulties with position vacancy rates particularly in filling the psychiatric positions.<br><br>She then stated that a Memorandum of Understanding (MOU) between TDCJ and the Department of Assistive Rehabilitative Services (DARS), the Department of Health Services (DSHS), and the Department of Aging and Disability Services (DADS) is provided in the agenda packet on pages 101-104. Ms. Wilson reported that the MOU establishes continuity of care and service program for offenders with physical disabilities, the elderly, the significantly or terminally ill, and the mentally ill.<br><br>Ms. Wilson stated that this MOU also develops interagency rules, policies and standards for the coordination of care and services of and exchange information on offenders with special needs, as well as, identifying services needed by offenders with special needs to re-enter successfully back into the community.<br><br>Ms. Wilson further noted that the definition of elderly vary slightly as TDCJ uses age 55+ whereas the DARS defines the elderly as 65+ and that number is what is being in use at this time. She then stated that he definition applied to the population such as significant medical or terminal illnesses will be 6 months or less.<br><br>Ms. Wilson concluded by stating that they will continue to monitor and track these individuals on their health care information and that she would entertain any questions. | Dr. Linthicum added that the reason TDCJ uses age 55+ is because an offender's physical condition in most cases is 10 years older anatomically. | |
| **IX. Joint Pharmacy and Therapeutics Committee Overview**<br><br>**- Stephanie Zepeda** | Hearing no further questions, Dr. Griffin stated that the next item on the agenda will be an overview of the Joint Pharmacy and Therapeutics (P & T) Committee and called on Ms. Stephanie Zepeda, Director of Pharmacy.<br><br>Ms. Zepeda began by stating that the Joint Pharmacy and Therapeutics Committee meets bi-monthly and the primary function of the committee is to develop the statewide medication formulary as well as the drug use policies and procedures. The committee also has the responsibility to ensure safe and cost effective drug therapy and disease management guidelines. | | |

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| Joint Pharmacy & Therapeutics Committee Overview (Cont.) | Ms. Zepeda then stated that the P & T provides corrective action plans on how to make improvements by developing quality assurance programs related to drug use; by developing medication use evaluation studies; and, of implementing changes as needed.<br><br>The P & T is a multi-disciplinary committee with representation from all three partner agencies. Current members include the university medical directors, the medical director for TDCJ Health Services and her designee, the university regional medical directors as well as divisional and district medical directors. Ms. Zepeda stated in addition to her role as the Director of Pharmacy, she also serves as the secretary for the committee. There are also appointed members to include nursing, dental, mental health representation and ex-officio members that the committee appoints on occasion to assist on special projects or in areas of special interest where their expertise is needed. She then added that the chairperson is appointed by the TDCJ Health Services Medical Director for a 2 year term. She then noted that the role of the Chair is to function as a nonpartisan facilitator that votes only to break a tie.<br><br>In terms of resources, Ms. Zepeda noted that the primary publications are the statewide CMC Drug Formulary book, the Policy and Procedures Manual, the Disease Management Guidelines (DMG) as well as the complimentary patient educational materials. She further added that the CMC formulary is available electronically on TDCJ's Forvus and the EMR/PRS system and they also have electronic copies of the Policy and Procedures Manual, the DMG and the educational materials on the UTMB-CMC internal website.<br><br>Ms. Zepeda next reported that the CMC Pharmacy Policy and Procedure Manual is reviewed at least annually but may be reviewed more frequently if there are any changes in rules or regulations from any other state agencies such as the Texas State Board of Pharmacy, or the Board of Medical or Nurse Examiners. She further stated that they also look at different state and national regulations or accreditation standards from organizations such as NCCHC or ACA.<br><br>The DMG tools are developed by the practitioners to ensure consistent and cost effective care is provided across all the facilities and are reviewed every three years or sooner as needed. | | |

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| Joint Pharmacy and Therapeutics Overview (Cont.) | Ms. Zepeda then stated they currently have 37 disease management guidelines that ranges in topics from acute, chronic, medical and mental health. The recent action items of interest include the new Hepatitis B vaccination program, review of new therapies for HIV, coronary artery disease, dyspepsia and non-formulary medication conversion chart.<br><br>Ms. Zepeda concluded by stating that her presentation can be found on pages 105 – 115 of the agenda packet. | Mr. John Allen asked what the new HIV therapies included and asked if it was less costly to do?<br><br>Ms. Zepeda responded that it is a new class of agents but is equivalently priced. However, she noted that there are some dosing requirements where the dosage doubles.<br><br>Dr. Linthicum then asked how much per month is being currently spent on HIV drugs?<br><br>Ms. Zepeda responded it was about 47% of the budgeted drug costs systemwide.<br><br>Mr. Sapp added that it was about $1.3M per month.<br><br>Dr. Griffin then asked what the greatest challenges were?<br><br>Ms. Zepeda responded that the 3 biggest price drivers are HIV with the new therapies that becomes more complicated and more expensive; Hepatitis C in terms of provider resources and moving the patients to a health care system in a timely manner; and mental health concerns with the use of the new generation psychotics which affect the budgetary issues as well as how best to utilize those agents and minimize the side affects with good results. She then stated that another challenge would be the emergent medication needs and how to address those.<br><br>Mr. Allen then asked how many scripts does the pharmacist review per day?<br><br>Ms. Zepeda stated they look at anywhere from 16,000 medication orders a day on the average to 30,000 after a holiday weekend. She added that the pharmacists are averaging in the mid-800's orders per day, but also are trained to make therapeutic interventions to | |

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| - Joint Pharmacy and Therapeutics Overview (Cont.) | | optimize drug therapy. For example, if an asthma patient was using an inhaler and it was being filled every 2 weeks, the pharmacist would intervene and recommend that a long term control medication be added.<br><br>Dr. Linthicum noted that the use of clinical pharmacists have resulted in better outcomes for the patients as they are part of the treatment team and have a critical role in the chronic care within the system. As the aging offender population become higher acuity patients and with cancer becoming the second leading cause of death, the pharmacy and the clinical pharmacist are crucial in helping manage those patients.<br><br>Dr. DeShields then added besides the HIV, Hepatitits C and mental health patients, they are also seeing increases in the standard formulary drugs to treat the cardiovascular and diabetic patients as the offender population ages.<br><br>Dr. Griffin then asked what the satisfaction level was for the pharmacists?<br><br>Ms. Zepeda stated that UTMB has been supportive of her needs and have been able to stay competitive in terms of salaries and that the employee moral was high and that they take pride in what they provide as part of the health care team. | |
| | Dr. Griffin hearing no further discussions, thanked Ms. Zepeda. He then noted that he would invite her back to provide an overview a little more frequently then the other joint committees as the pharmacy involves a large part of the budget and wanted the committee up to date on the drugs needed in terms of improving health care needs for the offender population. | | |

| Agenda Topic / Presenter | Presentation | Discussion | Action |
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| **XI. CMHCC Policy Updates**<br><br>**- Allen Sapp** | Dr. Griffin next called on Mr. Sapp for the CMHCC policy updates.<br><br>Mr. Sapp began by noting that starting on page 117 through 144 of the agenda packet, updates to the current CMHCC policies are found. Mr. Sapp further noted that a summary of the proposed changes are provided in the chart on page 117.<br><br>Mr. Sapp then reported that most of the revisions to the policies are proposed in order to conform to the changes in the Committee's statutory authorization as a result of the Sunset Review as passed in SB 909, 80th Legislature. He further noted that they also reflect contract changes and current practice.<br><br>One new policy, A-07, Alternative Dispute Resolution, was added as required by SB 909 to adopt a policy encouraging the use of alternative dispute resolution. This is prepared in line with Chapter 2009 of the Government Code in conformance with model guidelines established by the State Office of Administrative Hearings.<br><br>The next three policies relate to financial reporting and provides updated language related to the required financial reporting that references current practice; updates timelines for submission as agreed in contract discussion; references maintenance of financial information on the Committee's website; makes minor adjustments to description of monitoring process; language added permitting CMHC to consider hours spent by university internal auditors assisting the State Auditor's Office in audits specific to the correctional health care program; and delete language permitting the payment of moving costs for newly hired employees pursuant to SAO recommendation.<br><br>Mr. Sapp concluded by requesting that the committee approve the changes and updates made to the current CMHCC policy as presented. | | |

| Agenda Topic / Presenter | Presentation | Discussion | Action |
|---|---|---|---|
| - CMHCC Policy Updates (Cont.) | Dr. Griffin asked if there were any questions or comments, hearing none stated that he would entertain a motion. | | Dr. Ben Raimer moved that the Committee approve the updates and changes to the CMHCC policies as presented by Mr. Sapp and provided on pages 117-144 of the agenda packet.<br><br>Dr. Cynthia Jumper seconded the motion. Motion passes by unanimous vote. |
| **XII. CMHCC Website Update**<br><br>**- Allen Sapp** | Dr. Griffin stated that Mr. Sapp still has the floor and asked him to provide the update on the CMHCC website.<br><br>Mr. Sapp then stated that he would provide a quick demonstration on how to access the CMHCC website which also links to the UTMB, TTUHSC, TDCJ website and vice-versa.<br><br>The address to access the CMHCC website is http://www.cmhcc.state.tx.us. Once the homepage comes up, Mr. Sapp stated that you will be able to navigate to the various sites by clicking on the buttons at the top. The minutes and agenda packets for example are available by clicking on the "publication" button and it also contains other documents relating to the CMHCC program to include the contracts and financial reports. The "home" button contains the enabling statute, the list of CMHCC members; the "clinical performance" button provides the description of the monitoring mechanism; links to ACA; "complaint process" button includes the instructions and links for filing complaints.<br><br>Mr. Sapp then noted that the CMHCC website should be considered a work in progress and updates are added periodically and additional content developed to meet recommendations of the Sunset Commission. He concluded by stating that a sample of what is available by clicking on the various navigation buttons is briefly described on page 146 of the agenda packet. | | |

| Agenda Topic / Presenter | Presentation | Discussion | Action |
|---|---|---|---|
| **XIII. Financial Reports**<br><br>**- Allen Sapp** | Dr. Griffin hearing no further discussions, then asked Mr. Sapp to review the financial reports.<br><br>Mr. Sapp noted that the two latest financial reports for FY 2007 start on page 147 for the Third Quarter Financial Report and the June monthly financial report starts on page 167 of the agenda packet.<br><br>In terms of population indicators, Mr. Sapp reported that the average population served through the third quarter of FY 2007 was 151,782. In June, this population rose slightly to 151,810. The overall population is up approximately 0.4% over the same period last year. He then notes as shown on the presentation slide earlier in the meeting, the older offender population continues to rise at the rate of about 9.6% - 9.7% per year. The HIV+ offender population remains stable at about 2,587.<br><br>He next reported that through June of FY 2007, the health care costs totaled $353.3M. Of those, onsite services or those medical services provided at the prison units comprised $169.8M representing about 48% of the total health care expenses; pharmacy services totaled $34.3M representing approximately 9.7% of the total expenses; offsite services including hospitalization and specialty clinic care accounted for $104.6M or 29.6% of the total expenses; mental health services totaled $33.8M or 9.6% of the total costs and indirect support expenses accounted for $12.2M and represented 3.4% of the total costs.<br><br>Mr. Sapp then reported that the total cost per offender per day for all health care services statewide through June of FY 2007 was $7.68. When benchmarked against the average cost per offender per day for the prior four fiscal years of $7.53, Mr. Sapp noted that the cost has increased about 2.0%.<br><br>For UTMB, the cost per offender per day was $7.71 which was slightly higher than the average cost per day for the last four fiscal years of $7.66. The cost per offender per day for TTUHSC was $7.56 which is significantly higher than the average cost per day for the last four fiscal years of $7.05. | | |

| Agenda Topic / Presenter | Presentation | Discussion | Action |
|---|---|---|---|
| - Financial Report (Cont.) | Mr. Sapp next noted that the statistics relating to the costs for aging offenders continue to reflect their increased demand on health care resources as they are accessing three times as many encounters with heath care staff and utilization rates for hospitalizations are four times that of a younger offender. While the aging offender make up only 6.4% of the population, they encounter for more than 27% of hospital costs.<br><br>Mr. Sapp further reported that HIV care continues to be the single largest component in terms of drugs costs at almost $1.3M per month and comprising 47% of the total drug cost. Psychiatric drugs accounted for about 5.7% of the drugs costs, with Hepatitis C therapies now accounting for almost 4%.<br><br>In terms of fund balances, Mr. Sapp stated that both universities report that they hold no reserves for correctional health care. UTMB reported a shortfall through June of almost $0.5M while TTUHSC reported a $4.8M shortfall. At the end of June, the CMHCC accounts had a total balance on hand of $326,606. | | |
| - Monitoring Activities | Hearing no questions, Mr. Sapp next reported on monitoring activities by stating that detailed transaction level data from both providers is being tested on a monthly basis to verify reasonableness, accuracy and compliance with policies and procedures.<br><br>All corrective actions requested in prior months, including those identified in prior reports for February through April have been completed as agreed by UTMB and TTUHSC and verifying documentation was provided to the CMHCC Finance Manager.<br><br>Mr. Sapp then reported that the results of the detail transaction testing performed on TTUHSC's and UTMB's financial information for the month of May 2007 found no discrepancies requiring additional corrective action. Testing for June financial data is still in progress. | | |
| - TTUHSC Internal Audit Review | Mr. Sapp stated that he would next report on the TTUHSC Internal Audit Review on the monitoring controls related to pharmacy billing which is found on page 179 of the agenda packet. | | |

| Agenda Topic / Presenter | Presentation | Discussion | Action |
|---|---|---|---|
| - TTUHSC Internal Audit Review (Cont.) | Mr. Sapp then reported that the objective of the TTUHSC internal audit review was to determine whether monitoring controls have been established to assist management in ensuring correct billing for pharmaceuticals purchased by TTUHSC from the UTMB Central Pharmacy.<br><br>He then reported that the review noted two suggested recommendations. The first is to enhance monitoring processes relating to the invoice process by better standardizing processes for receiving and reconciling shipments to requisition to include a process to ensure that credits to the invoices are reported and recorded in a more consistent manner. The second is to enhance the record-keeping for tracking medicines returned for reclamation so that credits for reclaimed medications can be reconciled to the actual credits made.<br><br>TTUHSC management agreed with the recommendation and Mr. Sapp noted that an action plan was submitted to conduct pilot studies involving the use of hand-held bar code scanners to assist in improving the indicated processes. Once the results of the pilot studies are completed, revised processes will be provided to the remaining facilities. Mr. Sapp concluded by noting that the TTUHSC Internal Audit office will monitor the management action plan responses.<br><br>Dr. Griffin asked if there were any questions or comments and hearing none, thanked Mr. Sapp for all of the updates. | | |
| XIV. Public Comments<br><br>- James Griffin, M.D. | Dr. Griffin stated that the next agenda item is for public comments and then called on Ms. Marthann Dafft<br><br>Ms. Dafft stated that she was representing herself and her son and thanked the committee once again for providing a forum for which the public can come to express their concerns. She then stated that it was exciting to see the Director of Nursing being recognized and honored for her work ethics and to see how the nursing staff emphasized offenders as patients once inside a clinic and treating these patients with dignity. | | |

| Agenda / Presenter | Presentation | Discussion | Action |
|---|---|---|---|
| - Public Comments (Cont.) | Ms. Dafft then stated that her son was doing well, looking good and not agitated when she visited him this past weekend and again thanked the committee for stepping in to take care of his health care needs.<br><br>She then stated that her son who is scared of being in a dentist office told her that the dentist that worked on his filling did not hurt him and she wanted to write the dentist to thank him for treating her son.<br><br>Ms. Dafft also noted that she will be doing volunteer work for the prison system and stated that the people that she will be working for are a dedicated group of people. She further stated that her intent is to hopefully be able to assist other family members and friends on how to help out their love ones who are incarcerated. Ms. Dafft concluded by stating that if there was anything she could do to assist the committee to please let her know.<br><br>Dr. Griffin thanked Ms. Dafft for attending the meetings and for her comments and again noted how important it is for the Committee to hear from the public in order to see the whole picture.<br><br>Dr. Griffin then stated that Ms. Carole Heine, another public speaker who previously frequented the Committee meetings asked that her letter be read to the Committee and called on Mr. Sapp to do so.<br><br>Mr. Sapp noted as most everyone will recall that Ms. Carole Heine attended most all of the Committee meetings to share her concerns and had always expressed that she would bring her son to one of the meetings once he was released from TDCJ. Unfortunately, due to her ill health she has not been able to attend but has continued to correspond regularly with Dr. Raimer and asked that her letter be read and admitted officially into the Minutes. Mr. Sapp then read the letter which is provided at Attachment 2.<br><br>Dr. Griffin thanked Mr. Sapp for admitting Ms. Heine's letter officially into the minutes and on behalf of the Committee members and staff wished Ms. Heine well on her road to recovery. | Dr. DeShields responded that she will get the information Ms. Dafft requested on the dentist. | . |

| Agenda / Presenter | Presentation | Discussion | Action |
|---|---|---|---|
| **XV. Date and Location of Next Meeting**<br><br>**- James Griffin, M.D.** | Dr. Griffin then stated that the next meeting is scheduled for 9:00 a.m. on December 4, 2007 to be held at the Dallas Love Field Main Terminal Conference Room A and that the committee staff will be working on scheduling the future meeting dates for CY 2008. | | |
| **XVI. Adjournment**<br><br>**- James Griffin, M.D.** | Dr. Griffin hearing no further discussions thanked everyone for attending and thanked the committee staff for their hard work.<br><br>Hearing no further discussions, Dr. Griffin adjourned the meeting at 11:10 a.m. | | |

_____

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

_____

Date:

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# ATTACHMENT 1

# Resolution of Appreciation

## Nancy Hurt-Spain, R.N.

**WHEREAS**, Nancy Hurt-Spain began her career with the Texas Tech Health Sciences Center in June of 1986 as Head Nurse in the Pediatric Department and in 1988 was appointed Director of Quality Improvement for the Lubbock Campus School of Medicine where she successfully supervised the initial accreditation effort by the Joint Commission on Accreditation of Hospital Organizations; and,

**WHEREAS**, in 1994 Nancy was recruited for and accepted a position with the newly formed Texas Tech University Health Sciences Center Correctional Healthcare System as the Coordinator of Quality Improvement with responsibilities for the oversight of all QI activities, preparation for accreditation surveys, credentialing and compliance with medical nursing standards; and,

**WHEREAS**, Nancy was promoted in 1996 to serve as the Administrator, Office of Standards/Compliance and as Institutional Deputy Compliance Officer for TTUHSC and continued to serve a key leadership role in the correctional healthcare program; and,

**WHEREAS**, Nancy has more than 40 years of professional nursing experience, having worked in a variety of progressively more responsible clinical, administrative and leadership positions in the health care field; and,

**WHEREAS**, Nancy has served since the inception of the correctional managed healthcare system as the QI and Nursing representative for TTUHSC Correctional Healthcare on a wide variety of work groups and joint committees thereby contributing her time, experience, knowledge and skills towards the development, improvement and monitoring of the correctional health care program; and,

**WHEREAS**, Nancy was instrumental in developing and managing elements of the transition to the correctional health care program partnership between the Texas Department of Criminal Justice, the Texas Tech University Health Sciences Center and the University of Texas Medical Branch at Galveston and has provided consistent, thoughtful and dedicated guidance through a period of unprecedented growth and achievement; and,

**WHEREAS, s**he evidences a true "*West Texas*" work ethic and a gift for exercising and sharing common sense approaches to complex issues, all the while exhibiting a caring spirit that lifts those around her; and,

**WHEREAS**, the correctional health care program has greatly benefited from her demonstrated leadership, clinical expertise, professionalism and dedication to duty and the Correctional Managed Health Care Committee, its staff and its partner agencies wish to gratefully acknowledge the many contributions and steady leadership of Nancy Hurt-Spain as she retires after a distinguished career;

**THEREFORE BE IT RESOLVED**, that the Committee adopt this resolution as an expression of our sincere appreciation for her outstanding service to the Texas correctional health care program and present to her a framed copy of this resolution with our collective best wishes for success.

**Adopted this 25th day of September in the Year 2007, by the Correctional Managed Health Care Committee**

# ATTACHMENT 2

September 5, 2007

Correctional Healthcare Committee:

My son Greg and I have wanted to come to a committee meeting one more time, but due to my health we are not able to attend.

We both would like to thank all of you for the help and concern that you have showed to us during the last 5 years. Greg came home on February 5th, exactly 5 years to the day after he left. His health continues to be good considering the length of time he has been diabetic. He is working through the ironworkers union in Austin, just as he did before.

I have lung cancer, which is in remission at this time. I came home from the hospital on February 2. Greg's homecoming was not as we always wanted it to be, because he came home to take care of me. He has done the cooking and cleaning and helped me with so many things. Even with the problems, just having him home is wonderful. I have been hospitalized 5 times since January and hope I am finally going to get better.

Once again thank each and every one of you for the work that you do. My son came home in about the same state of health that he left.

Bless you all,

Carole Heine

# Consent Item 2

## TDCJ Health Services Monitoring Reports

ATTACHMENT 1

| Fourth Quarter, Fiscal Year 2007<br>June, July, and August 2007 | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Unit** | **Operations/** | | | **General Medical/Nursing** | | | **CID** | | | **Dental** | | | **Mental Health** | | | **Fiscal** | | |
| | **Items with** | | ***n*** | **Items with** | | ***n*** | **Items with** | | ***n*** | **Items with** | | ***n*** | **Items with** | | ***n*** | **Items with** | | ***n*** |
| **Baten** | 94% | 47 | 50 | 54% | 12 | 22 | 66% | 19 | 29 | 82% | 9 | 11 | 91% | 10 | 11 | 100% | 11 | 11 |
| **Bridgeport PPT** | 100% | 48 | 48 | 80% | 16 | 20 | 81% | 13 | 16 | 67% | 4 | 6 | 100% | 7 | 7 | N/A | N/A | N/A |
| **Clements** | 98% | 53 | 54 | 54% | 14 | 26 | 54% | 14 | 26 | 70% | 9 | 13 | 100% | 9 | 9 | 100% | 11 | 11 |
| **Clements H.S.** | 96% | 52 | 54 | 27% | 3 | 11 | 54% | 14 | 26 | 100% | 6 | 6 | 73% | 8 | 11 | 100% | 11 | 11 |
| **Dalhart** | 94% | 50 | 53 | 5% | 1 | 20 | 40% | 10 | 25 | 92% | 12 | 13 | 88% | 7 | 8 | 100% | 11 | 11 |
| **Hutchins** | 100% | 53 | 53 | 53% | 11 | 21 | 84% | 25 | 30 | 86% | 12 | 14 | 90% | 9 | 10 | 100% | 11 | 11 |
| **Johnston** | 100% | 53 | 53 | 65% | 13 | 20 | 84% | 27 | 32 | 94% | 15 | 16 | 100% | 5 | 5 | 55% | 6 | 11 |
| **Jordan** | 94% | 50 | 53 | 67% | 14 | 21 | 84% | 20 | 24 | 100% | 15 | 15 | 88% | 7 | 8 | 100% | 11 | 11 |
| **Kegans** | 97% | 35 | 36 | 78% | 7 | 9 | 47% | 8 | 17 | 82% | 9 | 11 | N/A | N/A | N/A | 100% | 11 | 11 |
| **Lindsey State Jail** | 100% | 53 | 53 | 67% | 14 | 21 | 65% | 20 | 31 | 77% | 10 | 13 | 63% | 5 | 8 | 80% | 8 | 10 |
| **Lychner** | 94% | 50 | 53 | 38% | 8 | 21 | 53% | 18 | 34 | 85% | 11 | 13 | 45% | 5 | 11 | 100% | 11 | 11 |
| **Mineral Wells PPT** | 100% | 53 | 53 | 76% | 16 | 21 | 84% | 16 | 19 | 82% | 9 | 11 | 100% | 8 | 8 | N/A | N/A | N/A |
| **Neal** | 100% | 53 | 53 | 60% | 12 | 20 | 54% | 14 | 26 | 73% | 11 | 15 | 90% | 9 | 10 | 100% | 11 | 11 |
| **PAMIO** | 100% | 48 | 48 | 44% | 3 | 7 | 64% | 14 | 22 | N/A | N/A | N/A | 98% | 41 | 42 | 100% | 11 | 11 |
| **Plane** | 100% | 53 | 53 | 68% | 17 | 25 | 50% | 15 | 30 | 83% | 10 | 12 | 90% | 9 | 10 | 100% | 11 | 11 |
| | | | | | | | | | | | | | | | | | | |

***n = number of applicable items audited.***

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

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

## ATTACHMENT 2

Percent Compliance Rate on Selected Items Requiring Medical Records Review
Fourth Quarter, Fiscal Year 2007
June, July, and August 2007

| Unit | Operations/ Administration | | | General Medical/Nursing | | | CID/TB | | | Dental | | | Mental Health | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Items in Compliance | *n* | | Items in Compliance | *n* | | Items in Compliance | *n* | | Items in Compliance | *n* | | Items in Compliance | *n* |
| Baten | N/A | N/A | N/A | 84% | 212 | 251 | 82% | 23 | 28 | 97% | 65 | 67 | 83% | 75 | 90 |
| Bridgeport PPT | N/A | N/A | N/A | 94% | 125 | 133 | 100% | 10 | 10 | 67% | 40 | 60 | 100% | 59 | 59 |
| Clements | 100% | 45 | 45 | 91% | 347 | 383 | 74% | 45 | 61 | 88% | 56 | 64 | 100% | 84 | 84 |
| Clements H. S. | 100% | 45 | 45 | 91% | 163 | 208 | 80% | 28 | 35 | 88% | 56 | 64 | 97% | 93 | 96 |
| Dalhart | 100% | 30 | 30 | 37% | 83 | 226 | 48% | 10 | 21 | 98% | 51 | 52 | 93% | 57 | 61 |
| Hutchins | 100% | 30 | 30 | 84% | 177 | 26 | 97% | 68 | 70 | 97% | 57 | 59 | 98% | 130 | 132 |
| Johnston | 100% | 23 | 23 | 78% | 178 | 229 | 97% | 60 | 62 | 100% | 72 | 72 | 100% | 42 | 42 |
| Jordan | 100% | 30 | 30 | 60% | 148 | 248 | 90% | 45 | 50 | 100% | 74 | 74 | 98% | 78 | 80 |
| Kegans | 100% | 1 | 1 | 98% | 59 | 60 | 83% | 45 | 54 | 95% | 39 | 41 | N/A | N/A | N/A |
| Lindsey State Jail | 100% | 30 | 30 | 85% | 216 | 255 | 82% | 49 | 60 | 83% | 66 | 80 | 92% | 48 | 52 |
| Lychner | 100% | 25 | 25 | 85% | 260 | 307 | 62% | 38 | 61 | 98% | 79 | 81 | 88% | 112 | 127 |
| Mineral Wells PPT | N/A | N/A | N/A | 98% | 229 | 234 | 97% | 36 | 37 | 67% | 40 | 60 | 100% | 94 | 94 |
| Neal | 100% | 15 | 15 | 73% | 188 | 259 | 40% | 17 | 42 | 95% | 59 | 62 | 99% | 93 | 94 |
| PAMIO | 100% | 45 | 45 | 69% | 56 | 81 | 95% | 18 | 19 | N/A | N/A | N/A | 100% | 147 | 147 |
| Plane | 100% | 30 | 30 | 92% | 297 | 323 | 97% | 67 | 69 | 97% | 60 | 62 | 97% | 112 | 116 |

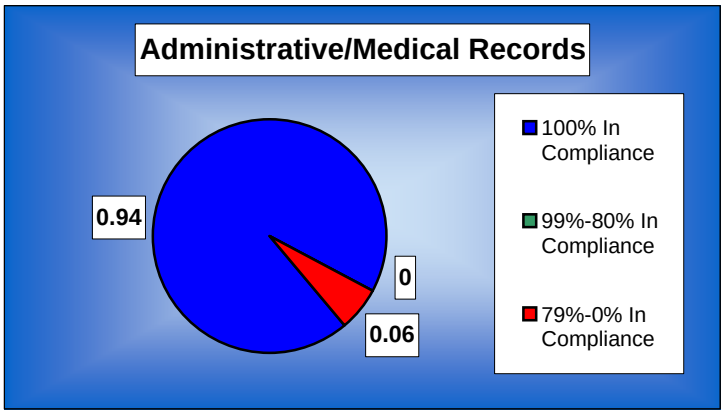
***n*** **= number of records audited for each question.**

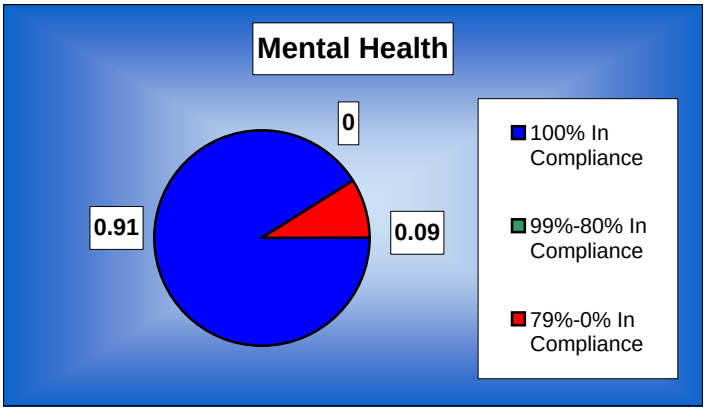
**Note: Selected items requiring medical record review are reflected in this table.**
**The items were chosen to avoid having interdependent items counted more than once.**

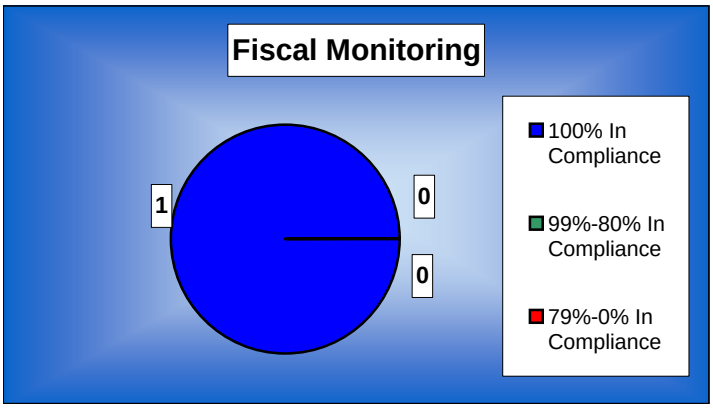
**Average Percent Compliance Rate = Sum of medical records audited that were in compliance X 100**
**Number of records audited**

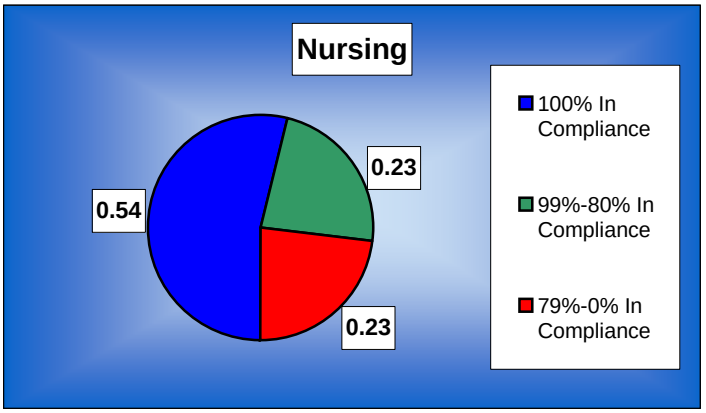
***The medical record review section of the Operations/Administration portion of the Operational Review Audit consists of only three questions, frequently with low numbers of applicable records.**

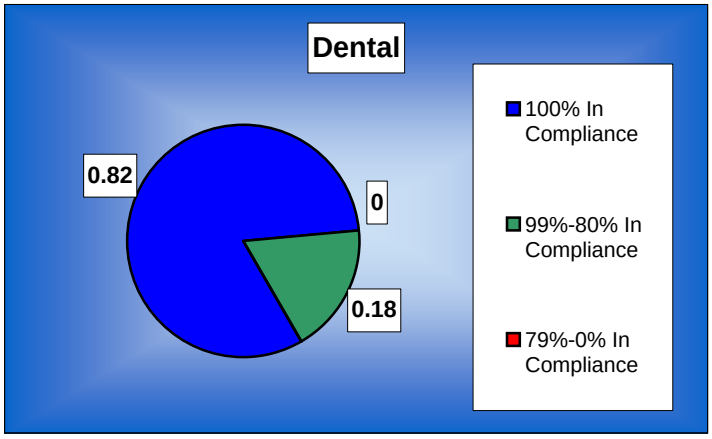
**Quarterly Reports for**
**Compliance Rate By Operational Categories**
**Baten Facility**
**July 9, 2007**

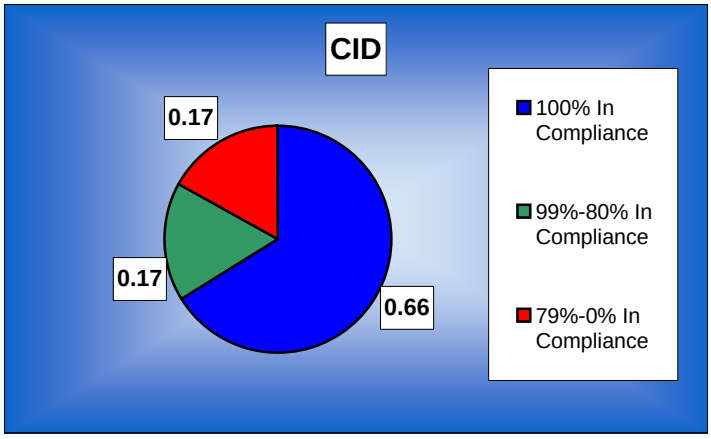


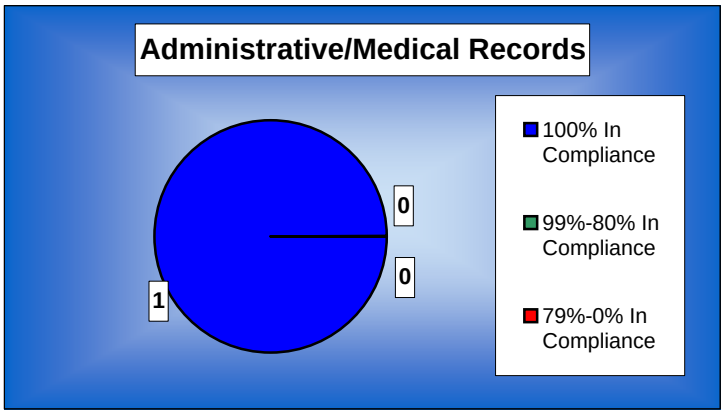



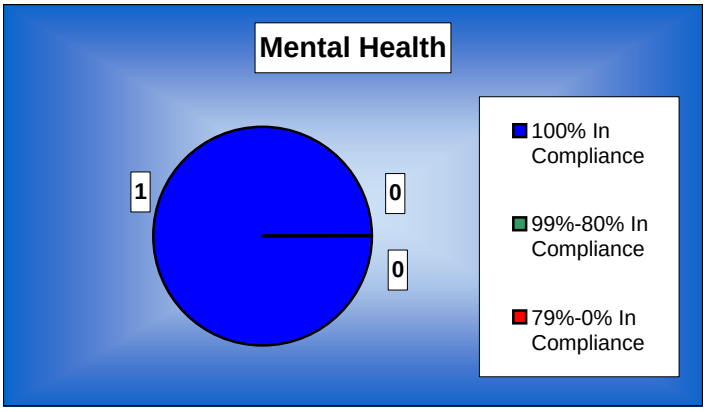



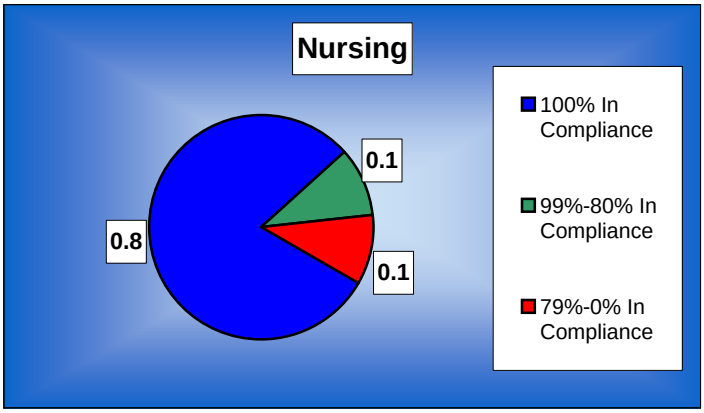



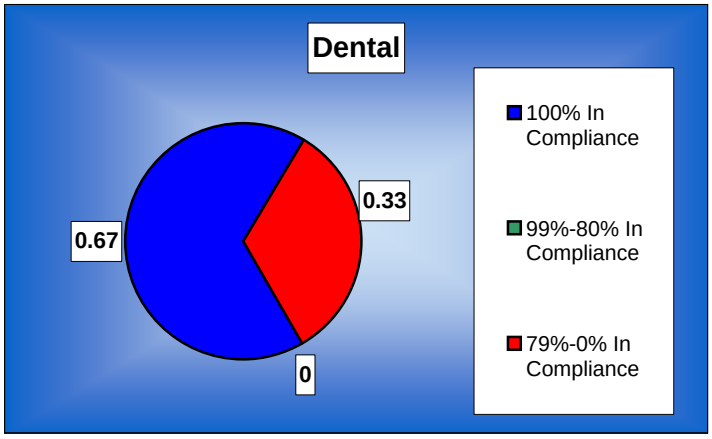



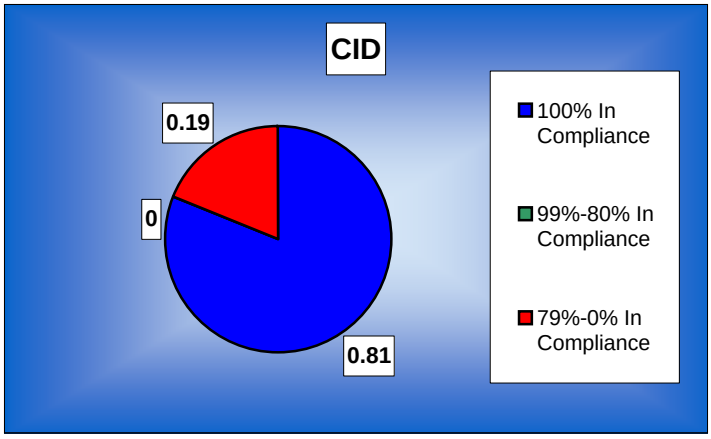
**Quarterly Reports for**
**Compliance Rate By Operational Categories**
**Bridgeport PPT (CCA) Facility**
**June 7, 2007**



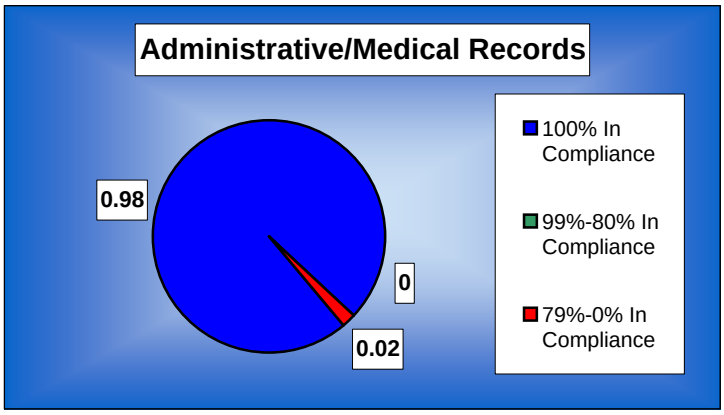



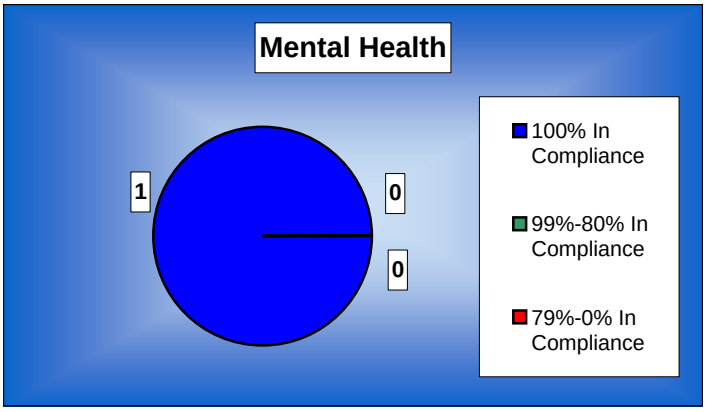



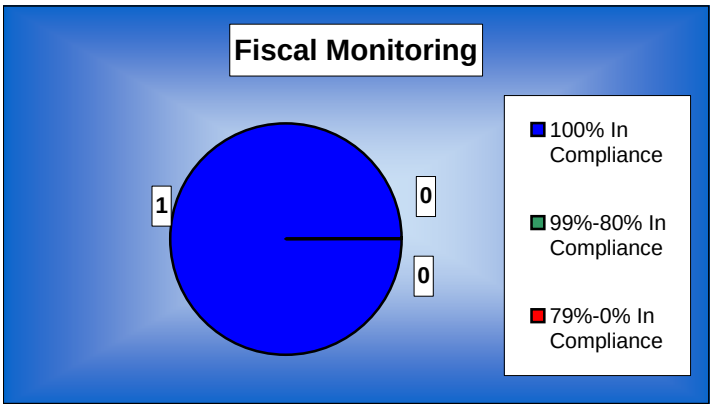



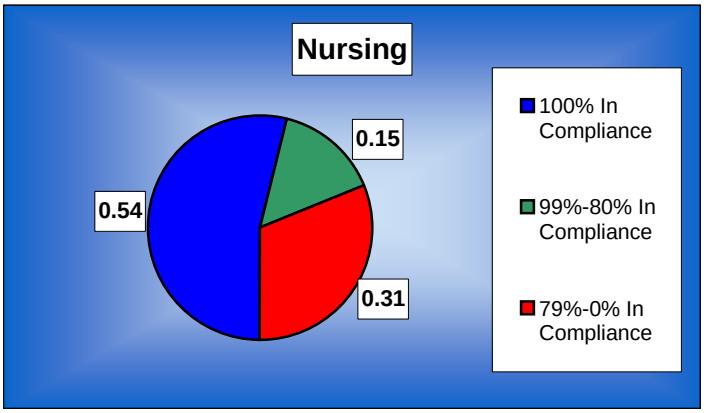



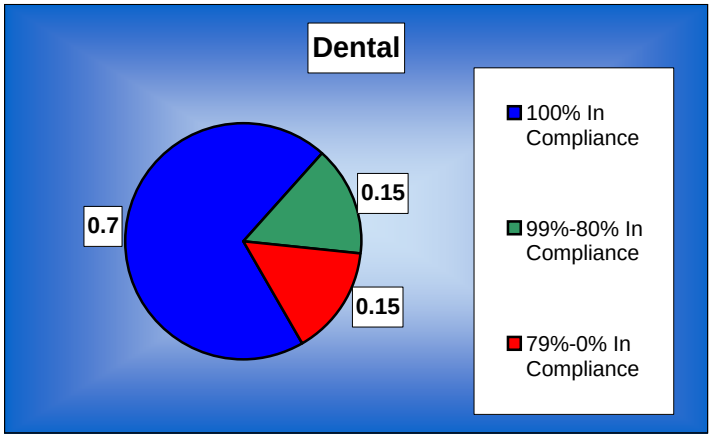
**Quarterly Reports for**
**Compliance Rate By Operational Categories**
**Clements Facility**
**July 12, 2007**

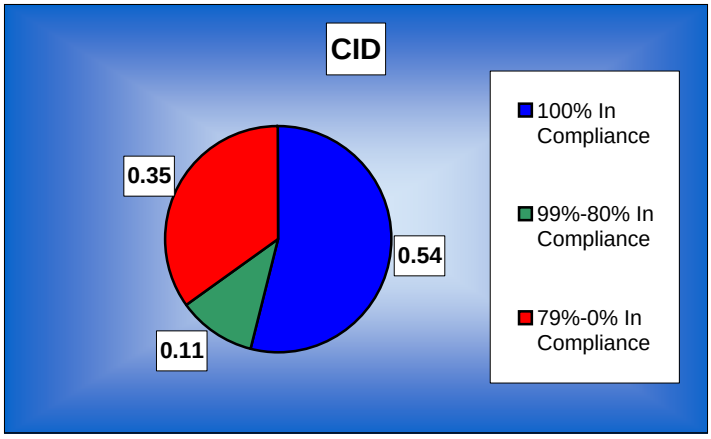


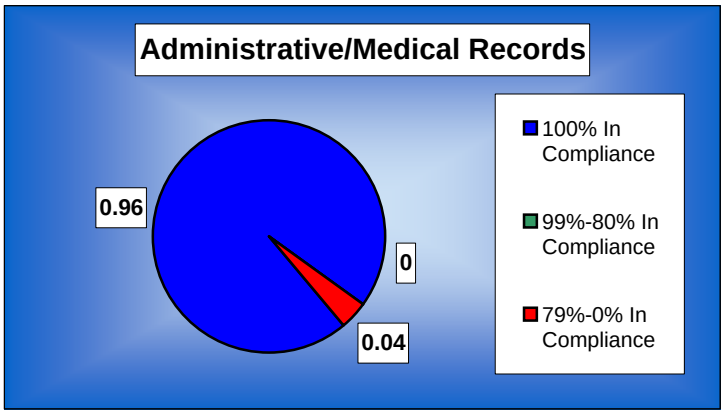



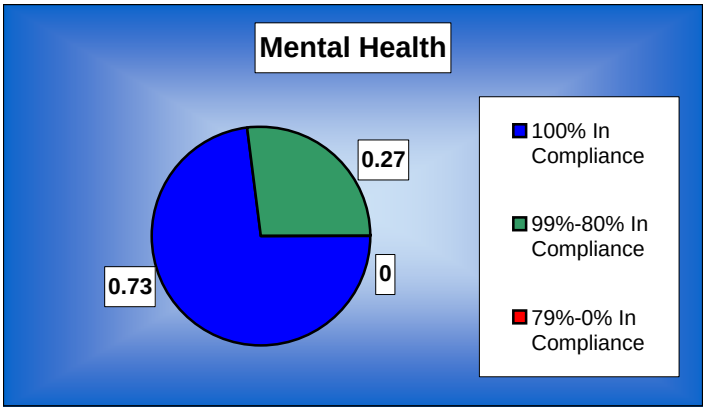



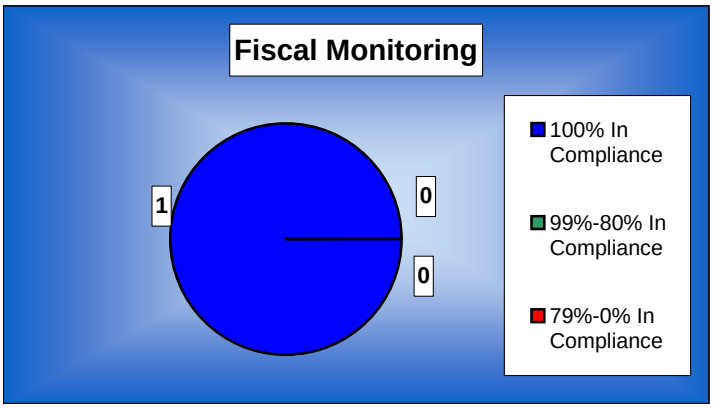



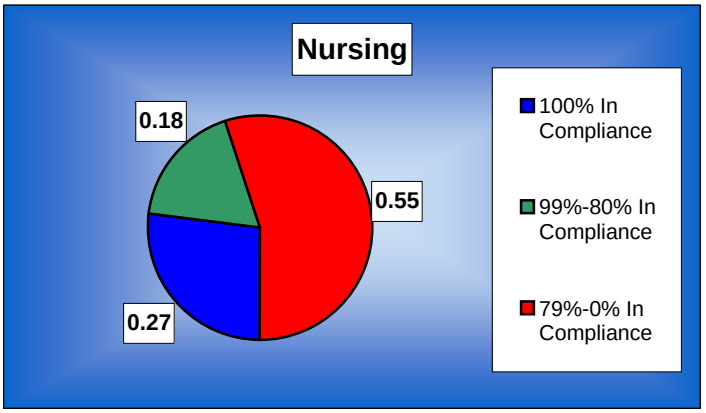



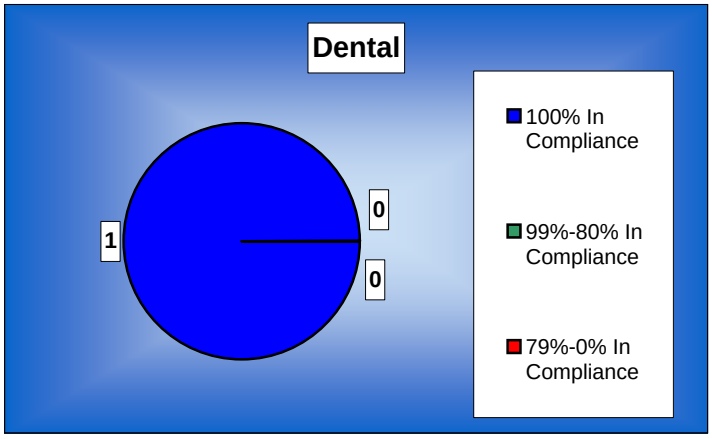
**Quarterly Reports for**
**Compliance Rate By Operational Categories**
**Clements High Security Facility**
**July 13, 2007**

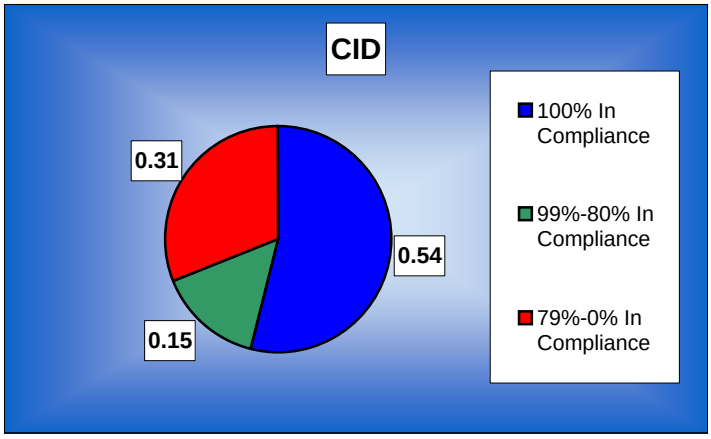


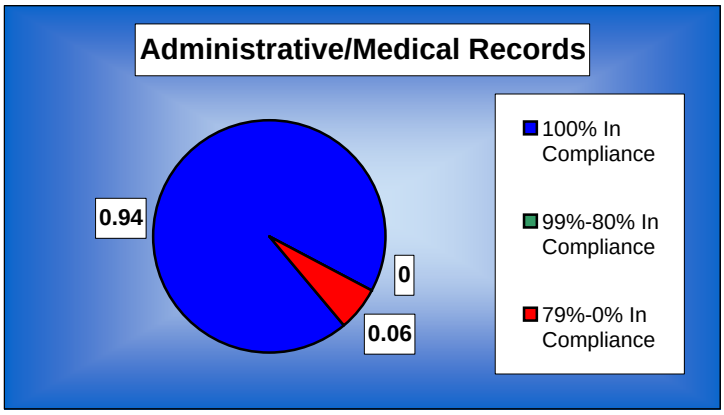



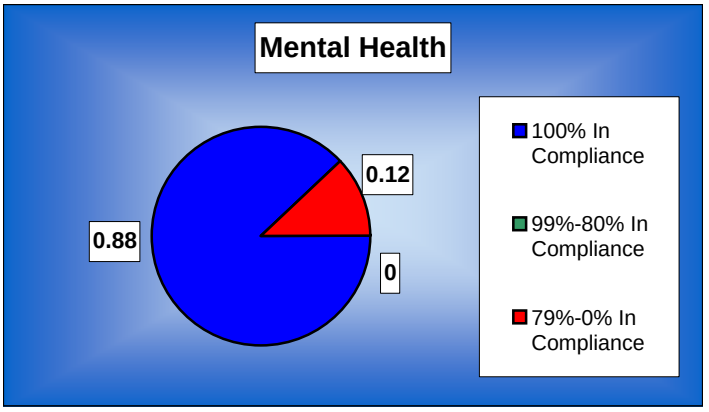



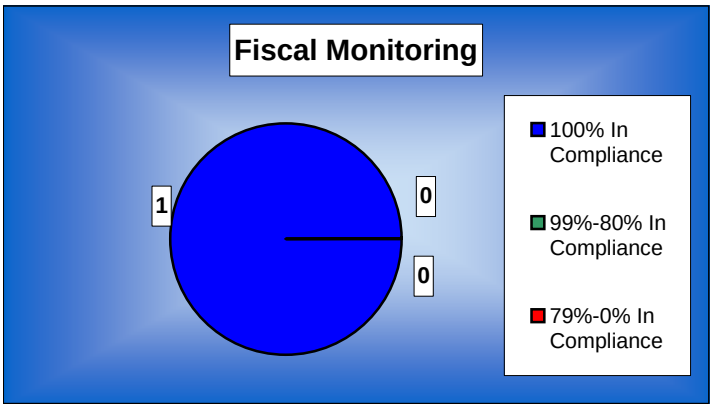



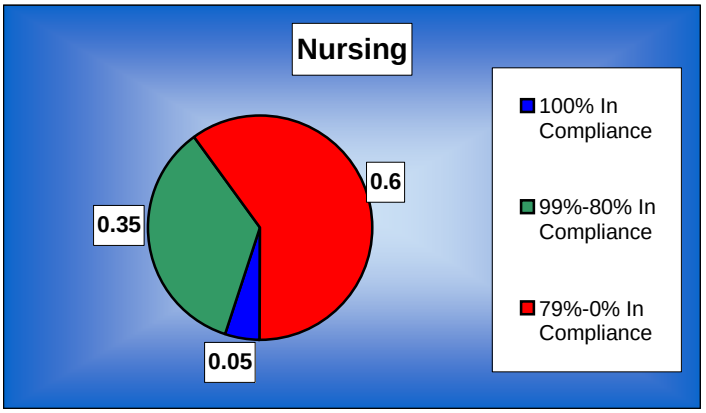



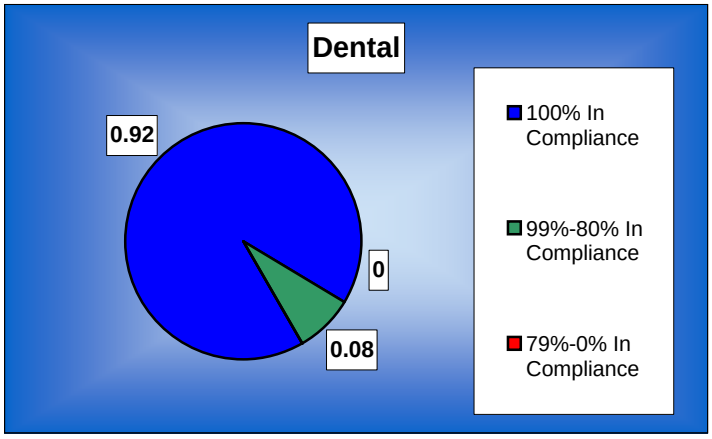
**Quarterly Reports for**
**Compliance Rate By Operational Categories**
**Dalhart Facility**
**July 10, 2007**

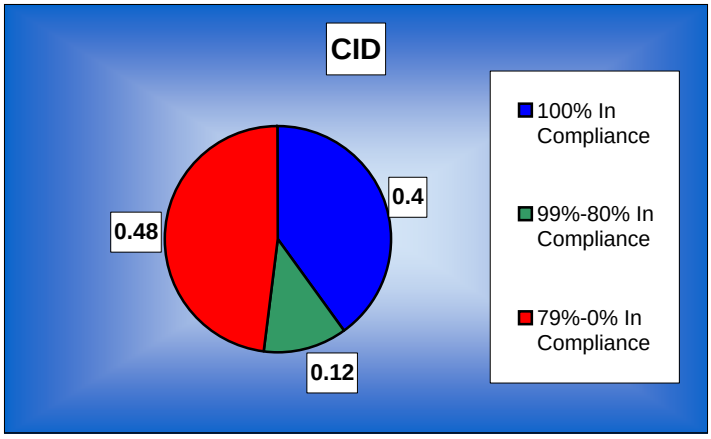


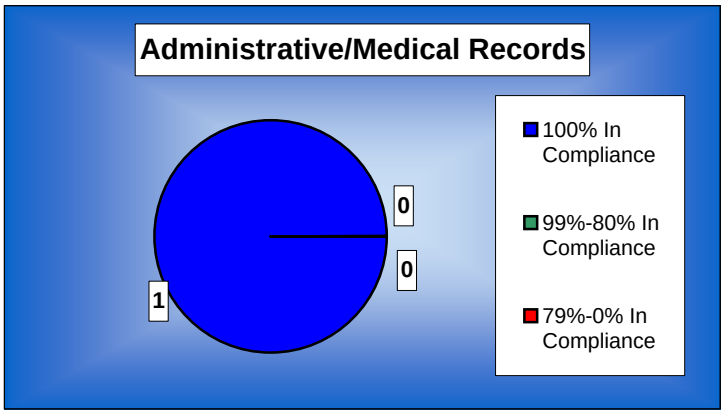



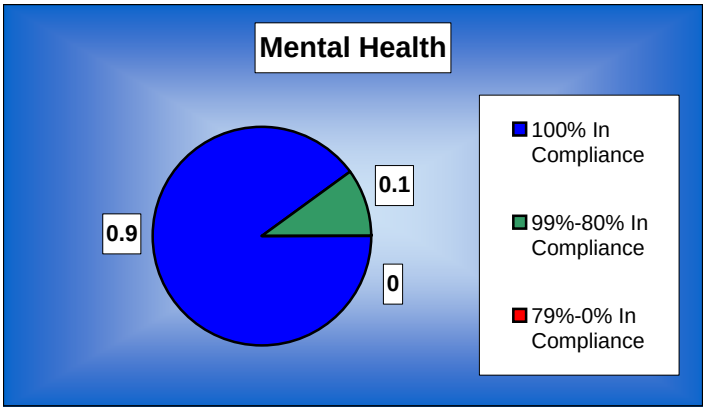



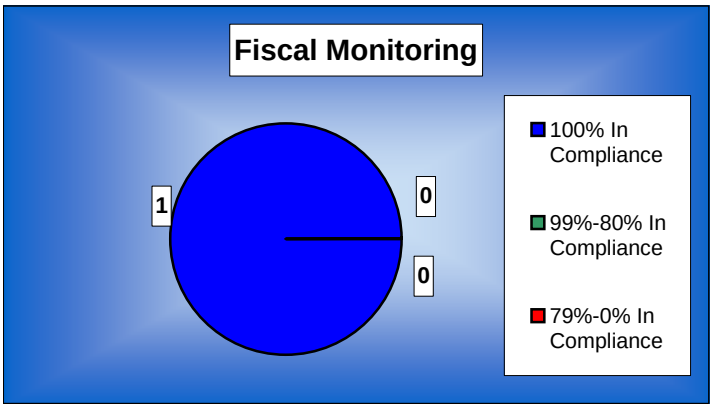



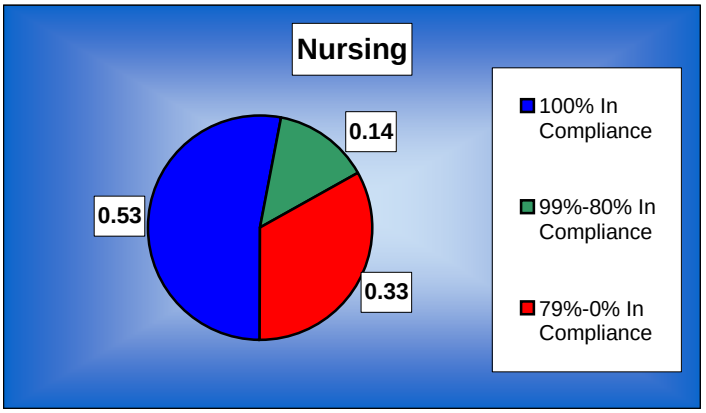



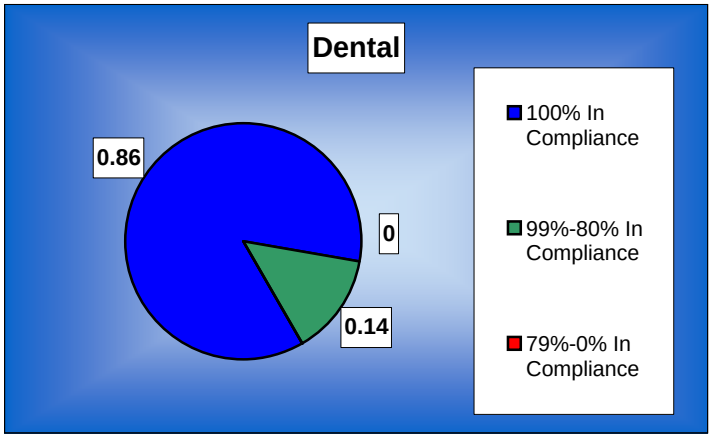
**Quarterly Reports for**
**Compliance Rate By Operational Categories**
**Hutchins Facility**
**June 5, 2007**

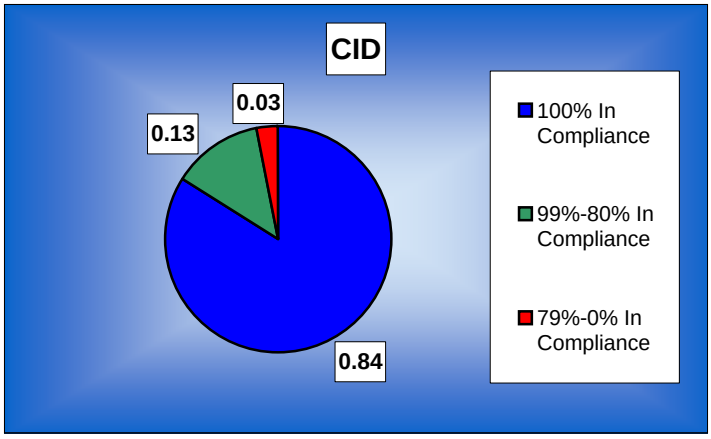


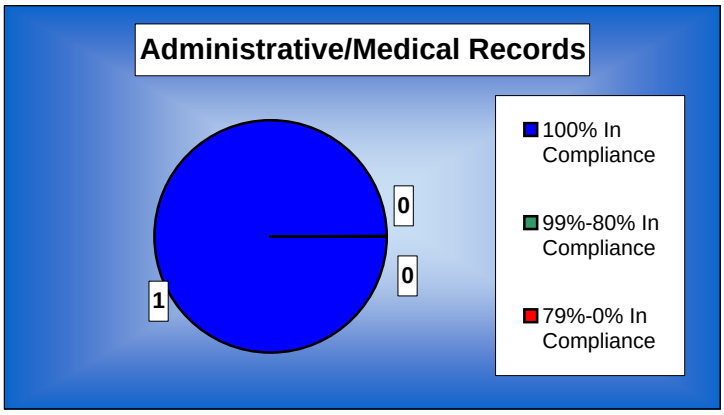



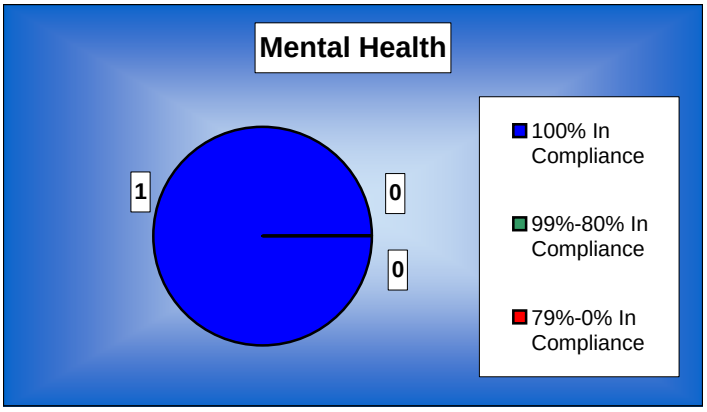



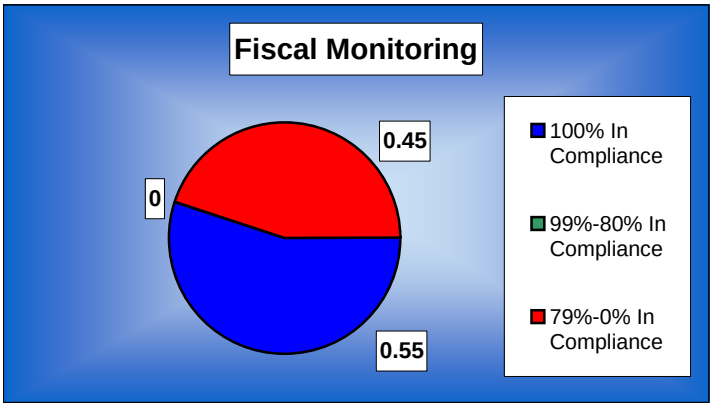



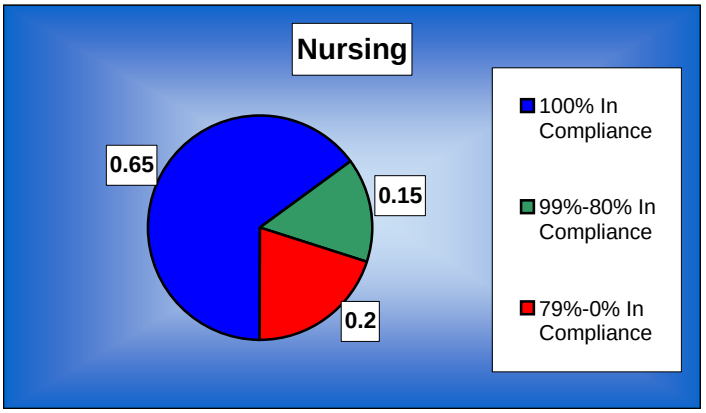



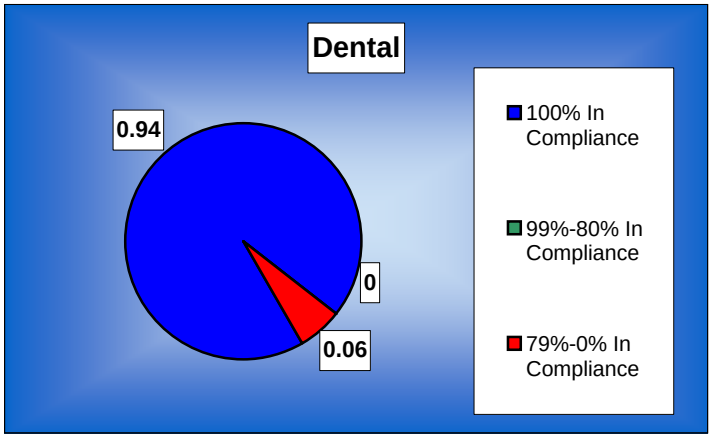
**Quarterly Reports for**
**Compliance Rate By Operational Categories**
**Johnston Facility**
**June 6, 2007**

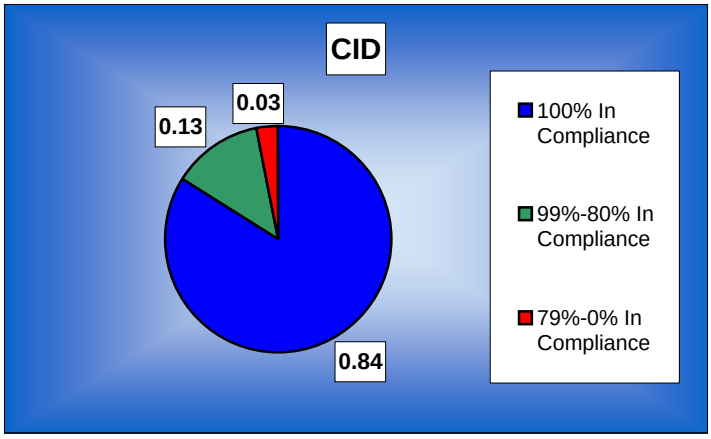


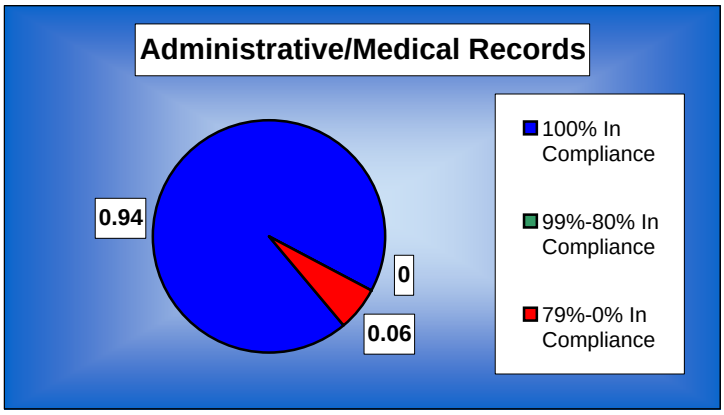



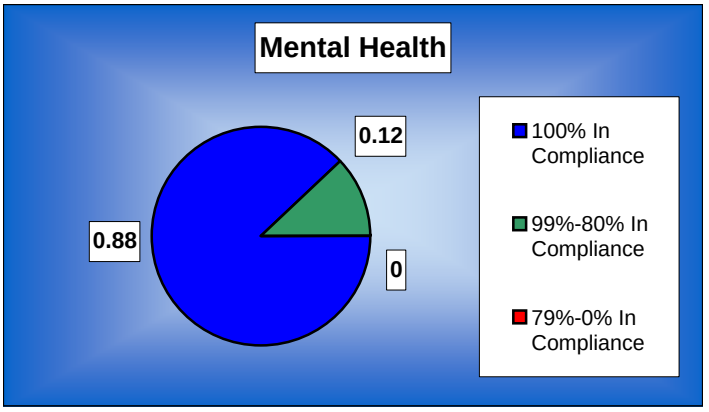



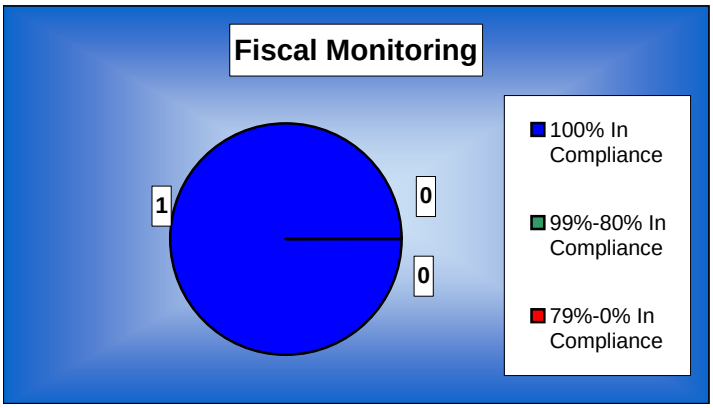



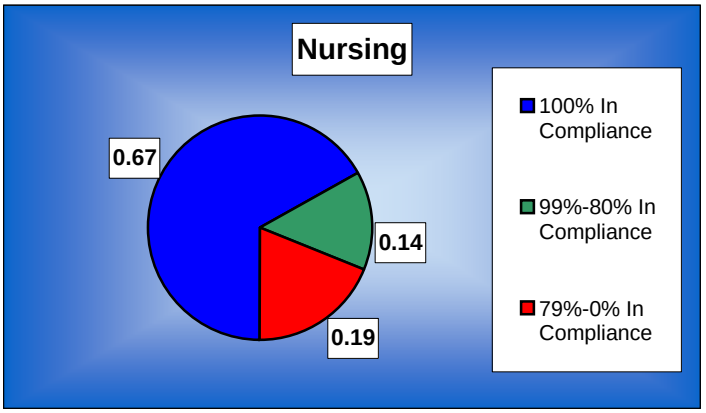



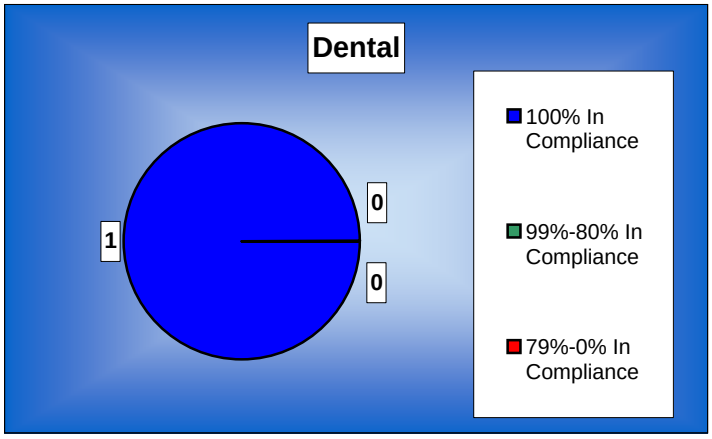
**Quarterly Reports for**
**Compliance Rate By Operational Categories**
**Jordan Facility**
**July 9, 2007**

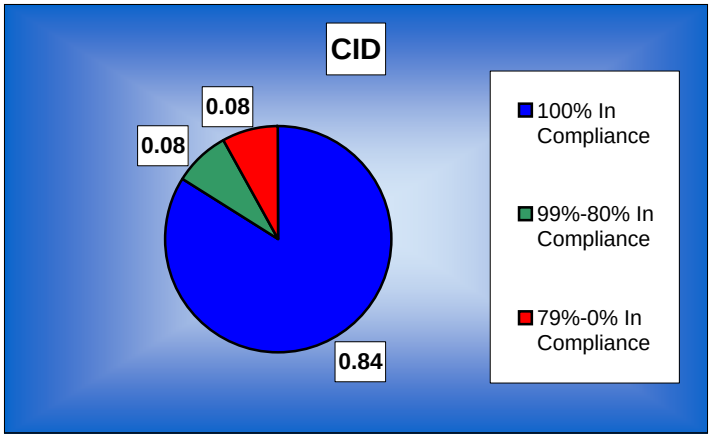


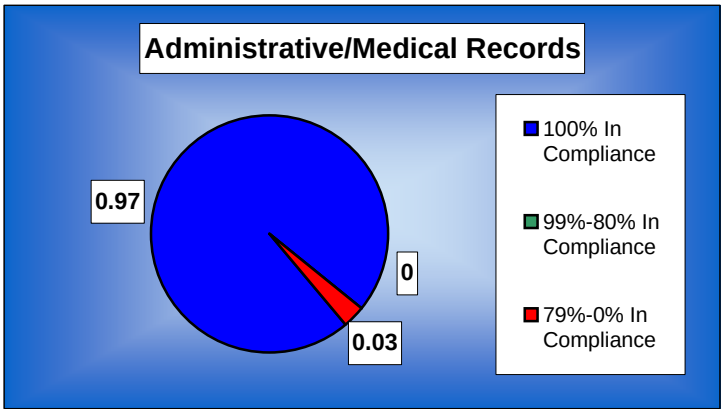



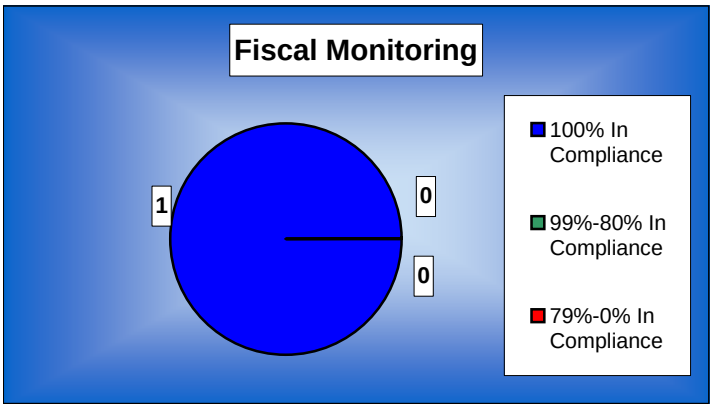



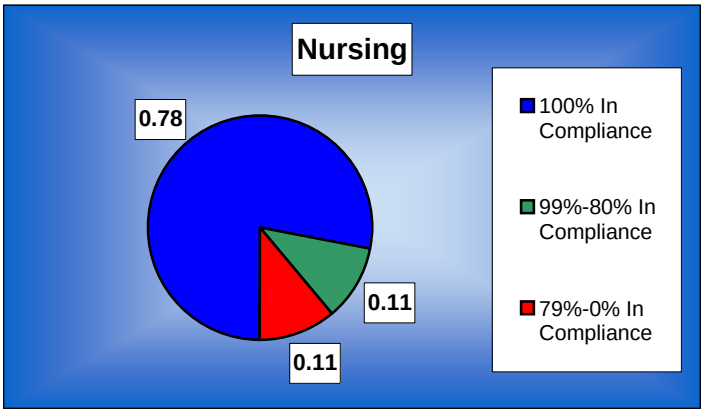



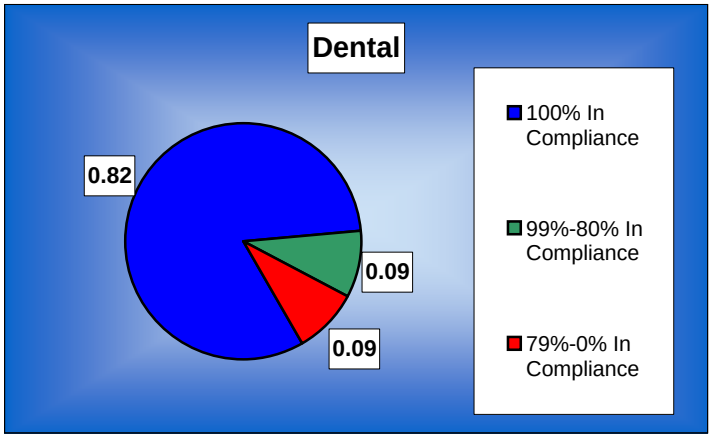



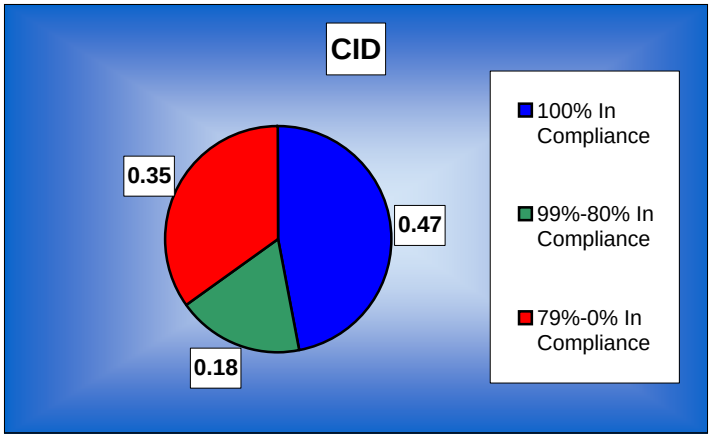
**Quarterly Reports for**
**Compliance Rate By Operational Categories**
**Kegans Facility**
**August 1, 2007**



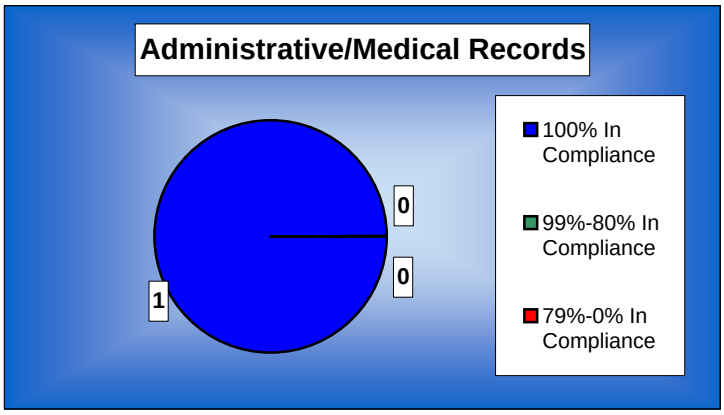



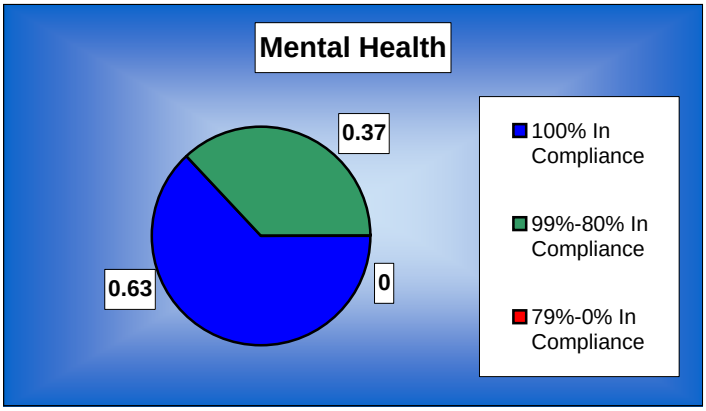



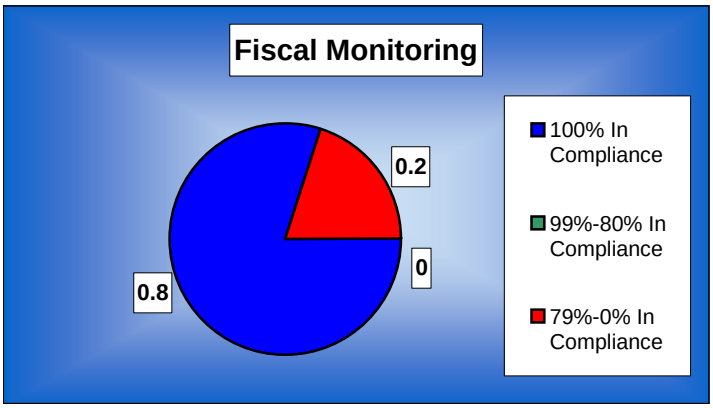



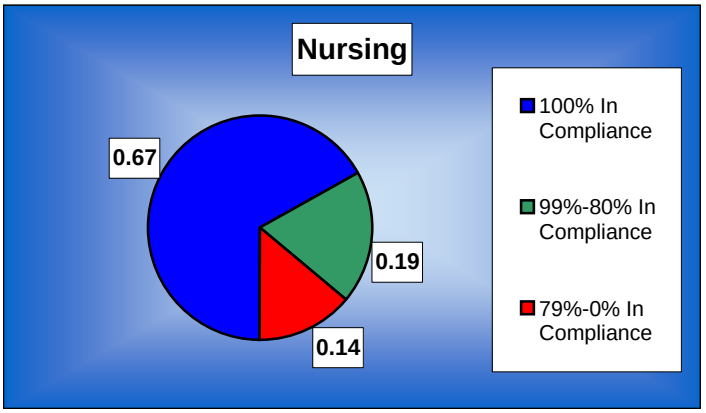



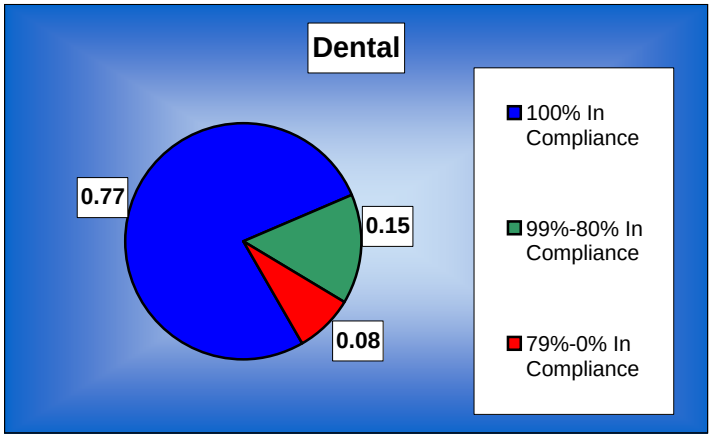
**Quarterly Reports for**
**Compliance Rate By Operational Categories**
**Lindsey State Jail Facility**
**June 6, 2007**

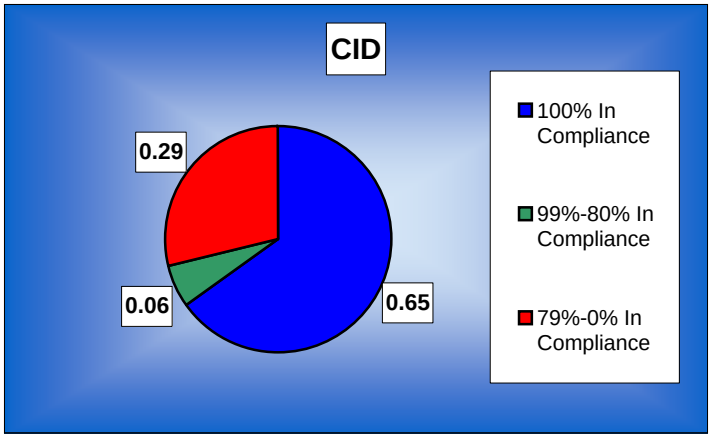


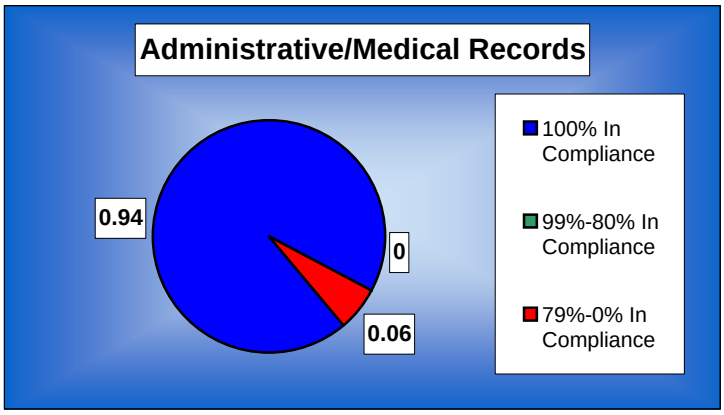



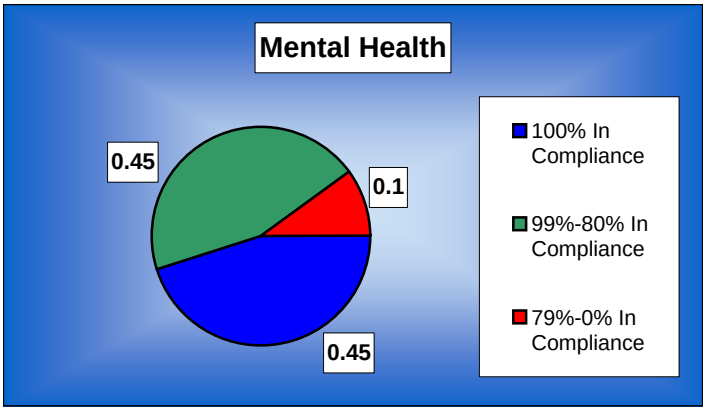



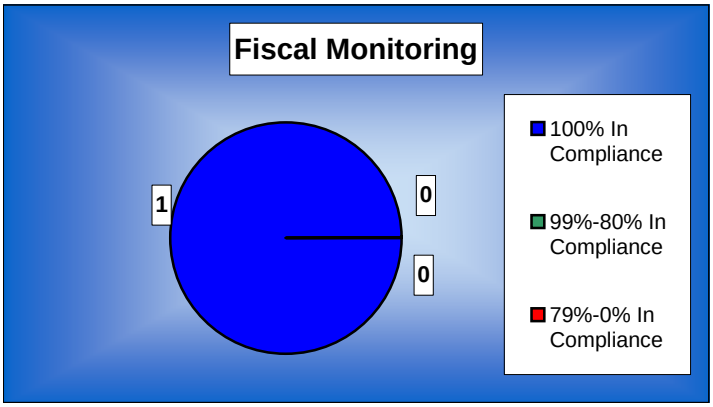



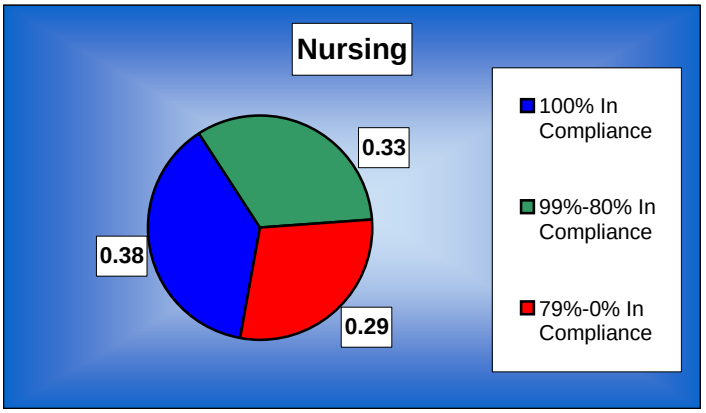



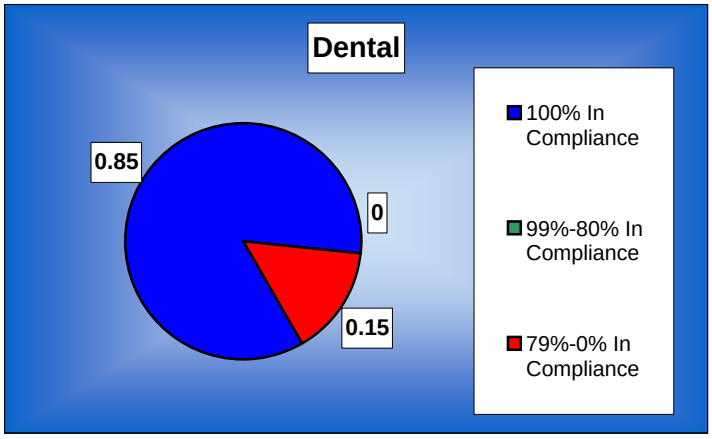
**Quarterly Reports for**
**Compliance Rate By Operational Categories**
**Lychner Facility**
**August 1, 2007**

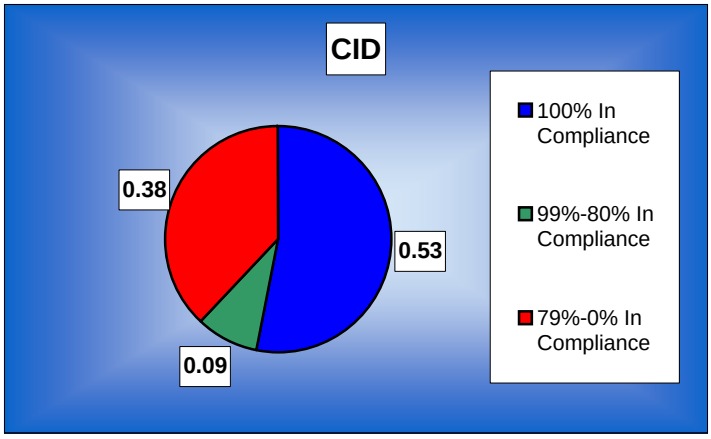


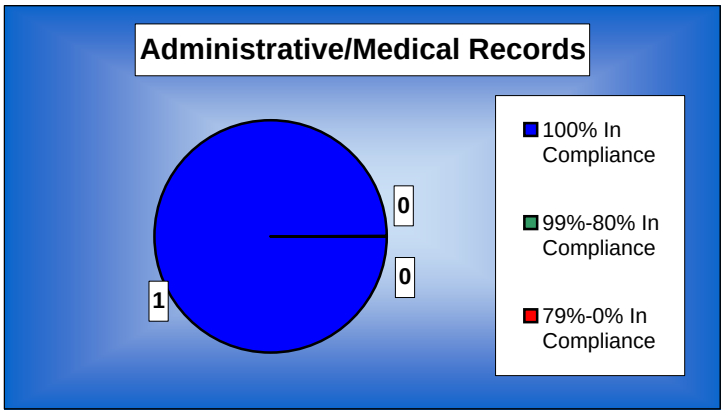



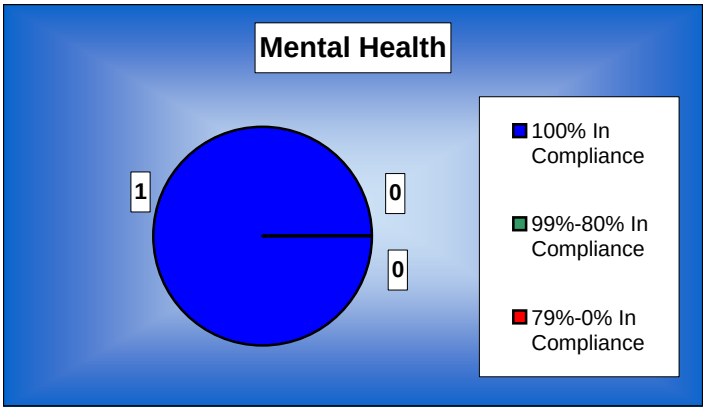



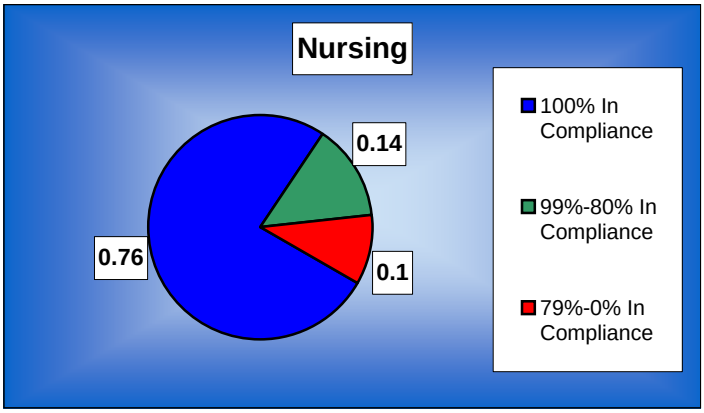



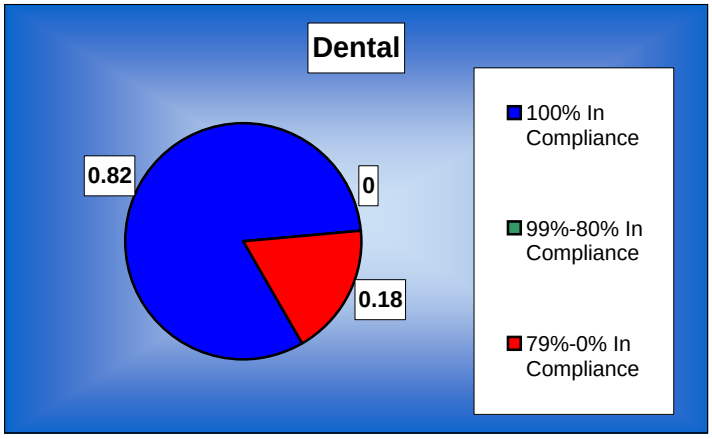



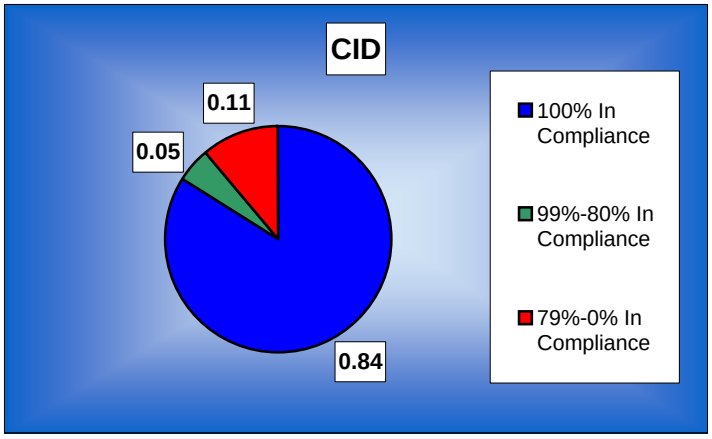
**Quarterly Reports for**
**Compliance Rate By Operational Categories**
**Mineral Wells PPT (CCA) Facility**
**June 5, 2007**



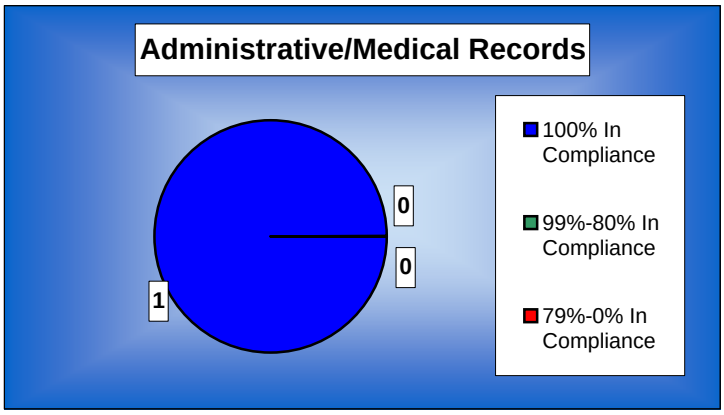



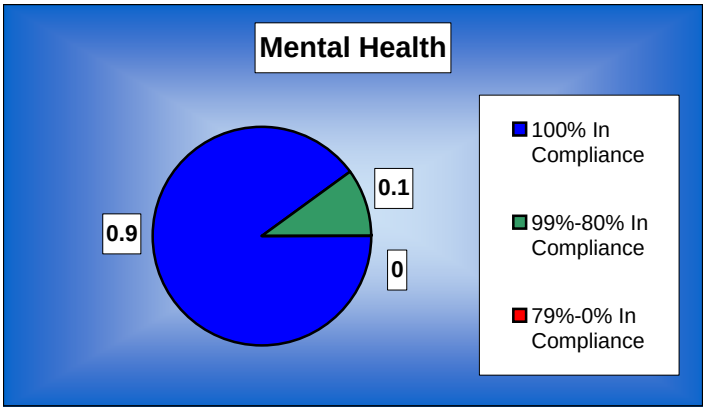



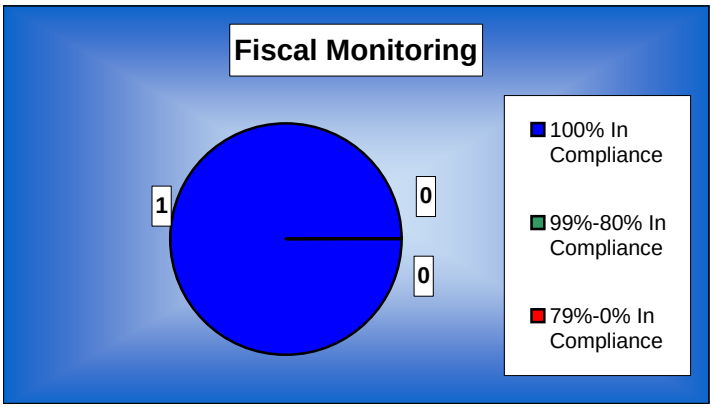



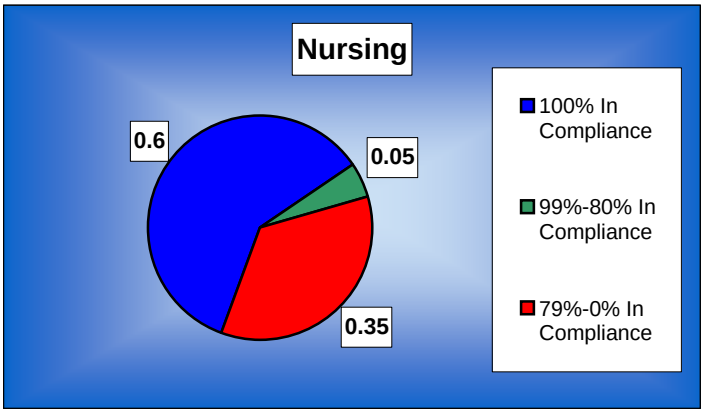



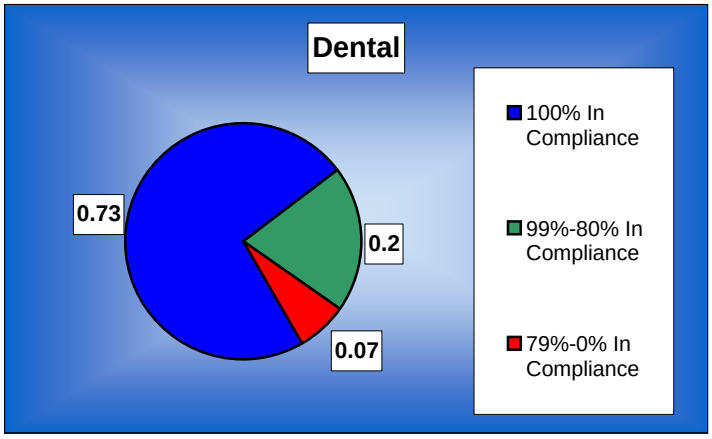
**Quarterly Reports for**
**Compliance Rate By Operational Categories**
**Neal Facility**
**July 11, 2007**

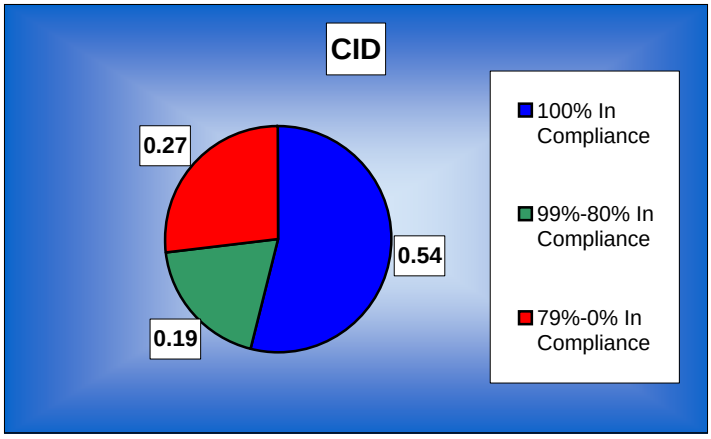


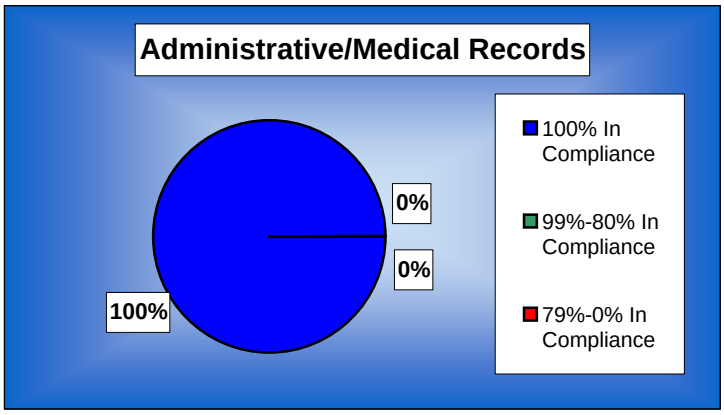



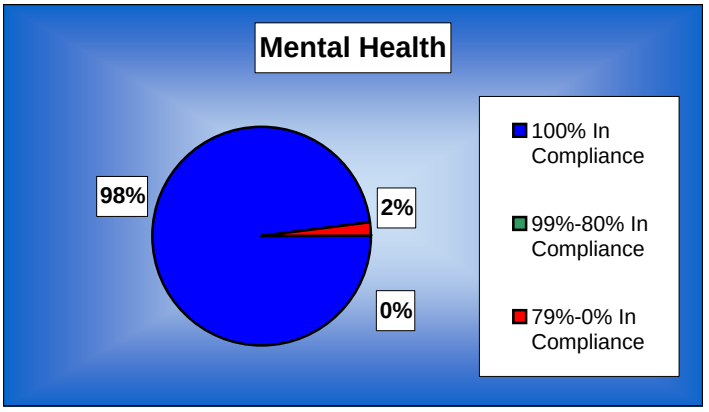



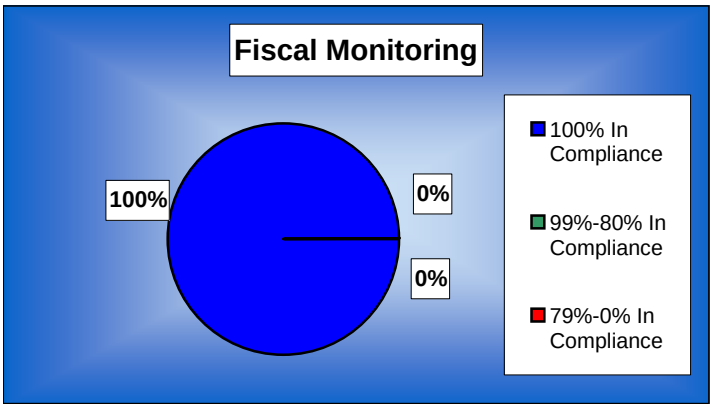



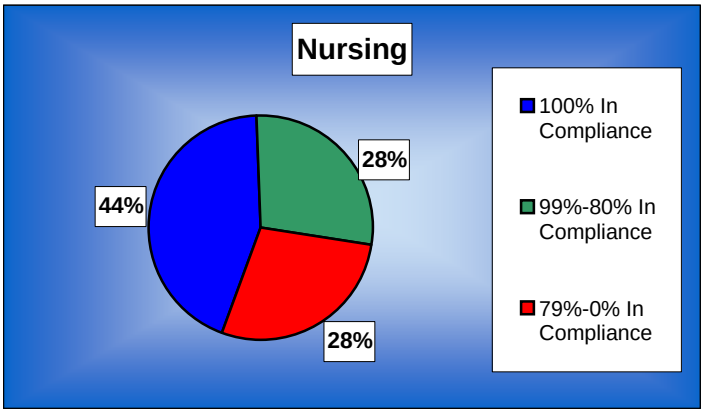



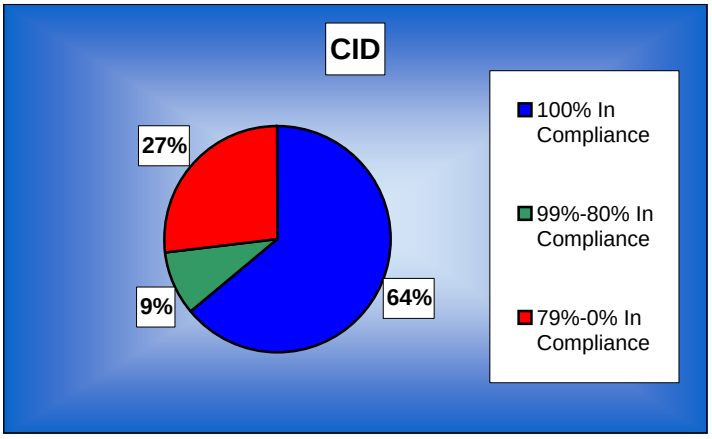
**Quarterly Reports for**
**Compliance Rate By Operational Categories**
**PAMIO Facility**
**July 13, 2007**



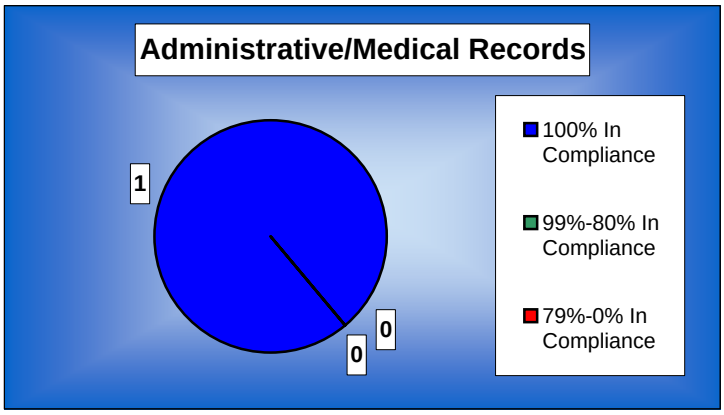



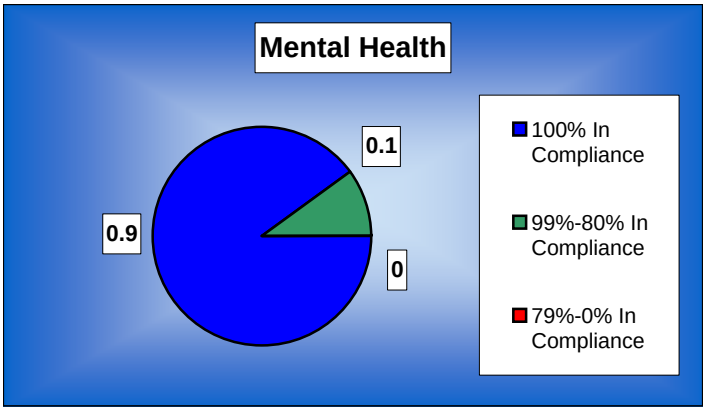



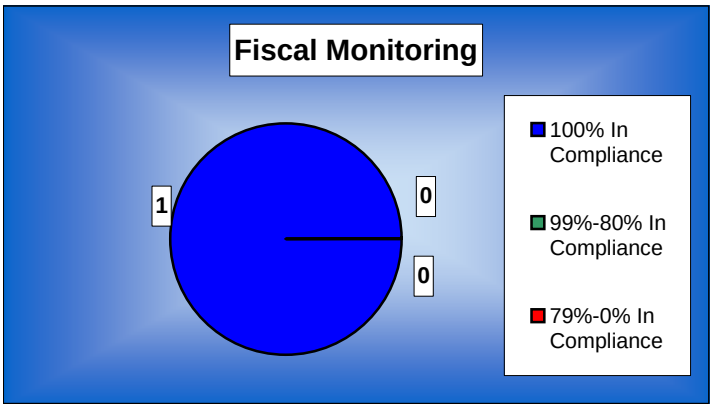



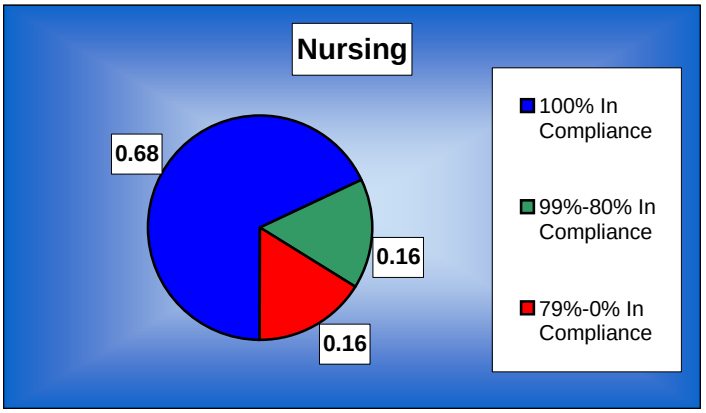



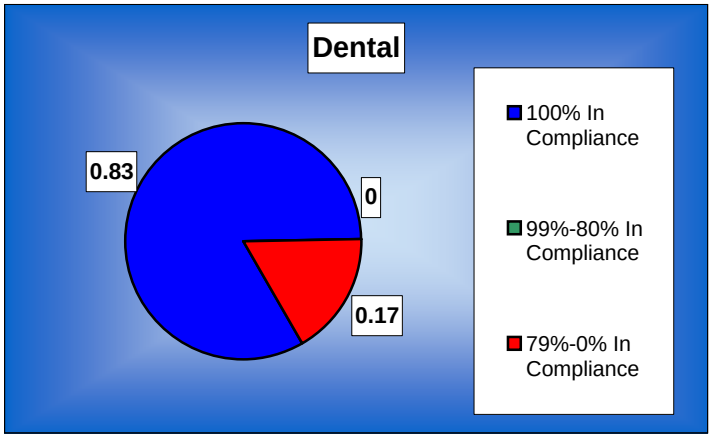
**Quarterly Reports for**
**Compliance Rate By Operational Categories**
**Plane Facility**
**August 6, 2007**

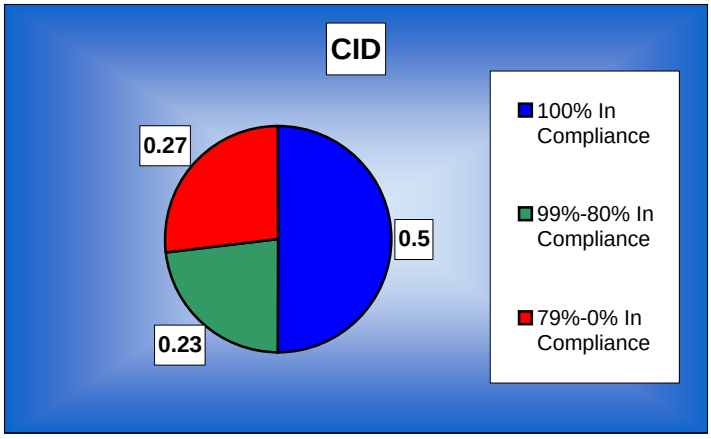


# PATIENT LIAISON AND STEP II GRIEVANCE STATISTICS

## QUALITY OF CARE/PERSONNEL REFERRALS AND ACTION REQUESTS

### Fourth Quarter FY2007

**(June, July and August)**

| STEP II GRIEVANCE PROGRAM (GRV) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| FY2007 | Total # of **GRV** Correspondence Received Each Month | Total # of Action Requests (Quality of Care, Personnel, and Process Issues) | % of Action Requests from Total # of **GRV** Correspondence | Total # of Action Requests Referred to **UTMB-CMHC** | | Total # of Action Requests Referred to **TTUHSC-CMHC** | | Total # of Action Requests Referred to **PRIVATE FACILITIES** | |
| | | | | | % of Total Action Requests Referred | | % of Total Action Requests Referred | | % of Total Action Requests Referred |
| Jun-07 | 537 | 21 | 3.91% | 15 | 2.79% | 6 | 1.12% | 0 | 0.00% |
| Jul-07 | 559 | 49 | 8.77% | 37 | 6.62% | 9 | 1.61% | 3 | 0.54% |
| Aug-07 | 598 | 58 | 9.70% | 49 | 8.19% | 9 | 1.51% | 0 | 0.00% |
| **Totals:** | **1694** | **128** | **7.56%** | **101** | **5.96%** | **24** | **1.42%** | **3** | **0.18%** |

| PATIENT LIAISON PROGRAM (PLP) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| FY2007 | Total # of **PLP** Correspondence Received Each Month | Total # of Action Requests (Quality of Care, Personnel, and Process Issues) | % of Action Requests from Total # of **PLP** Correspondence | Total # of Action Requests Referred to **UTMB-CMHC** | | Total # of Action Requests Referred to **TTUHSC-CMHC** | | Total # of Action Requests Referred to **PRIVATE FACILITIES** | |
| | | | | | % of Total Action Requests Referred | | % of Total Action Requests Referred | | % of Total Action Requests Referred |
| Jun-07 | 411 | 23 | 5.60% | 20 | 4.87% | 3 | 1.00% | 1 | 0.24% |
| Jul-07 | 429 | 24 | 5.59% | 19 | 4.43% | 5 | 1.17% | 2 | 0.47% |
| Aug-07 | 519 | 7 | 1.35% | 6 | 1.16% | 1 | 0.19% | 0 | 0.00% |
| **Totals:** | **1359** | **54** | **3.97%** | **45** | **3.31%** | **9** | **0.66%** | **3** | **0.22%** |

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

**Month: June 2007**

| Reports Received | This Month | Same Month Last | Year to Date | Last Year to Date |
|---|---|---|---|---|
| Chlamydia | 4 | 2 | 30 | 29 |
| Gonorrhea | 2 | 2 | 16 | 11 |
| Syphilis | 64 | 35 | 336 | 443 |
| Hepatitis A | 0 | 0 | 0 | 0 |
| Hepatitis B (acute cases) | 0 | 2 | 10 | 8 |
| Hepatitis C | 410 | 516 | 2105 | 2311 |
| HIV Screens (non-pre-release) | 5948 | 5827 | 36598 | 32447 |
| HIV Screens (pre-release) | 2887 | 2927 | 20647 | 21912 |
| HIV + pre-release tests | 3 | 2 | 20 | 35 |
| HIV Infections | 68 | 52 | 309 | 329 |
| AIDS | 16 | 6 | 145 | 70 |
| Methicillin-Resistant *Staph Aureus* | 428 | 450 | 2675 | 2602 |
| Methicillin-Sensitive *Staph Aureus* | 135 | 151 | 1855 | 888 |
| Occupational Exposures (TDCJ Staff) | 8 | 18 | 78 | 108 |
| Occupational Exposures (Medical Staff) | 5 | 6 | 23 | 34 |
| HIV CPX Initiation | 6 | | 22 | |
| Tuberculosis skin tests – intake (#positive) | 150 | 415 | 1653 | 2361 |
| Tuberculosis skin tests – annual (#positive) | 30 | 61 | 385 | 365 |
| Tuberculosis cases: | | | | |
| (1) Diagnosed during intake and attributed to county of origin | 0 | 1 | 2 | 5 |
| (2) Entered TDCJ on TB medications | 2 | 2 | 13 | 9 |
| (3) Diagnosed during incarceration in TDCJ | 4 | 3 | 7 | 11 |
| TB cases under management | 19 | 21 | | |
| Peer Education Programs | 0 | 2 | 94 | 74 |
| Peer Education Educators | 0 | 37 | 682 | 946 |
| Peer Education Participants | 3898 | 2004 | 17582 | 9887 |
| Sexual Assault In-Service (sessions/units) | 12/5 | 16/1 | 29/22 | 36/55 |
| Sexual Assault In-Service Participants | 45 | 40 | 161 | 298 |
| Alleged Assaults & Chart Reviews | 41 | N/A | 282 | N/A |

NOTE: Some category totals may change to reflect late reporting.
Date Compiled: 11/12/07

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

**Month: JULY 2007**

| Reports Received | This Month | Same Month | Year to Date | Last Year to Date |
|---|---|---|---|---|
| Chlamydia | 3 | 2 | 33 | 29 |
| Gonorrhea | 2 | 2 | 18 | 11 |
| Syphilis | 45 | 35 | 379 | 443 |
| Hepatitis A | 0 | 0 | 0 | 0 |
| Hepatitis B (acute cases) | 1 | 0 | 11 | 8 |
| Hepatitis C | 325 | 361 | 2430 | 2672 |
| HIV Screens (non-pre-release) | 5996 | 6321 | 42594 | 38768 |
| HIV Screens (pre-release) | 2304 | 2691 | 23529 | 24985 |
| HIV + pre-release tests | 0 | 5 | 20 | 40 |
| HIV Infections | 42 | 43 | 351 | 372 |
| AIDS | 3 | 9 | 148 | 79 |
| Methicillin-Resistant *Staph Aureus* | 529 | 493 | 3204 | 3095 |
| Methicillin-Sensitive *Staph Aureus* | 164 | 97 | 1019 | 985 |
| Occupational Exposures (TDCJ Staff) | 10 | 14 | 88 | 103 |
| Occupational Exposures (Medical Staff) | 2 | 6 | 25 | 34 |
| HIV CPX Initiation | 2 | | 24 | |
| Tuberculosis skin tests – intake (#positive) | 179 | 393 | 2007 | 2754 |
| Tuberculosis skin tests – annual (#positive) | 32 | 62 | 459 | 427 |
| Tuberculosis cases: | | | | |
| (1) Diagnosed during intake and attributed to county of origin | 1 | 1 | 3 | 5 |
| (2) Entered TDCJ on TB medications | 2 | 3 | 15 | 12 |
| (3) Diagnosed during incarceration in TDCJ | 1 | 0 | 8 | 11 |
| TB cases under management | 22 | 20 | | |
| Peer Education Programs | 1 | 0 | 94 | 74 |
| Peer Education Educators | 20 | 0 | 702 | 946 |
| Peer Education Participants | 2522 | 1796 | 22203 | 13039 |
| Sexual Assault In-Service (sessions/units) | 6-Apr | 9-Jan | 33/28 | 37/64 |
| Sexual Assault In-Service Participants | 13 | 35 | 184 | 333 |
| Alleged Assaults & Chart Reviews | 65 | N/A | 347 | N/A |

NOTE: Some category totals may change to reflect late reporting.
Date Compiled: 11/12/07

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

**Month: August 2007**

| Reports Received | This Month | Same Month | Year to Date | Last Year to Date |
|---|---|---|---|---|
| Chlamydia | 2 | 8 | 35 | 37 |
| Gonorrhea | 5 | 7 | 23 | 18 |
| Syphilis | 60 | 73 | 439 | 512 |
| Hepatitis A | 0 | 0 | 0 | 0 |
| Hepatitis B (acute cases) | 0 | 9 | 11 | 17 |
| Hepatitis C | 399 | 346 | 2829 | 3018 |
| HIV Screens (non-pre-release) | 6536 | 6592 | 49130 | 45360 |
| HIV Screens (pre-release) | 3298 | 3402 | 27571 | 28387 |
| HIV + pre-release tests | 5 | 3 | 28 | 60 |
| HIV Infections | 45 | 60 | 396 | 432 |
| AIDS | 8 | 9 | 156 | 88 |
| Methicillin-Resistant *Staph Aureus* | 328 | 617 | 3532 | 3712 |
| Methicillin-Sensitive *Staph Aureus* | 121 | 104 | 1140 | 1089 |
| Occupational Exposures (TDCJ Staff) | 18 | 22 | 106 | 156 |
| Occupational Exposures (Medical Staff) | 8 | 8 | 33 | 49 |
| HIV CPX Initiation | 12 | | 36 | |
| Tuberculosis skin tests – intake (#positive) | 153 | 356 | 2320 | 3110 |
| Tuberculosis skin tests – annual (#positive) | 35 | 84 | 509 | 511 |
| Tuberculosis cases: | | | | |
| (1) Diagnosed during intake and attributed to county of origin | 1 | 0 | 4 | 5 |
| (2) Entered TDCJ on TB medications | 0 | 2 | 15 | 14 |
| (3) Diagnosed during incarceration in TDCJ | 1 | 1 | 9 | 12 |
| TB cases under management | 22 | 21 | | |
| Peer Education Programs | 0 | 0 | 94 | 74 |
| Peer Education Educators | 0 | 0 | 702 | 946 |
| Peer Education Participants | 3340 | 1181 | 25974 | 16124 |
| Sexual Assault In-Service (sessions/units) | N/A | 18-Aug | 33/28 | 45/82 |
| Sexual Assault In-Service Participants | N/A | 105 | 184 | 438 |
| Alleged Assaults & Chart Reviews | 67 | N/A | 414 | N/A |

NOTE: Some category totals may change to reflect late reporting.
Date Compiled: 11/12/07

# Office of Health Services Liaison
# Utilization Review Monitoring

Hospital and Infirmary Discharges
Fourth Quarter FY2007
(June, July and August)

| Medical Provider | University | Number of Audits | Number of Deficiencies | Comments (See Footnotes) |
|---|---|---|---|---|
| Brownfield Regional | TTUHSC | | | |
| Cogdell Memorial | TTUHSC | | | |
| Electra Memorial | TTUHSC | | | |
| Hendrick Memorial | TTUHSC | 4 | 2 | #1a |
| Hospital Del Sol | TTUHSC | | | |
| Hospital Galveston | UTMB | 204 | 56 | #1=8; #1a=19; #2=3; #4=11; #5=11 |
| Mitchell County | TTUHSC | | | |
| Northwest Texas | TTUHSC | 7 | 4 | #1a=3; #5=1 |
| Pecos County | TTUHSC | 2 | 0 | |
| Scenic Mountain | TTUHSC | | | |
| Thomason | TTUHSC | | | |
| University Medical | TTUHSC | 3 | | #1a=1 |
| United Regional 11th St. | TTUHSC | | | |

*The remainder of the hospitals were not selected during this quarter's random audit.

| Medical Provider | University | Number of Audits | Number of Deficiencies | Comments (See Footnotes) |
|---|---|---|---|---|
| Allred | TTUHSC | | | |
| Beto | UTMB | 2 | 1 | #1a |
| Clements | TTUHSC | 5 | 0 | |
| Connally | UTMB | | | |
| Estelle | UTMB | 3 | 0 | |
| Hughes | UTMB | 1 | 0 | |
| Jester 3 | UTMB | | | |
| Montford | TTUHSC | 21 | 2 | #1a |
| Polunsky | UTMB | 1 | 0 | |
| Robertson | TTUHSC | 5 | 1 | #1a |
| Stiles | UTMB | | | |
| Telford | UTMB | 1 | 0 | |
| CT Terrell | UTMB | 8 | 4 | #1a |
| Young | UTMB | | | |

*The remainder of the infirmaries were not selected during this quarter's random audit.

| **Footnotes:** | |
|---|---|
| 1 | The patient was not medically stable when returned to general population. |
| 1a | Vital signs were not record in the electronic medical record for the date of discharge so it is not possible to verify that these offenders were stable when they returned to general population. |
| 2 | The level of medical services available at the facility were insufficient. |
| 3 | The patient was unable to ambulate the distances required to access the dining hall, shower and unit medical department upon discharge. |
| 4 | The patient required unscheduled medical care related to the admitting diagnosis within the first seven days after discharge. |
| 5 | Was pertinent documentation regarding the inpatient stay included in the electronic medical record (i.e., results of diagnostic tests, discharge planning, medication recommendations and/or treatments, etc.)? |

# CAPITAL ASSETS CONTRACT MONITORING AUDIT
# BY UNIT
# FOURTH QUARTER, FISCAL YEAR 2007

| June | Numbered Property On Inventory Report | Total Number of Deletions | Total Number of Transfers | Total Number of New Equipment |
|---|---|---|---|---|
| **Hutchins** | 65 | 0 | 2 | 2 |
| **Johnston** | 22 | 0 | 2 | 2 |
| **Lindsey** | 19 | 0 | 0 | 0 |

| July | Numbered Property On Inventory Report | Total Number of Deletions | Total Number of Transfers | Total Number of New Equipment |
|---|---|---|---|---|
| **Baten** | 10 | 0 | 0 | 0 |
| **Clements** | 53 | 0 | 0 | 0 |
| **Clements H.S.** | 16 | 0 | 0 | 0 |
| **Dalhart** | 31 | 0 | 0 | 0 |
| **Jordan** | 33 | 0 | 0 | 0 |
| **Neal** | 50 | 0 | 0 | 0 |
| **PAMIO** | 79 | 0 | 0 | 2 |

| | Numbered Property | Total Number | Total Number | Total Number |
|---|---|---|---|---|

| August | On Inventory Report | of Deletions | of Transfers | of New Equipment |
|---|---|---|---|---|
| **Kegans** | 6 | 0 | 0 | 0 |
| **Lychner** | 78 | 0 | 4 | 2 |
| **Plane** | 90 | 0 | 0 | 8 |

# CAPITAL ASSETS AUDIT
# FOURTH QUARTER, FISCAL YEAR 2007

| Audit Tools | June | July | August | Total |
|---|---|---|---|---|
| **Total number of units audited** | 3 | 7 | 3 | 13 |
| **Total numbered property** | 106 | 272 | 174 | 552 |
| **Total number out of compliance** | 1 | 0 | 1 | 2 |
| **Total % out of compliance** | 0.94% | 0.00% | 0.57% | 0.36% |

**AMERICAN CORRECTIONAL ASSOCIATION**
**ACCREDITATION STATUS REPORT**
**Fourth Quarter FY-2007**

## University of Texas Medical Branch

| Unit | Audit Date | % Compliance | |
|---|---|---|---|
| | | Mandatory | Non-Mandatory |
| Michael | June 11 – 14, 2007 | 100 | 98.4 |
| Dominguez | June 25 – 27, 2007 | 100 | 99.3 |
| Eastham | July 23 – 26, 2007 | 100 | 98.6 |

## Texas Tech University Health Science Center

| Unit | Audit Date | % Compliance | |
|---|---|---|---|
| | | Mandatory | Non-Mandatory |
| Robertson | June 4 – 7, 2007 | 100 | 98.6 |
| Sanchez | July 16 – 18, 2007 | 100 | 99.7 |

# Executive Services
# Active Monthly Research Projects – Medical
# Health Services Division

# October 2007

## Project Number: 408-RM03

**Researcher:** Ned Snyder

**IRB Number:** 02-377

**IRB Expires:** June 30, 2008

**Research Began:** June 03, 2003

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

**Data Collection Began:** July 1, 2003

**Proponent:** University of Texas Medical Branch at Galveston

**Data Collection End:** July 03, 2008

**Project Status:** Data Analysis

**Progress Report Due:** January 14, 2008

**Projected Completion Date:** July 31, 2008

**Units:** Hospital Galveston

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## Project Number: 433-RM04

**Researcher:** Ned Snyder

**IRB Number:** 03-357

**IRB Expires:** July 31, 2008

**Research Began:** March 19, 2004

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

**Data Collection Began:** March 22, 2004

**Proponent:** University of Texas Medical Branch at Galveston

**Data Collection End:** July 31, 2008

**Project Status:** Data Collection

**Progress Report Due:** January 3, 2008

**Projected Completion Date:** July 31, 2008

**Units:** UTMB

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## Project Number: 450-RM04

**Researcher:** Everett Lehman

**IRB Number:** 04.DSHEFS.02XP

**IRB Expires:** July 14, 2007

10/19/07: E-mail Mr. Lehman requesting current IRB.

**Research Began:** September 30, 2004

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

**Data Collection Began:** November 16, 2004

**Proponent:** Centers for Disease Control and Prevention; National Institute for Occupational Safety and Health

**Data Collection End:** June 30, 2006

**Project Status:** Formulating Results; Data Collection Complete

**Progress Report Due:** September 12, 2007

10/19/07: Email to Mr. Lehman requesting Progress Report.

**Projected Completion Date:** September 1, 2007

**Units:** Lychner, Stringfellow

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## Project Number: 475-RM05

**Researcher:**
Robert Morgan

**IRB Number:**
L05-077

**IRB Expires:**
February 27, 2008

**Research Began:**
August 1, 2005

**Title of Research:**
Tailoring Services for Mentally Ill Offenders

**Data Collection Began:**
January 20, 2006

**Proponent:**
Texas Tech University

**Data Collection End:**
July 31, 2007

**Project Status:**
Data Collection

**Progress Report Due:**
January 6, 2008

**Projected Completion Date:**
January 1, 2008

**Units:** Gatesville, Montford

---

## Project Number: 486-RM05

**Researcher:**
William O'Brien

**IRB Number:**
05-298

**IRB Expires:**
August 31, 2007

09/05/07: E-mail requesting current approval.

10/19/07: E-mail second request for new IRB.

**Research Began:**
January 17, 2006

**Title of Research:**
A Phase III randomized, double-blinded, placebo-controlled trial to investigate the efficacy, tolerability, and safety of TMC125 as part of an ART including TMC114/RTV and an investigator-selected OBR in HIV-1 infected subjects with limited to no treatment options (TMC 125-C206)

**Data Collection Began:**
January 17, 2006

**Proponent:**
University of Texas Medical Branch at Galveston

**Data Collection End:**
November 30, 2007

**Project Status:**
Data Analysis / Data Collection

**10/22/07: Received e-mail from Dr. O'Brien, the sponsor has withdrawn support, and now it will be funded by Merck, and not Tibotec. Dr. O'Brien will submit a revision of the proposal for renewal.**

**Progress Report Due:**
July 18, 2007

09/05/07: E-mail requesting updated progress report.

10/19/07: E-mail second request for update.

**Projected Completion Date:**
November 31, 2008

**Units:** Hospital Galveston

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## Project Number: 490-RM06

**Researcher:**
Sharon Melville

**IRB Number:**
Exempt

**IRB Expires:**
DNA

**Research Began:**
March 1, 2006

**Title of Research:**
Medical Monitoring Project (MMP)

**Data Collection Began:**
August 11, 2006

**Proponent:**
Texas Department of State Health Services; US Center for Disease Control (CDC)

**Data Collection End:**
April 30, 2010

**Project Status:**
Data Collection

**Progress Report Due:**
October 22, 2008

**Projected Completion Date:**
April 30, 2010

**Units:** System-wide

---

## Project Number: 499-RM06

| Researcher: | IRB Number: | IRB Expires: | Research Began: |
|---|---|---|---|
| Albert D. Wells | 06-307 | August 31, 2008 | April 4, 2007 |

**Title of Research:**
Past Drug Use Among Recently Incarcerated Offenders in TDCJ and Oral Health Ramifications

**Data Collection Began:**
May 1, 2007

**Proponent:**
University of Texas Medical Branch, Galveston

**Data Collection End:**
June 7, 2007

| Project Status: | Progress Report Due: | Projected Completion Date: |
|---|---|---|
| Data Analysis | January 31, 2008 | August 31, 2008 |

**Units:** N/A (Data Only)

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## Project Number: 503-RM06

| Researcher: | IRB Number: | IRB Expires: | Research Began: |
|---|---|---|---|
| William O'Brien | 06-189 | April 30, 2008 | October 23, 2006 |

**Title of Research:**
TMC125-C217 An open-label trial with TMC125 as part of an ART including TMC114/rtv and an investigator-selected OBR in HV-1 infected subjects who participated in a DUET trial (TMC125-C206 or TMC125-C216)

**Data Collection Began:**
October 26, 2006

**Proponent:**
University of Texas Medical Branch at Galveston

**Data Collection End:**
October 31, 2008

| Project Status: | Progress Report Due: | Projected Completion Date: |
|---|---|---|
| Data Collection | July 16, 2007<br>09/05/07: E-mail requesting updated progress report.<br>10/19/07: E-mail second request for progress report. | To be determined by trial sponsor |

**Units:** UTMB

---

## Project Number: 513-MR07

| Researcher: | IRB Number: | IRB Expires: | Research Began: |
|---|---|---|---|
| H. Morgan Scott | Exempt | DNA | November 21, 2006 |

**Title of Research:**
Do variable monthly levels of antibiotic usage affect the levels of resistance of enteric bacteria isolated from human and swine wastewater in multisite integrated human and swine populations?

**Data Collection Began:**
November 21, 2006

**Proponent:**
Texas A&M, Department of Veterinary Integrative Biosciences, College of Veterinary Medicine

**Data Collection End:**
August 31, 2007

| Project Status: | Progress Report Due: | Projected Completion Date: |
|---|---|---|
| Data Analysis | March 6, 2008 | August 31, 2008 |

**Units:** Beto, Byrd, Central, Clemens, Coffield, Darrington, Eastham, Ellis, Estelle, Ferguson, Jester I, Jester III, Luther, Michael, Pack, Powledge, Scott, Terrell, Wynne

---

## Project Number: 515-MR07

**Researcher:** Jacques Baillargeon

**IRB Number:** 06-249

**IRB Expires:** January 18, 2008

**Research Began:** October 27, 2006

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

**Data Collection Began:** March 5, 2007

**Proponent:** University of Texas Medical Branch, Galveston

**Data Collection End:** December 31, 2007

**Project Status:** Data Analysis

**Progress Report Due:** January 2, 2008

**Projected Completion Date:** December 31, 2009

**Units:** N/A (Data Only)

---

## Project Number: 523-MR07

**Researcher:** Robert Morgan

**IRB Number:** L06-193

**IRB Expires:** August 22, 2007

09/05/07: E-mail requesting current approval.

*See Projected Completion Date

**Research Began:** April 17, 2007

**Title of Research:** An Examination of the Combined Use of the PAI and the M-FAST in Detecting Malingering Among Inmates

**Data Collection Began:** April 23, 2007

**Proponent:** Texas Tech University, Department of Psychology

**Data Collection End:** May 7, 2007

**Project Status:** Data Collection

**Progress Report Due:** March 6, 2008

**Projected Completion Date:** *Currently analyzing data and as they complete the data analyses, research reports will be submitted.

**Units:** Montford

---

## Project Number: 527-MR07

**Researcher:** Ned Snyder

**IRB Number:** 05-277

**IRB Expires:** July 31, 2007

09/05/07: E-mail requesting current approval.

10/19/07: E-mail second request for current IRB approval.

**Research Began:** April 17, 2007

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

**Data Collection Began:** March 12, 2007

**Proponent:** University of Texas Medical Branch, Galveston

**Data Collection End:** July 31, 2008

**Project Status:** Data Collection

**Progress Report Due:** January 12, 2008

**Projected Completion Date:** July 31, 2008

**Units:** UTMB

---

# Medical Research Projects Pending Approval
# October 2007

## Project Number: 541-MR07

**Researcher:**
Michael Davis

**IRB Number:**
07-007

**IRB Expires:**
February 16, 2008

**Application Received:**
May 8, 2007

**Title of Research:**
Effects of telecardiology on cardiovascular disease management: Recent review of health outcomes

**Completed Application Received:**
May 25, 2007

**Proponent:**
UTMB

**Peer Panel Scheduled:**
June 13, 2007

**Project Status:**
10/19/07: Research Agreement prepared and waiting approval to send to Primary Researcher.

**Progress Report Due:**
N/A

**Peer Panel Recommendations:**
Approved w/ Conditions

**Units:** N/A

---

## Project Number: 542-MR07

**Researcher:**
Dr. Jacques Baillargeon

**IRB Number:**
**07-277**

**IRB Expires:**
August 31, 2008

**Application Received:**
September 14, 2007

**Title of Research:**
Psychiatric Barriers to Outpatient Care in Released HHIV-Infected Offenders

**Completed Application Received:**

**Proponent:**
University of Texas Medical Branch

**Peer Panel Scheduled:**

**Project Status:**
10/19/07: Proposal prepared and sent to OGC for approval.
10/19/07: Proposal prepared and sent to Health Services (Dr. Kelley) for approval.

**Progress Report Due:**

**Peer Panel Recommendations:**

**Units:**

---

## Project Number: 544-MR07

**Researcher:**
Dr. Roger Soloway

**IRB Number:**

**IRB Expires:**

**Application Received:**
September 27, 2007

**Title of Research:**
Prevention of Hepatocellular Carcinoma Recurrence with Pegylated Alpha-Interferon + Ribavirin in Chronic Hepatitis C after Definitive Treatment

**Completed Application Received:**

**Proponent:**
University of Texas Medical Branch at Galveston

**Peer Panel Scheduled:**
Not Scheduled

**Project Status:**
10/04/07: Faxed to OIG for background check of researchers.

10/09/07: Received clearance on all researchers.

10/19/07: E-mail to Dr. Soloway with update of project

10/19/07: Mailed application and proposal to OGC and Health Services for approval/disapproval.

10/26/07: E-mail to Dr. Soloway requesting copy of the IRB.

**Progress Report Due:**

**Peer Panel Recommendations:**

**Units:**

---

***TDCJ HEALTH SERVICES***
***MENTAL HEALTH SERVICES MONITORING & LIAISON***
***ADMINISTRATIVE SEGREGATION MENTAL HEALTH AUDITS***
***FOURTH QUARTER FY 2007***

| UNIT | DATE(S) | ATC 4 & 5 | ATC 6 | REF'D | REQ. FWD | OFFENDERS SEEN | OFFENDERS INTERVIEWED | STAFF INTERVIEWED |
|---|---|---|---|---|---|---|---|---|
| | (Audit dates) | (48-72 Hrs) | (14 Days) | (Referred for evaluation) | (Requests Forwarded) | Total | MHS Caseload/Non-caseload | MHS/Security |
| **MICHAEL** | 6/7&8/2007 | 83% | 100% | 3 | 10 | 451 | 63/101 | 2/6 |
| **DARRINGTON** | 6/19/2007 | 83% | 100% | 0 | 2 | 165 | 27/46 | 2/6 |
| **RAMSEY 1** | 6/20/2007 | 92% | 100% | 0 | 0 | 43 | 13/30 | 3/3 |
| **ESTELLE** | 6/26&27/2007 | 100% | 100% | 1 | 13 | 555 | 52/151 | 1/6 |
| **TELFORD** | 7/2&3/2007 | 100% | 100% | 1 | 12 | 501 | 45/160 | 3/6 |
| **STILES** | 7/11&16/2007 | 100% | 100% | 0 | 5 | 478 | 62/138 | 2/6 |
| **EASTHAM** | 7/19/2007 | 100% | 100% | 0 | 6 | 432 | 38/115 | 1/6 |
| **SMITH (ECB)** | 7/25&26/2007 | 100% | 100% | 0 | 9 | 475 | 138/107 | 3/6 |
| **ROBERTSON** | 8/8&9/2007 | 100% | 100% | 0 | 6 | 476 | 78/119 | 3/6 |
| **ELLIS** | 8/23/2007 | 100% | 100% | 0 | 3 | 109 | 11/42 | 2/4 |
| **FERGUSON** | 8/29/2007 | 100% | 100% | 1 | 7 | 398 | 17/98 | 4/6 |
| | | | | | | | | |
| | | | | | | | | |
| **TOTAL** | | 1,058 | 1100 | 6 | 73 | 4,083 | 544/1,107 | 26/61 |
| **AVERAGE** | | 96.18% | 100% | 0.54 | 6.64 | 371.18 | 49.45/100.64 | 2.36/5.54 |

# Consent Item 3(a)

## University Medical Director's Report

## The University of Texas Medical Branch

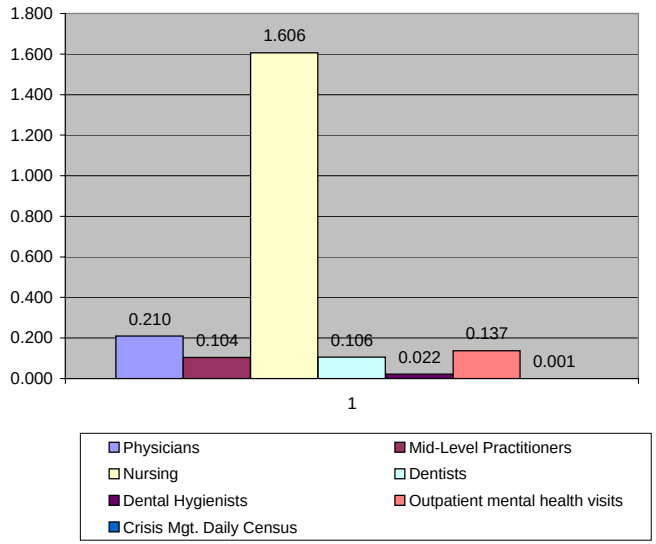

# Correctional Health Care
# MEDICAL DIRECTOR'S REPORT

## FOURTH QUARTER
## FY2007

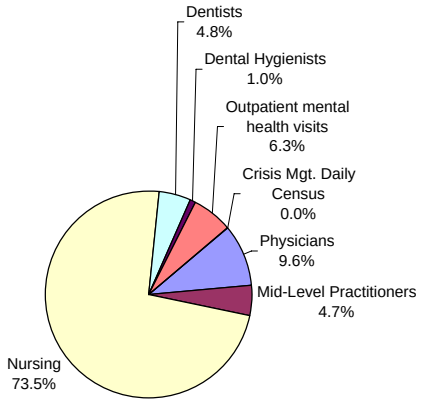
# *Medical Director's Report:*

| *Average Population* | June 120,568 | | July 120,279 | | August 120,337 | | Qtly Average 120,395 | |
|---|---|---|---|---|---|---|---|---|
| | Number | Rate Per Offender | Number | Rate Per Offender | Number | Rate Per Offender | Number | Rate Per Offender |
| ***Medical encounters*** | | | | | | | | |
| Physicians | 25,345 | 0.210 | 24,889 | 0.207 | 25,610 | 0.213 | **25,281** | **0.210** |
| Mid-Level Practitioners | 12,036 | 0.100 | 12,551 | 0.104 | 12,810 | 0.106 | **12,466** | **0.104** |
| Nursing | 187,464 | 1.555 | 190,156 | 1.581 | 202,322 | 1.681 | **193,314** | **1.606** |
| **Sub-total** | **224,845** | **1.865** | **227,596** | **1.892** | **240,742** | **2.001** | **231,061** | **1.919** |
| ***Dental encounters*** | | | | | | | | |
| Dentists | 12,121 | 0.101 | 12,965 | 0.108 | 13,170 | 0.109 | **12,752** | **0.106** |
| Dental Hygienists | 2,517 | 0.021 | 2,531 | 0.021 | 2,833 | 0.024 | **2,627** | **0.022** |
| **Sub-total** | **14,638** | **0.121** | **15,496** | **0.129** | **16,003** | **0.133** | **15,379** | **0.128** |
| ***Mental health encounters*** | | | | | | | | |
| Outpatient mental health visits | 16,252 | 0.135 | 16,652 | 0.138 | 16,617 | 0.138 | **16,507** | **0.137** |
| Crisis Mgt. Daily Census | 87 | 0.001 | 83 | 0.001 | 83 | 0.001 | **84** | **0.001** |
| **Sub-total** | **16,339** | **0.136** | **16,735** | **0.139** | **16,700** | **0.139** | **16,591** | **0.138** |
| ***Total encounters*** | **255,822** | **2.122** | **259,827** | **2.160** | **273,445** | **2.272** | **263,031** | **2.185** |

**Encounters as Rate Per Offender Per Month**



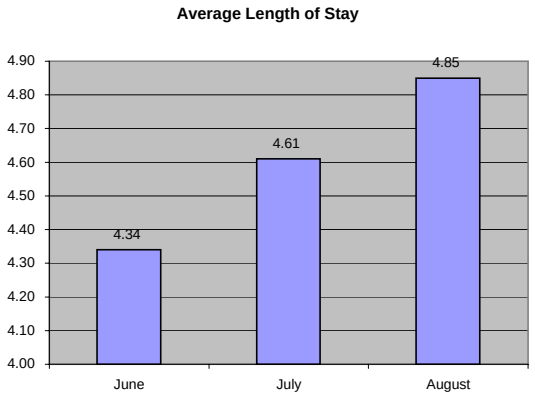

**Encounters by Type**

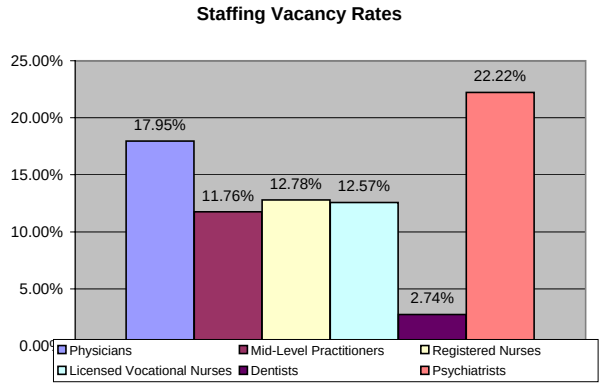


## *Medical Director's Report (Page 2):*

| | June | July | August | Qtly Average |
|---|---|---|---|---|
| ***Medical Inpatient Facilities*** | | | | |
| Average Daily Census | 86.00 | 84.00 | 83.00 | **84.33** |
| Number of Admissions | 437.00 | 456.00 | 416.00 | **436.33** |
| Average Length of Stay | 4.34 | 4.61 | 4.85 | **4.60** |
| Number of Clinic Visits | 1,957.00 | 1,871.00 | 1,628.00 | **1,818.67** |
| ***Mental Health Inpatient Facilities*** | | | | |
| Average Daily Census | 1,060.00 | 1,057.45 | 1,047.35 | **1,054.93** |
| PAMIO/MROP Census | 710.94 | 703.91 | 704.71 | **706.52** |
| ***Specialty Referrals Completed*** | 1,199.00 | 1,093.00 | 1,195.00 | **1,162.33** |
| ***Telemedicine Consults*** | 485 | 464 | 627 | **525.33** |

| | Average This Quarter | | | Percent |
|---|---|---|---|---|
| ***Health Care Staffing*** | **Filled** | **Vacant** | **Total** | **Vacant** |
| Physicians | 64.00 | 14.00 | 78.00 | 17.95% |
| Mid-Level Practitioners | 120.00 | 16.00 | 136.00 | 11.76% |
| Registered Nurses | 348.00 | 51.00 | 399.00 | 12.78% |
| Licensed Vocational Nurses | 647.00 | 93.00 | 740.00 | 12.57% |
| Dentists | 71.00 | 2.00 | 73.00 | 2.74% |
| Psychiatrists | 14.00 | 4.00 | 18.00 | 22.22% |



# Consent Item 3(b)

## University Medical Director's Report

## Texas Tech University Health Sciences Center


# Correctional Managed Health Care
# MEDICAL DIRECTOR'S REPORT

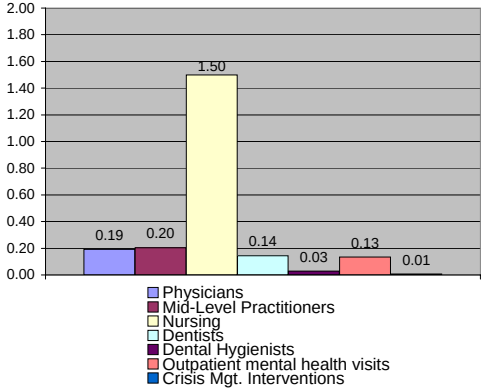
## FOURTH QUARTER
## FY 2007

*Medical Director's Report:*

| | June | July | August | Quarterly Average |
|---|---|---|---|---|
| *Average Population* | 31,490.53 | 31,544.34 | 31,499.45 | 31,511.44 |

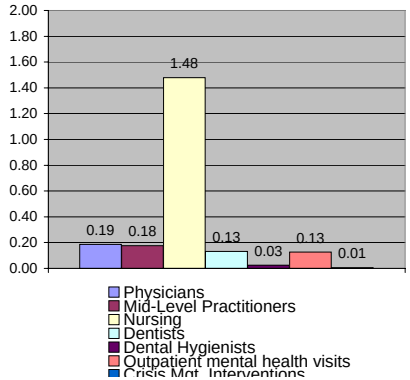
| *Medical Encounters* | June Number | June Rate Per Offender | July Number | July Rate Per Offender | August Number | August Rate Per Offender | Quarterly Average Number | Quarterly Average Rate Per Offender |
|---|---|---|---|---|---|---|---|---|
| Physicians | 5,749 | 0.183 | 6,218 | 0.197 | 5,958 | 0.189 | 6,085 | 0.193 |
| Mid-Level Practitioners | 6,624 | 0.210 | 6,592 | 0.209 | 7,618 | 0.242 | 6,432 | 0.204 |
| Nursing | 43,253 | 1.374 | 48,199 | 1.528 | 52,077 | 1.653 | 47,374 | 1.503 |
| Sub-Total | **55,626** | **1.766** | **61,009** | **1.934** | **65,653** | **2.084** | **59,891** | **1.901** |
| *Dental Encounters* | | | | | | | | |
| Dentists | 4,840 | 0.154 | 4,484 | 0.142 | 4,814 | 0.153 | 4,546 | 0.144 |
| Dental Hygienists | 844 | 0.027 | 941 | 0.030 | 951 | 0.030 | 895 | 0.028 |
| Sub-Total | **5,684** | **0.180** | **5,425** | **0.172** | **5,765** | **0.183** | **5,441** | **0.173** |
| *Mental Health Encounters* | | | | | | | | |
| Outpatient mental health visits | 4,178 | 0.133 | 4,089 | 0.130 | 4,395 | 0.140 | 4,211 | 0.134 |
| Crisis Mgt. Interventions | 222 | 0.007 | 223 | 0.007 | 228 | 0.007 | 190 | 0.006 |
| Sub-Total | **4,400** | **0.140** | **4,312** | **0.137** | **4,623** | **0.147** | **4,401** | **0.140** |
| *Total Encounters* | **65,710** | **2.087** | **70,746** | **2.243** | **76,041** | **2.414** | **69,733** | **2.213** |

**Encounters as Rate Per Offender Per Month**



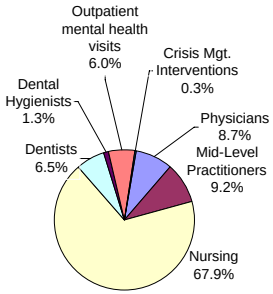

**3rd Quarter 2007**

**Encounters as Rate Per Offender Per Month**



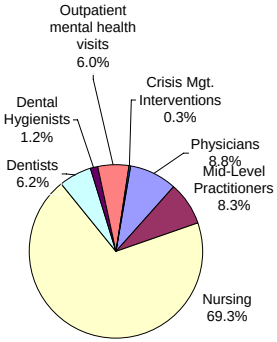

**4th Quarter 2007**

**Encounters by Type**




**3rd Quarter 2007**

**Encounters by Type**



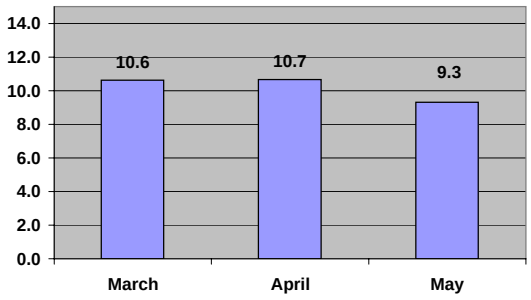

**4th Quarter 2007**

*Medical Director's Report (page 2):*

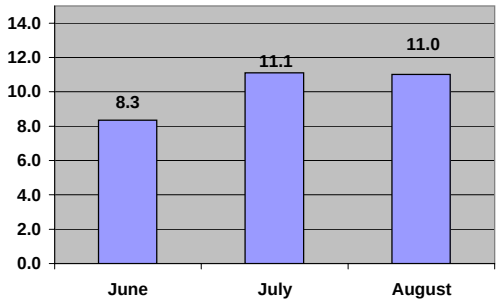
| | June | July | August | Quarterly Average |
|---|---|---|---|---|
| *Medical Inpatient Facilities* | | | | |
| Average Daily Census | 87 | 86.1 | 85.82 | **86.31** |
| Number of Admissions | 267 | 266 | 256 | **263.00** |
| Average Length of Stay | 8.34 | 11.1 | 11.01 | **10.15** |
| Number of Clinic Visits | 697 | 569 | 651 | **639.00** |
| *Mental Health Inpatient Facilities* | | | | |
| Average Daily Census | 532 | 538 | 519 | **529.67** |
| PAMIO/MROP Census | 431 | 432 | 416 | **426.33** |
| *Specialty Referrals Completed* | 1241 | 1219 | 1290 | **1250.00** |
| *Telemedicine Consults* | 273 | 280 | 334 | **295.67** |

| *Health Care Staffing* | Average This Quarter | | | Percent |
|---|---|---|---|---|
| | Filled | Vacant | Total | Vacant |
| Physicians | 24.96 | 0.00 | 24.96 | 0.00% |
| Mid-Level Practitioners | 24.61 | 2.25 | 26.86 | 8.38% |
| Registered Nurses | 166.10 | 31.38 | 197.48 | 15.89% |
| Licensed Vocational Nurses | 334.15 | 53.12 | 387.27 | 13.72% |
| Dentists | 19.77 | 0.43 | 20.20 | 2.13% |
| Psychiatrists | 8.71 | 3.08 | 11.79 | 26.12% |

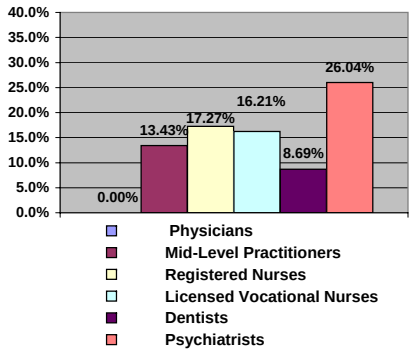
**2007 3rd Quarter: Average Length of Stay**



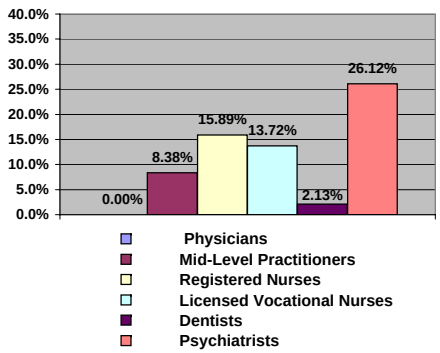

**2007 4th Quarter: Average Length of Stay**




**2007 3rd Quarter: Staffing Vacancy Rates**




**2007 4th Quarter: Staffing Vacancy Rates**



# Consent Item 4

## Summary of CMHCC Joint Committee / Work Group Activities

# Correctional Managed Health Care
# Joint Committee/Work Group Activity Summary
# for December 2007 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: November 8, 2007

Key Activities:

(1) Reviewed monthly detailed Access to Care Indicator data for the Fourth Quarter of FY 2007. Discussed compliance issues and corrective actions taken.

| ATC Indicators | Percent of Facilities with Quarterly Average 80% Compliance or Above |
|---|---|
| #1: SCR physically triaged within 48 hrs (72 hrs Fri and Sat) | *100.0%* |
| #2: Dental chief complaint documented in MR at time of triage | *100.0%* |
| #3: Referral to dentist (nursing/dental triage) seen within 7 days of SCR receipt | *98.1%* |
| #4: SCR/referrals (mental health) physically triaged within 48 hrs (72 hrs Fri/Sat) | *100.0%* |
| #5: MH chief complaint documented in the MR at time of triage | *100.0%* |
| #6: Referred outpatient MH status offenders seen within 14 days of referral/triage | *98.1%* |
| #7: SCR for medical services physically triaged within 48 hrs (72 hrs Fri/Sat) | *99.1%* |
| #8: Medical chief complaint documented in MR at time of triage | *100.0%* |
| #9: Referrals to MD, NP or PA seen within 7 days of receipt of SCR | *97.1%* |

(2) Reviewed Statewide SLC Quality of Care Indicator data:
- Dental X-Ray
- Mental Health PULHES

(3) Introduction of new CMHC committee staff members, David McNutt, Assistant Director for Administrative Services and Lynn Webb, Finance Manager.

(4) Reviewed Monthly Medical Grievance Exception Reports.

(5) Discussed issues related to SAFE Prisons Program

(6) Discussed issues related to EMR

(7) Heard an update on Nursing Work Group

(8) Discussed issues related to the Board of Medical Examiners

(9) Discussed issues related to Board of Nurse Examiners

**Joint Policy and Procedure Committee**

Co-Chairs: Allen Sapp, CMHCC staff and Dr. Mike Kelley, TDCJ Health Services Division

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

Meeting Date: October 11, 2007

Key Activities:

(1) Approved policy revisions to E-39.1, Health Evaluation and Documentation – Offenders in Segregation

(2) Approved policy revisions to I-70.1 Informed Consent

(3) Approved revisions to policy A-11.2 Pronouncement of Death by Licensed Nurses.

(4) Approved revisions to policy B-14.4, Prevention of Hepatitis B Virus (HPB) Infection in TDCJ Facilities.

(5) Approved revisions to policy B-15.2, Heat Stress

(6) Approved revisions to C-23.1, Position Descriptions

(7) Approved revisions to C-23.2, Supervising Medical Assistants Performing Tasks Delegated by Physicians.

(8) Approved revisions to D-27.3 Photosensitivity

Mr. Sapp announced that he would be retiring in November and that this would be his last P & P meeting. He then thanked and acknowledged the Committee for all their hard work.

**Joint Pharmacy and Therapeutics Committee**

Chair: Dr. Sheri Talley

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

Meeting Dates: Nov. 8, 2007

A. Key Activities

(1) Received and reviewed reports from the following P&T subcommittees:

- Psychiatry
- HIV
- Coronary Artery Disease
- Linezolid

(2) Reviewed and discussed monthly reports as follows:

- Pharmacy clinical activity
- Non-formulary deferrals
- Utilization related reports on:
  - HIV interventions
  - HIV utilization
  - Hepatitis C utilization
- Quarterly Medication Incident Reports

(3) Follow-up discussion related to Enfuvirtide (Fuzeon) patients.

(4) Follow-up discussion of wound care DMG addendum materials.

(**5)** Updated National Asthma Guidelines

(6) Follow-up discussion on nonformulary medication conversion chart

(7) Reviewed action request to revise the bipolar depression disease management guidelines.

(8) Reviewed manufacturer discontinuation of Gladase® and Gladase-C®.

(9) Reviewed clarification of membership of the P & T Committee (P&P 05-05).

(10) Discussed adolescent diabetes pathway revision-dental referral.

(11) Reviewed matters relating to anti-infectives, formulary addition request on QuickClot®, Omeprazole (Prilosec®),triamterene; reviewed action requests on Levothyroxine generic, Hepatitis B vaccine selection.

(12) Reviewed Policy and Procedures Revisions:

- P&P 10-05: Prescribing and ordering medications
- P&P 10-40: Medication procurement after hours
- P&P 15-05: Medication area security
- P&P 15-10: Storage of pharmaceuticals

- P&P 15-15: Transfer of medications
- P&P 15-25: Medication security during courier transport
- P&P 15-35: Reclamation of drugs
- P&P 40-20: Missing medication policy
- P&P 75-15: Pharmacy medication areas inspections and audits
- P&P 75-20: Record retention policy

(13) Discussed manufacturer discontinuations on Procainamide SR 500mg tablets.

**Joint Infection Control Committee**

Chair: Dr. Mike Kelley

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

Meeting Date: October 11, 2007

Key Activities:

(1) Review of preventive medicine statistics related to surveillance; Pandamic Flu - Tamiflu

(2) Review and updated policies:

| | |
|---|---|
| Policy B-14.13 | Hepatitis Policy |
| Policy B-14-07 | Immunization – Hepatitis B vaccination process |
| Policy B-14.10 | Tuberculosis |
| Policy B-14.12 | Syphilis - Changes to the HSM85 reporting form |

**Joint Dental Work Group**

Co-Chairs: Dr. Sonny Wells and Dr. Brian Tucker

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

Meeting Date: September 20, 2007

Key Activities:

(1) Discussion of X-Ray Focus Study Review

(2) Review of staffing and non-compliance reports.

(3) Review of Dental Services Manual.

(4) Heard report on oral surgery referral.

(5) Discussion of FY 2008-2009 Contract Changes.

(6) Heard report on sick call verification audit.

(7) Discussion on the vacant specialty coordinators positions (endodontic and prosthodontic)

(8) Discussion on the prophylaxis guidelines

**Joint Mortality and Morbidity Committee**

Chair: Dr. Mike Kelley

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

Meeting Dates: September 12, 2007 (review of 41 cases) and October 10, 2007 (review of 39 cases).

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

**Joint Nursing Work Group**

Chair: Mary Goetcher, RN

Purpose: To provide a forum for the discussion of information technology issues related to the statewide operations of the correctional health care program.

Meeting Date: October 29, 2007

Key Activities:

(1) Heard update on legislatively mandated staffing plan.

(2) Heard update on TDCJ's planned quality of care monitoring

(3) Reviewed changes to policies relating to pronouncement of death; telephone triage; draft policy relating to LVN on-calls; and peer review policy revisions.

# 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***


To: Chairman James D. Griffin, M.D.
Members, CMHCC

Date: November 19, 2007

From: Allen Hightower, Executive Director

Subject: Executive Director's Report

This report summarizes a number of significant activities relating to the correctional health care program since our last meeting:

## Legislative Budget Board Tour of Hospital Galveston and Carole Young Facility

Wayne Pulver, Assistant Director and Susan Dow, Budget Analyst of the Legislative Budget Board toured the Galveston Hospital and Carole Young unit on November 16, 2007. UTMB staff assisting in the tour were Ben G. Raimer, M.D., Vice-President of UTMB-CMC and Community Health Services, John Allen, Assistant Vice-President, Owen Murray, D.O., Chief Physician Executive, Lauren Neumann, Legislative Coordinator, Laura Smith, Assistant Vice-President for Legislative Affairs, Troy Sybert, M.D., Hospital Galveston Medical Director, Andrew DeYoung, Clinical Operations Administrator and Athena Cherian, Carole Young Practice Manager. CMHCC staff, David McNutt, Lynn Webb and I were also in attendance as was Jerry McGinty, Deputy Chief Financial Officer who represented TDCJ.

## Staff Transitions

The CMHCC Assistant Director for Administrative Services, Allen Sapp retired November 2, 2007. The position was posted and interviews held in October. David McNutt has since been selected and began work on November 5, 2007.

## Legislative Budget Board Uniform Cost Project

Cost data by facility was obtained from Texas Tech University Health Sciences Center and the University of Texas Medical Branch and submitted to the Texas Department of Criminal Justice in preparation for the Legislative Budget Board Uniform Cost Project. This will provide cost for FY 2007 by facility.

**Correctional Managed Health Care Limitation of Expenditure**

In accordance with Rider 69, TDCJ Appropriations, Article V, Senate Bill 1, 79th Legislature, 2005, a total of $35,601.16 was refunded to TDCJ for the purposes of lapsing to the General Revenue Fund as required by the rider.

Rider 69 reads as follows:

> **Correctional Managed Healthcare: Limitation of Expenditure.** *Out of the funds appropriated above, the Correctional Managed Health Care Committee shall not transfer any funds in excess of the capitation rates established in contracts to the University of Texas Medical Branch or the Texas Tech University Health Sciences Center without prior approval of the Governor and the Legislative Budget Board. Any funds appropriated for Correctional Managed Health Care remaining unexpended or unobligated on August 31st of each fiscal year, shall lapse to the General Revenue Fund.*

**Annual Financial Reporting Requirements**

The CMHCC was required to submit the annual financial report schedules for the Committee for FY 2007. This was the first time that the State Comptroller's Office has required the CMHCC to submit these schedules.

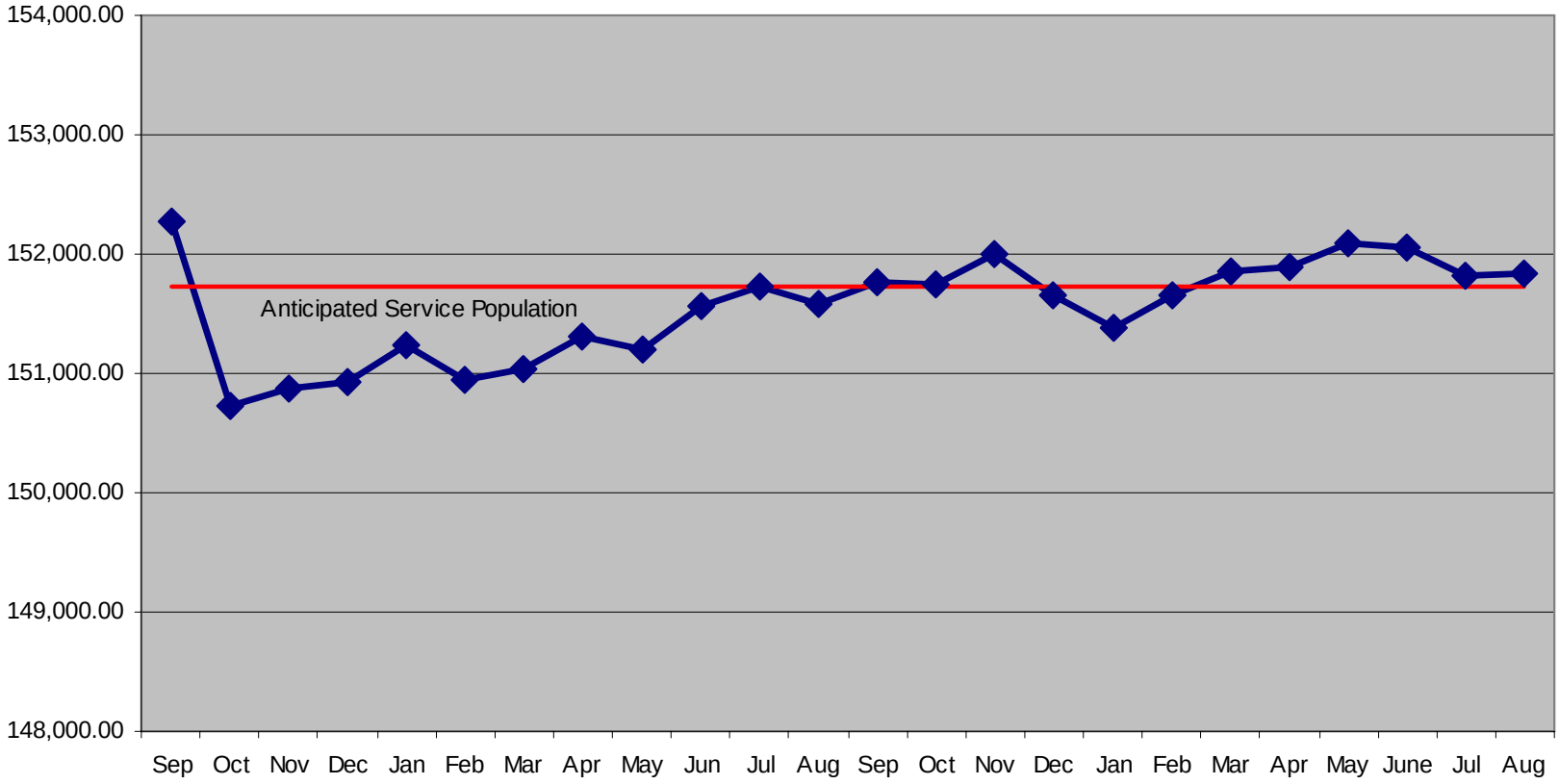
ARH:tb

# *Correctional Managed Health Care Committee*

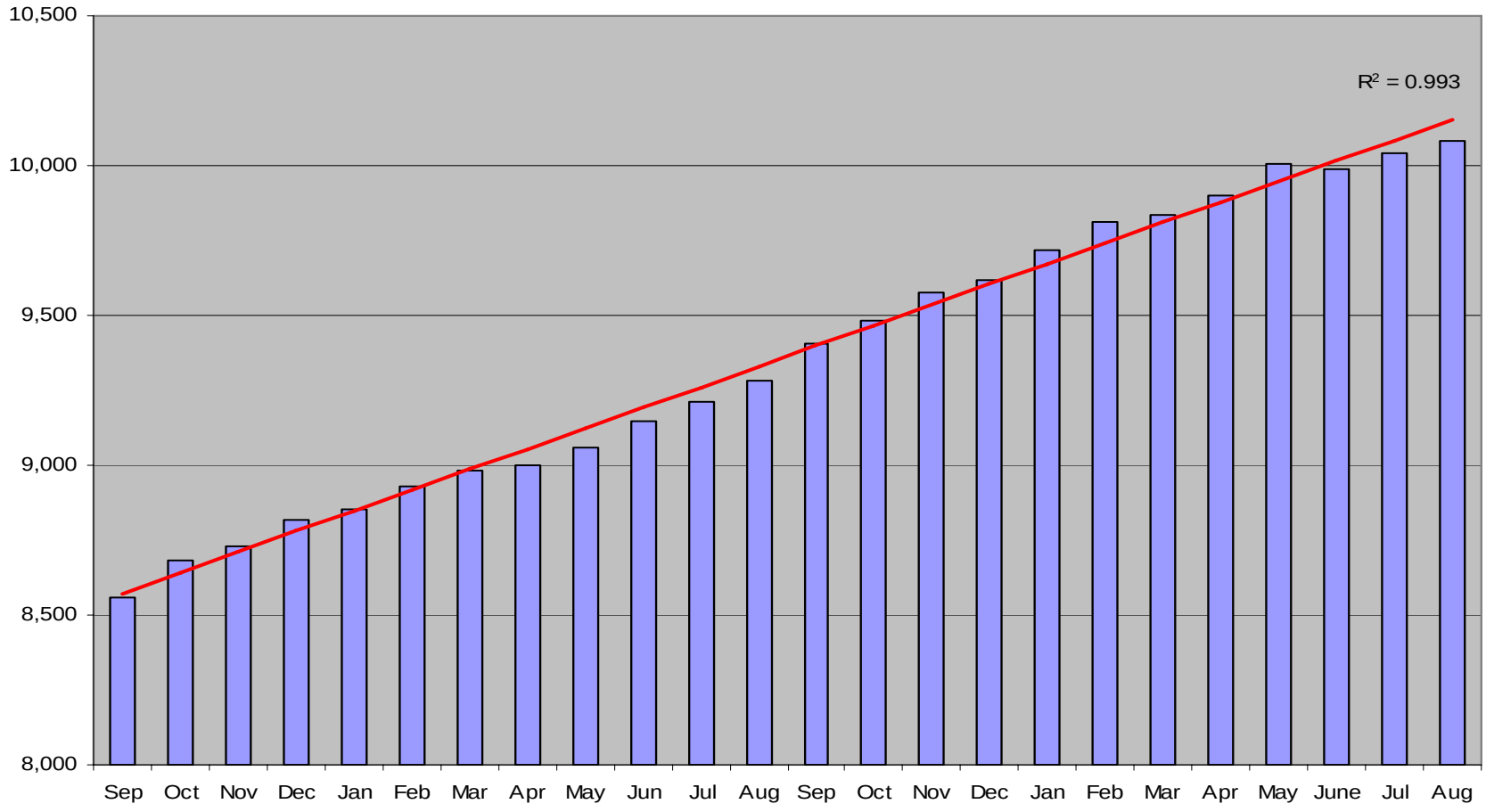
## Key Statistics Dashboard

**December 2007**

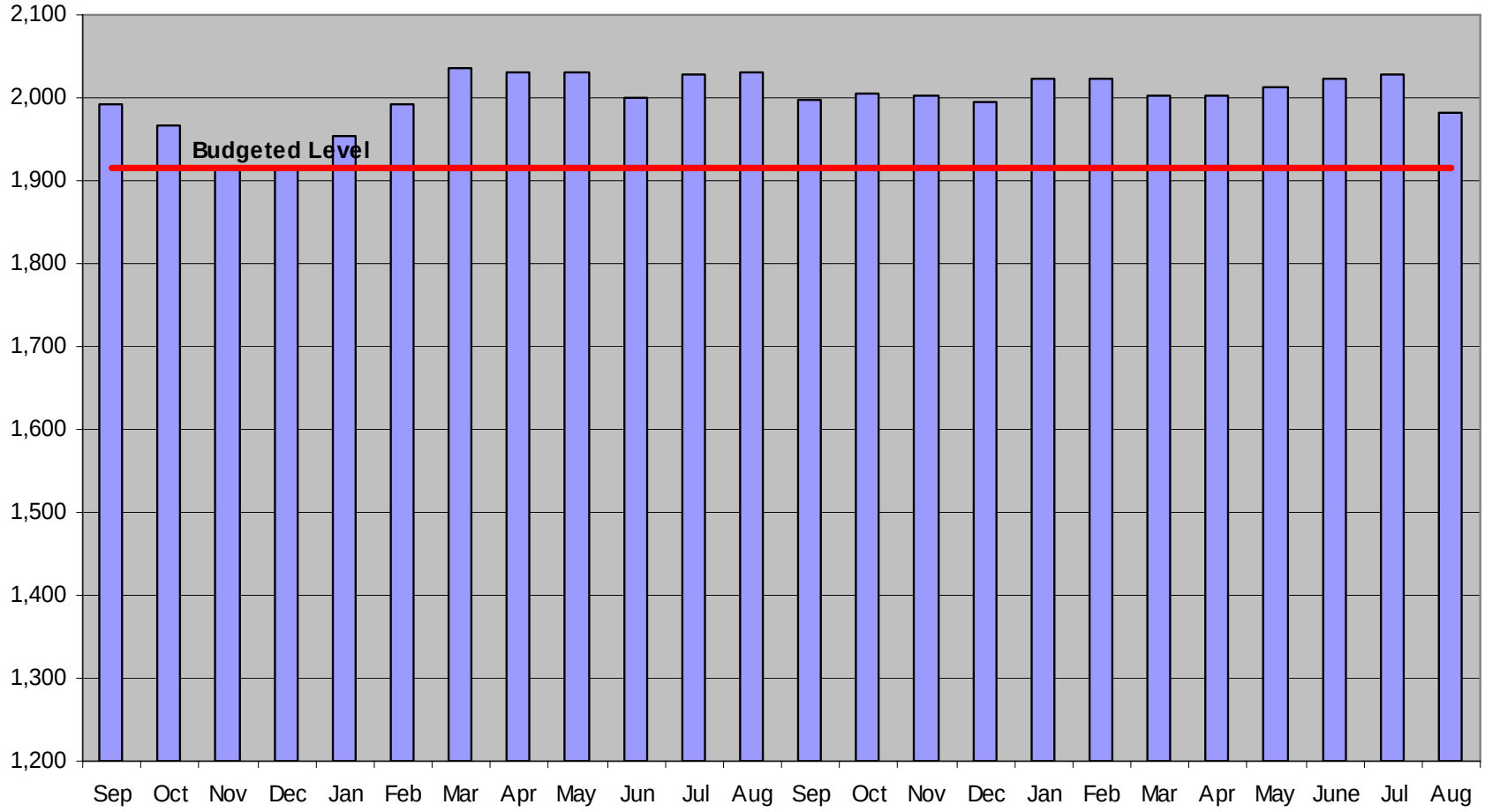
## CMHC Service Population
## FY 2006-2007 to Date



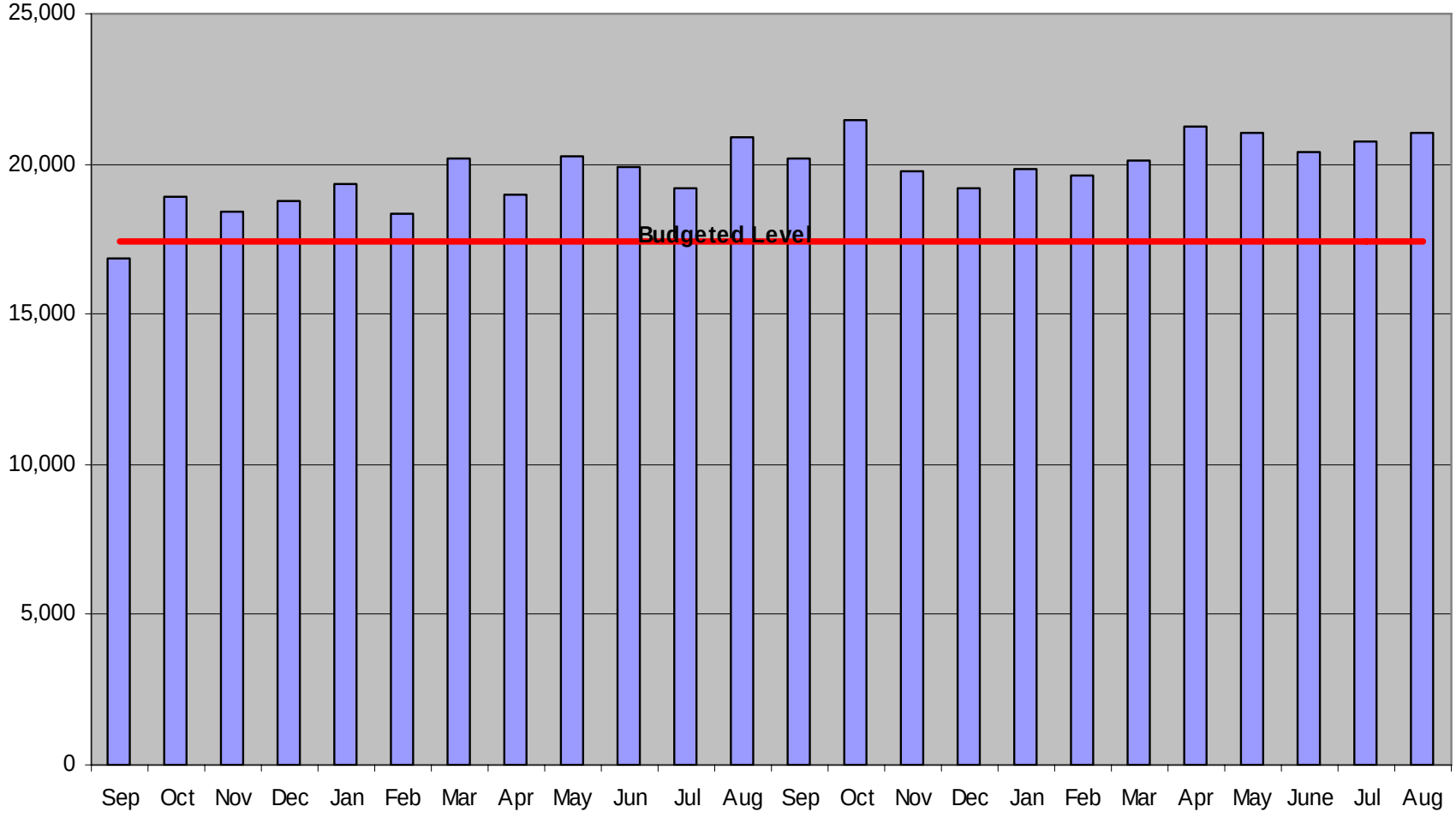
# Offenders Age 55+
# FY 2006-2007 to Date



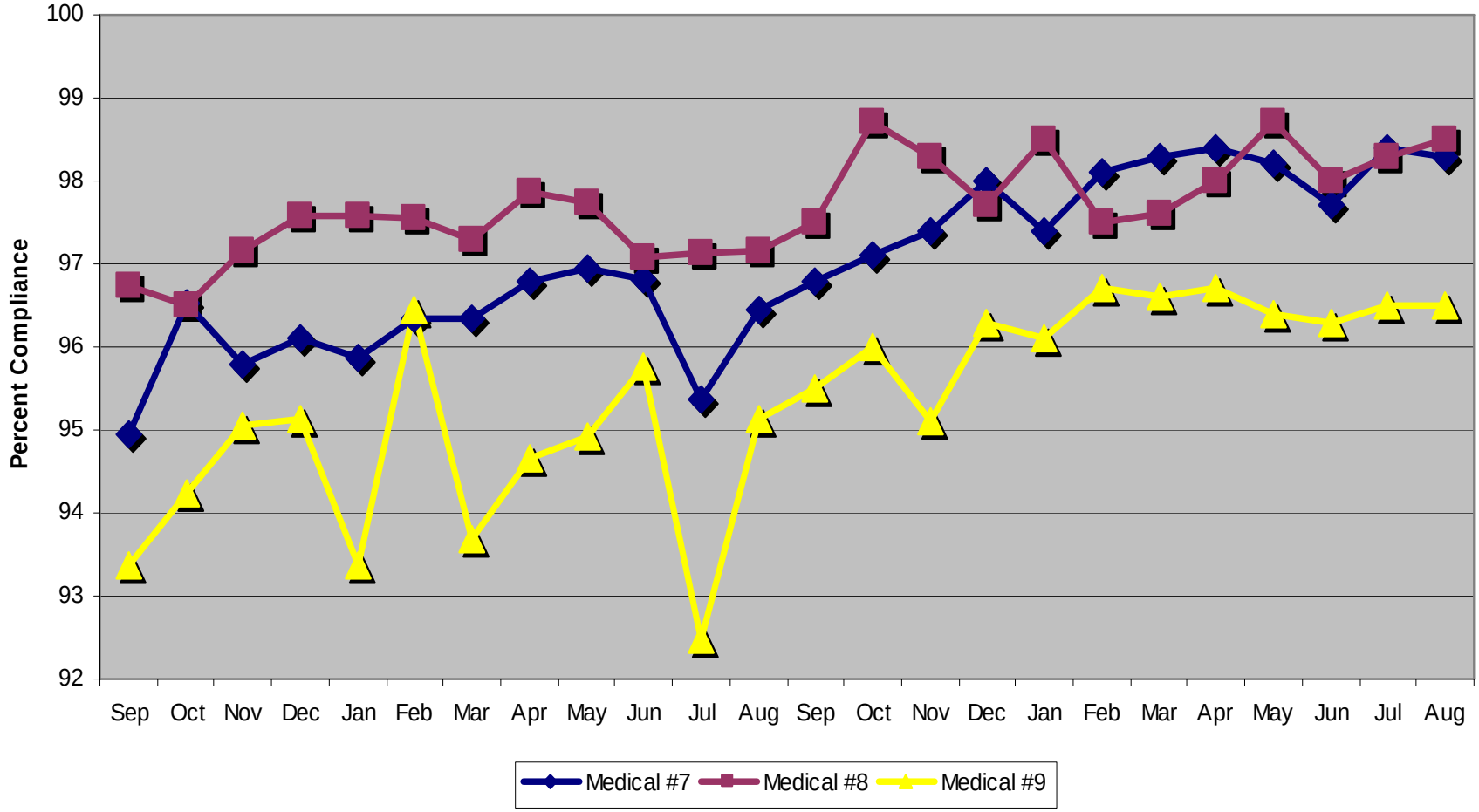
# Psychiatric Inpatient Census



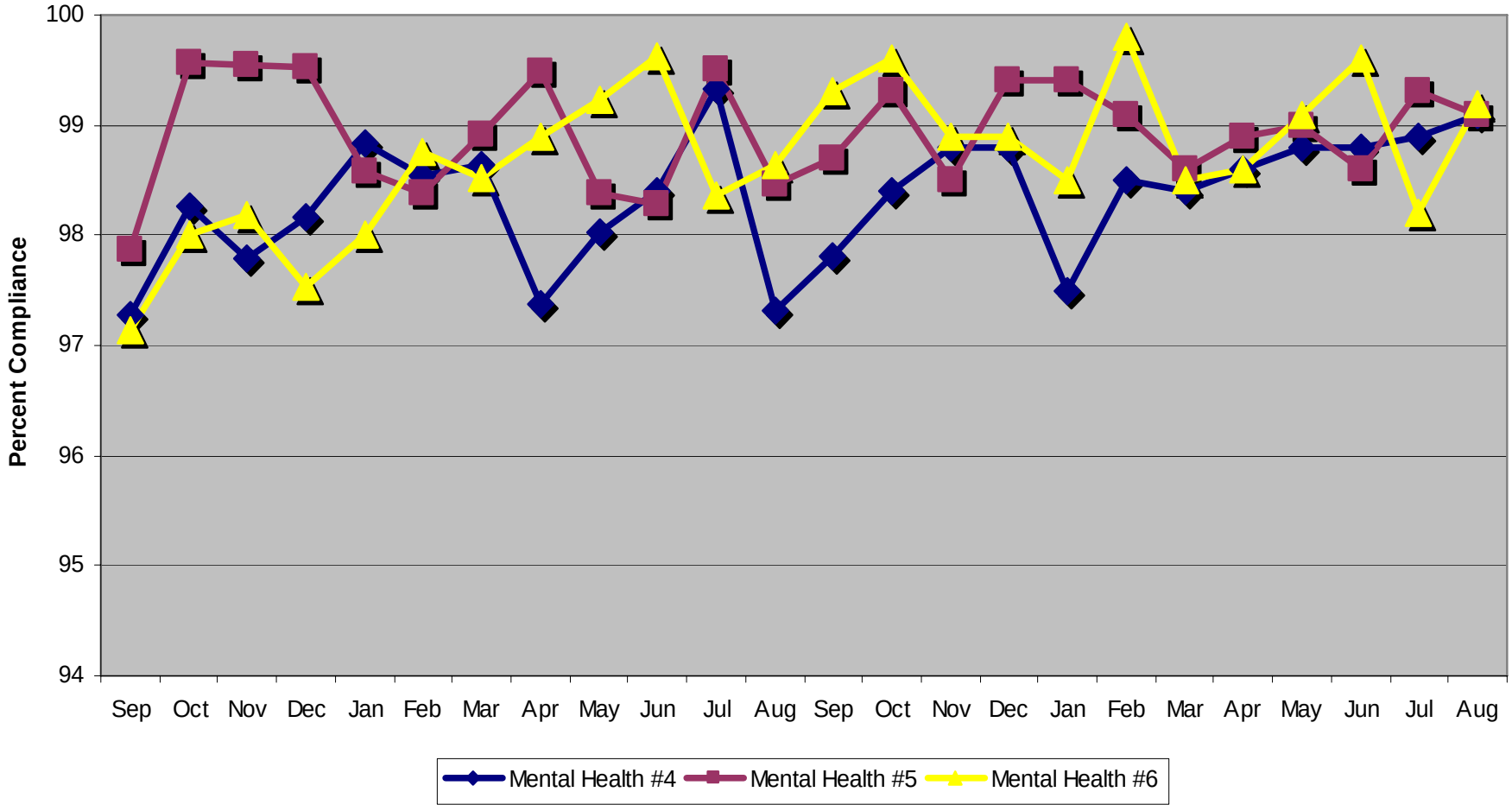
# Psychiatric Outpatient Census



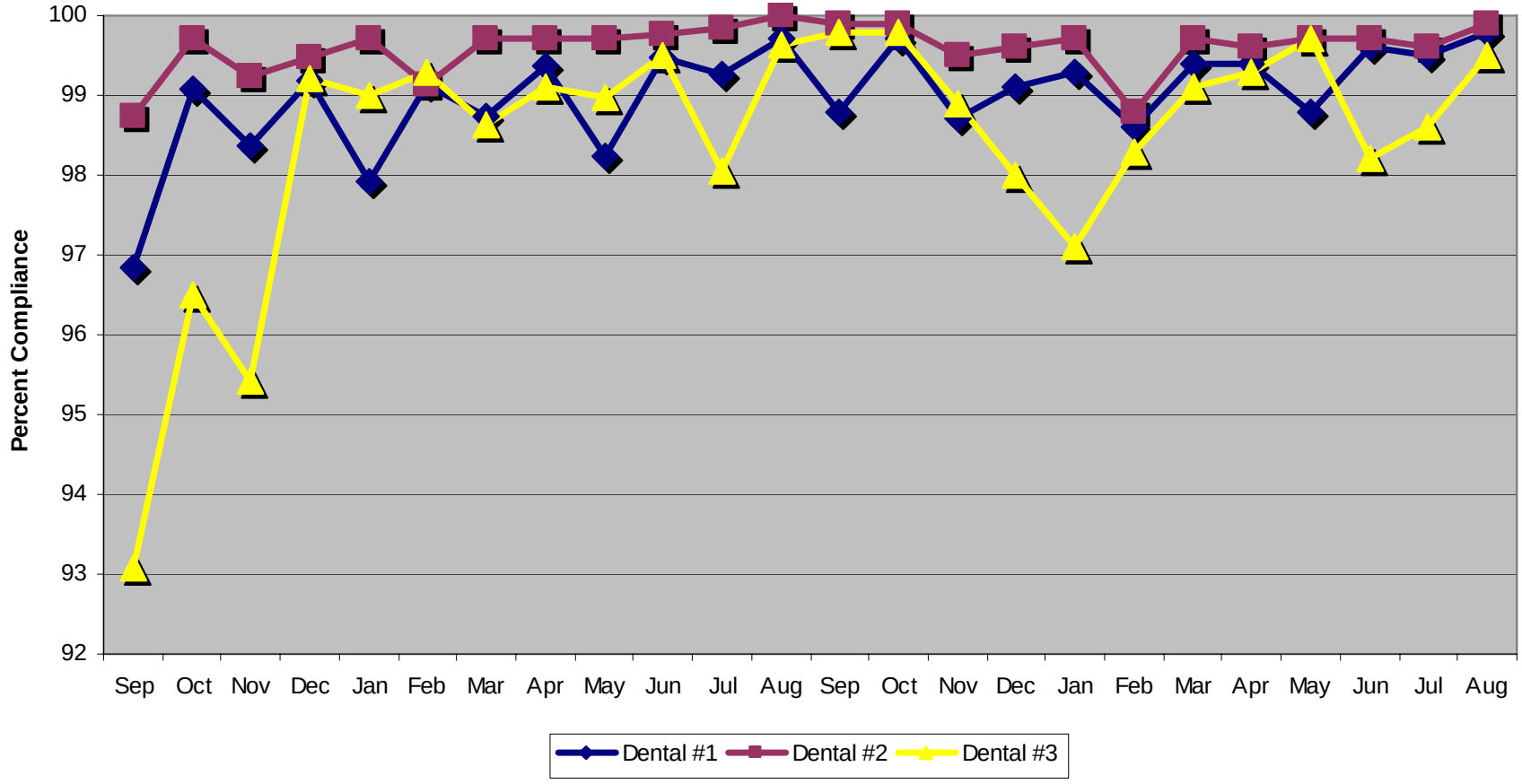
# Medical Access to Care
# Indicators FY 2006-2007 to Date



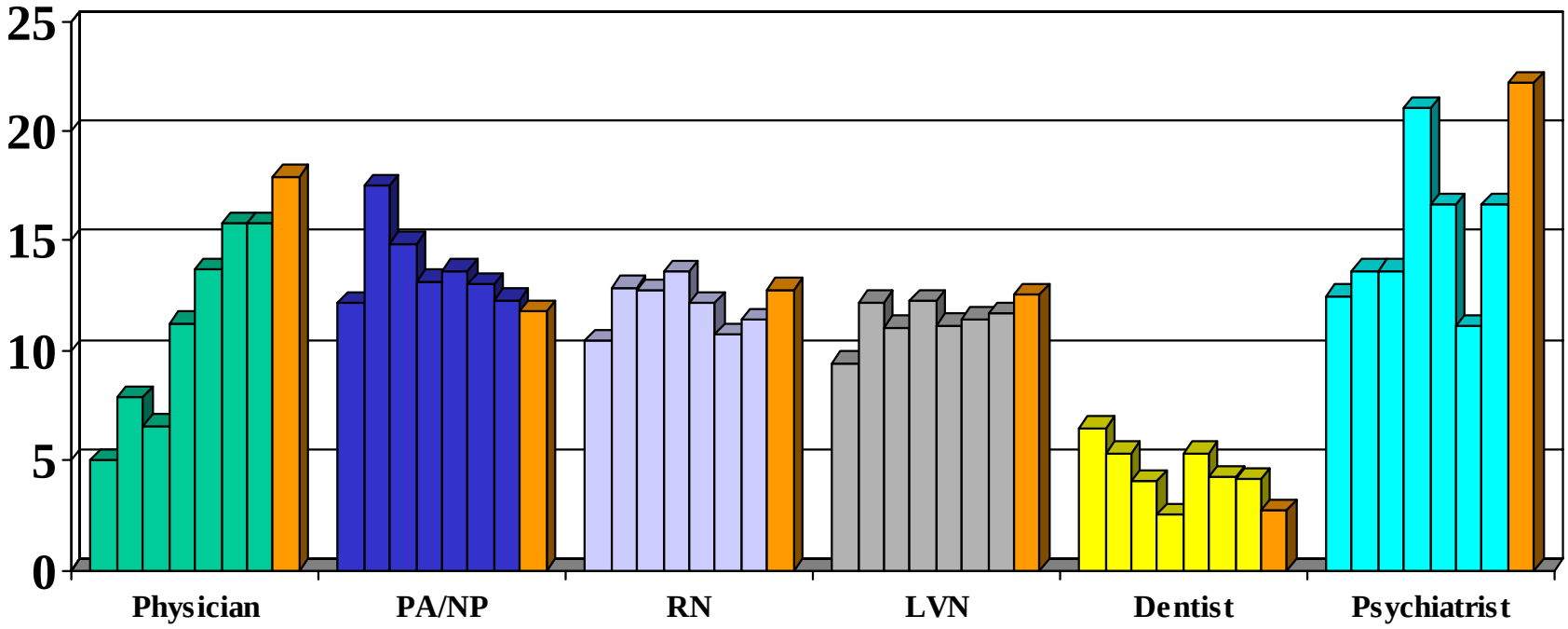
# Mental Health Access to Care
# Indicators FY 2006-2007 to Date



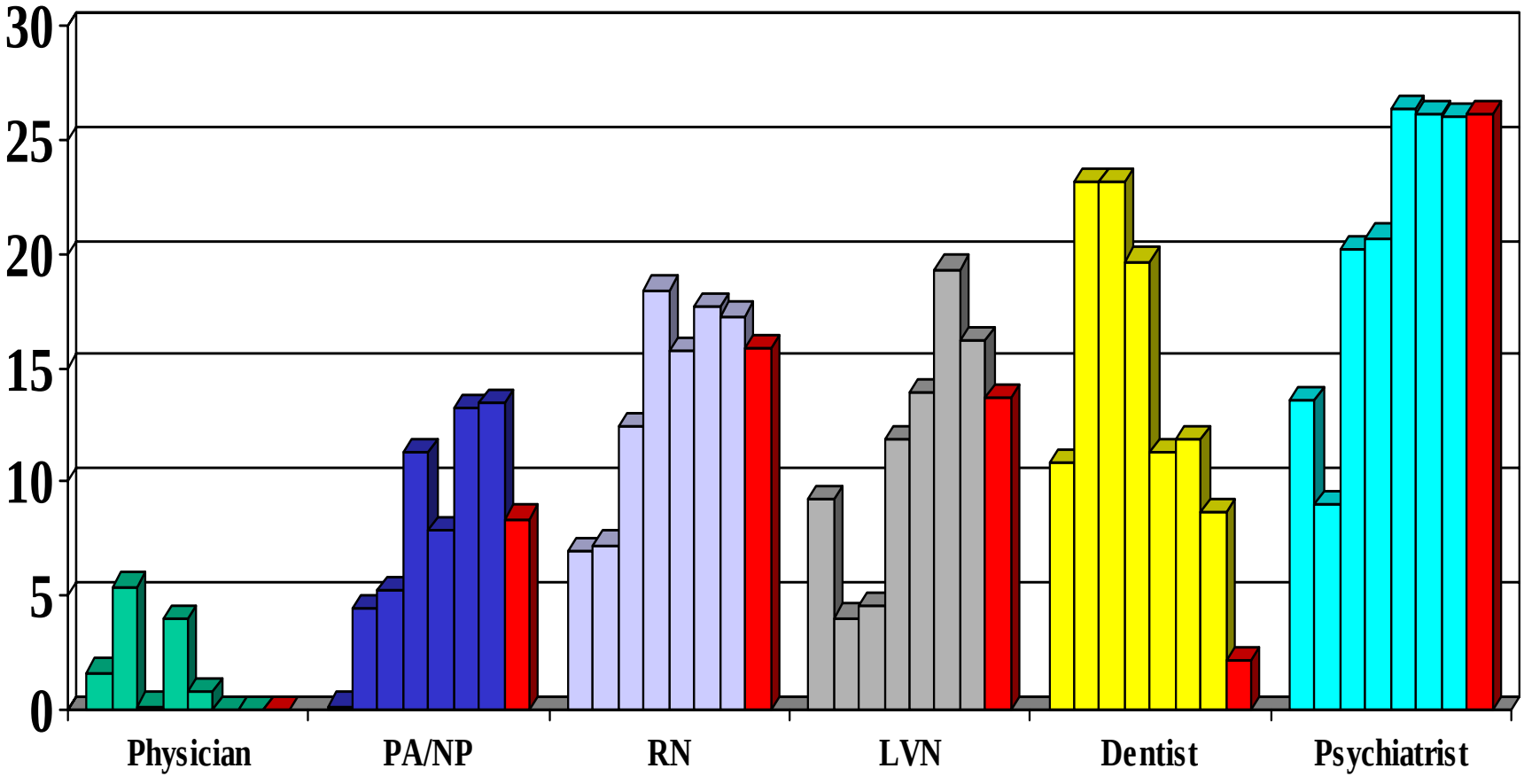
# Dental Access to Care
# Indicators FY 2006-2007 to Date



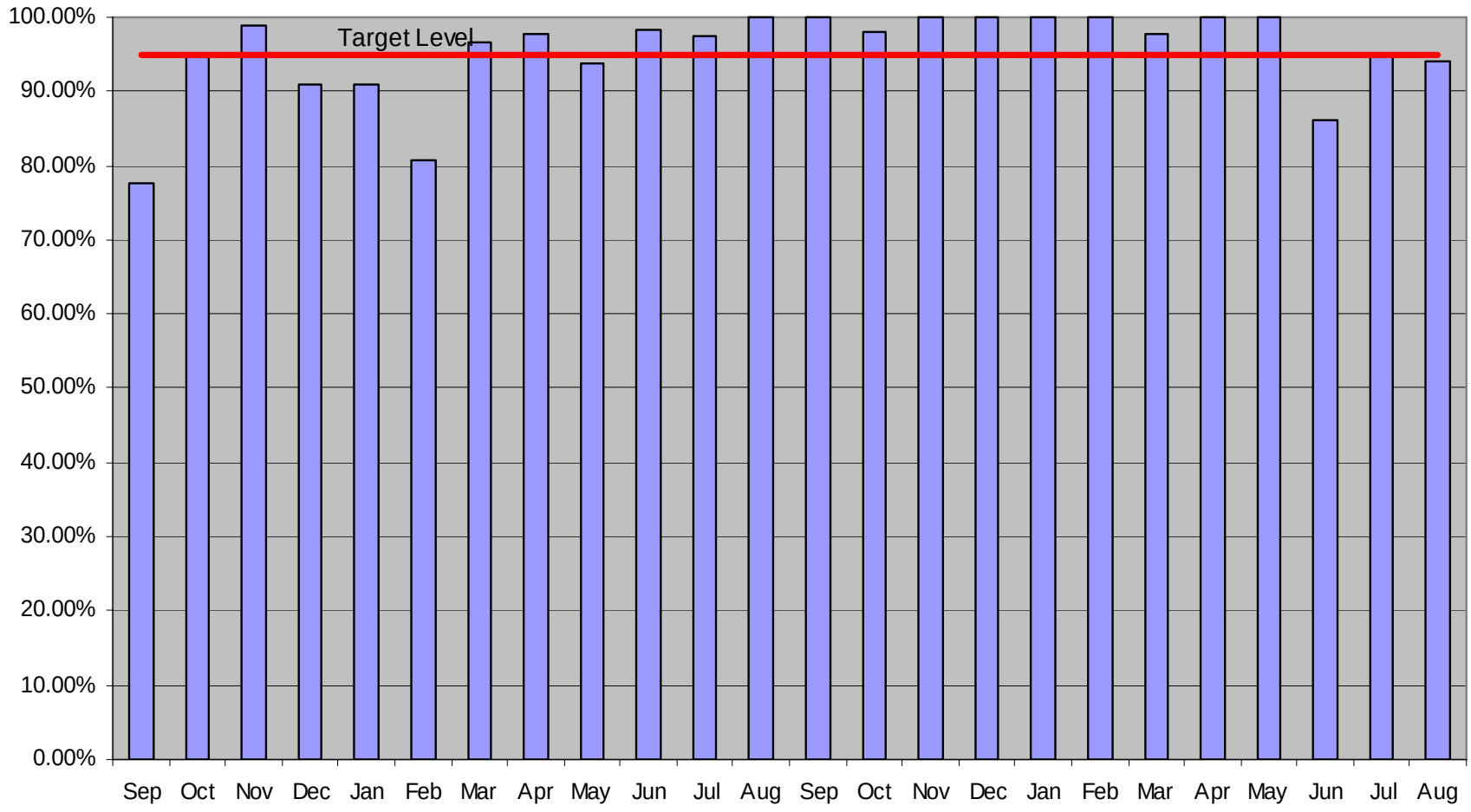
# UTMB Vacancy Rates (%) by Quarter FY 2006-FY 2007



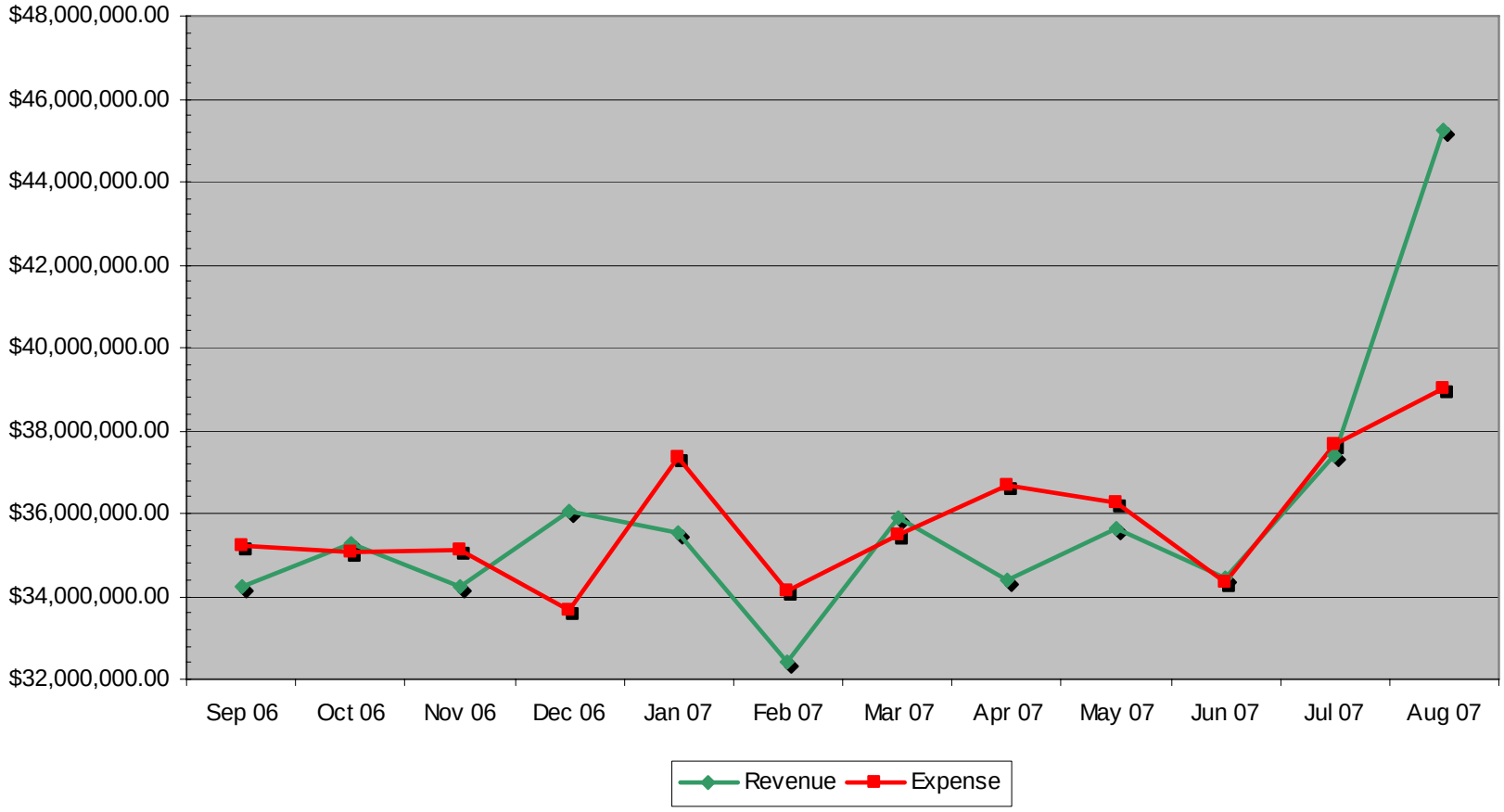
# TTUHSC Vacancy Rates (%) by Quarter FY 2006-FY 2007



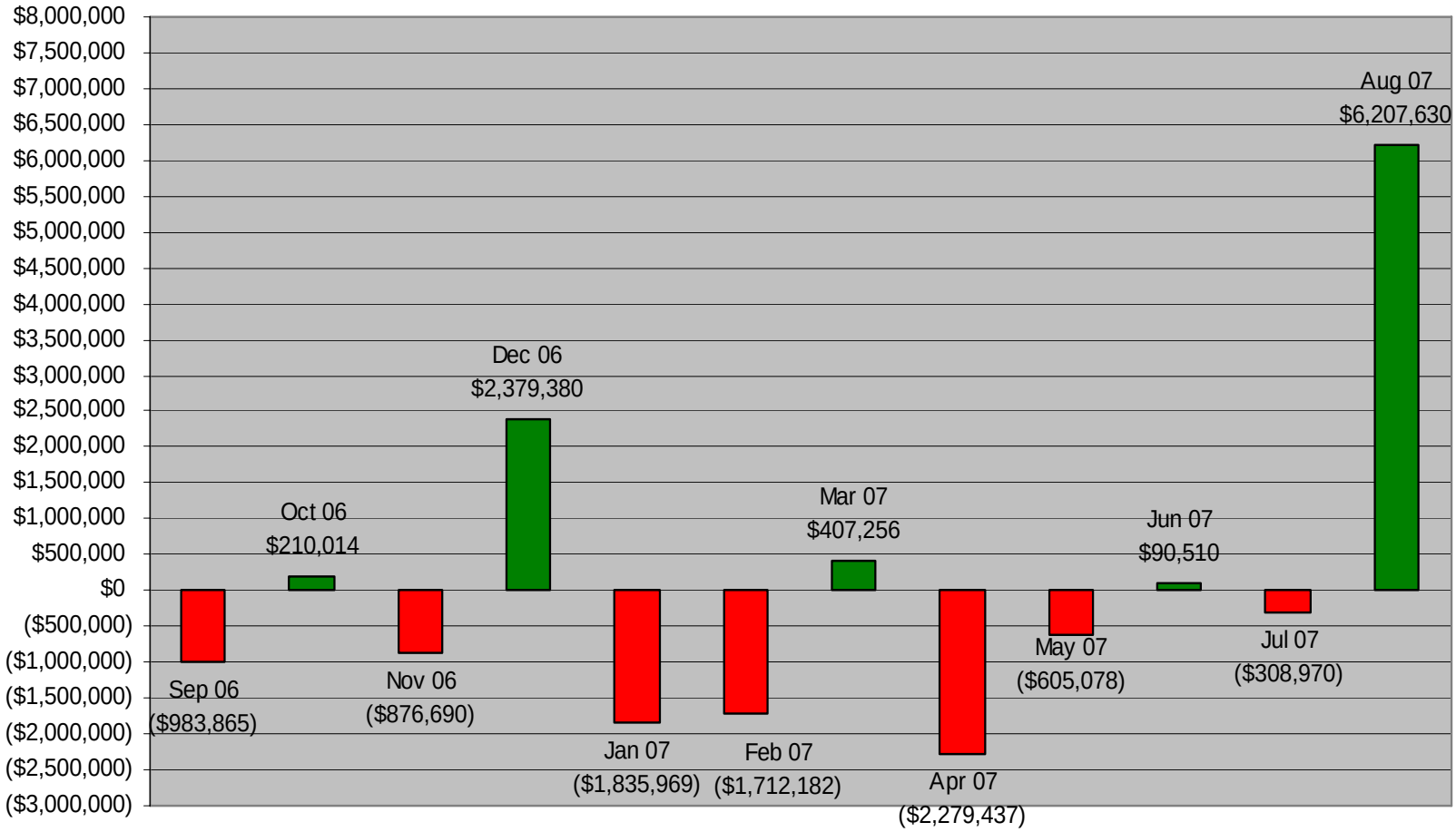
# Percent of Timely MRIS Summaries



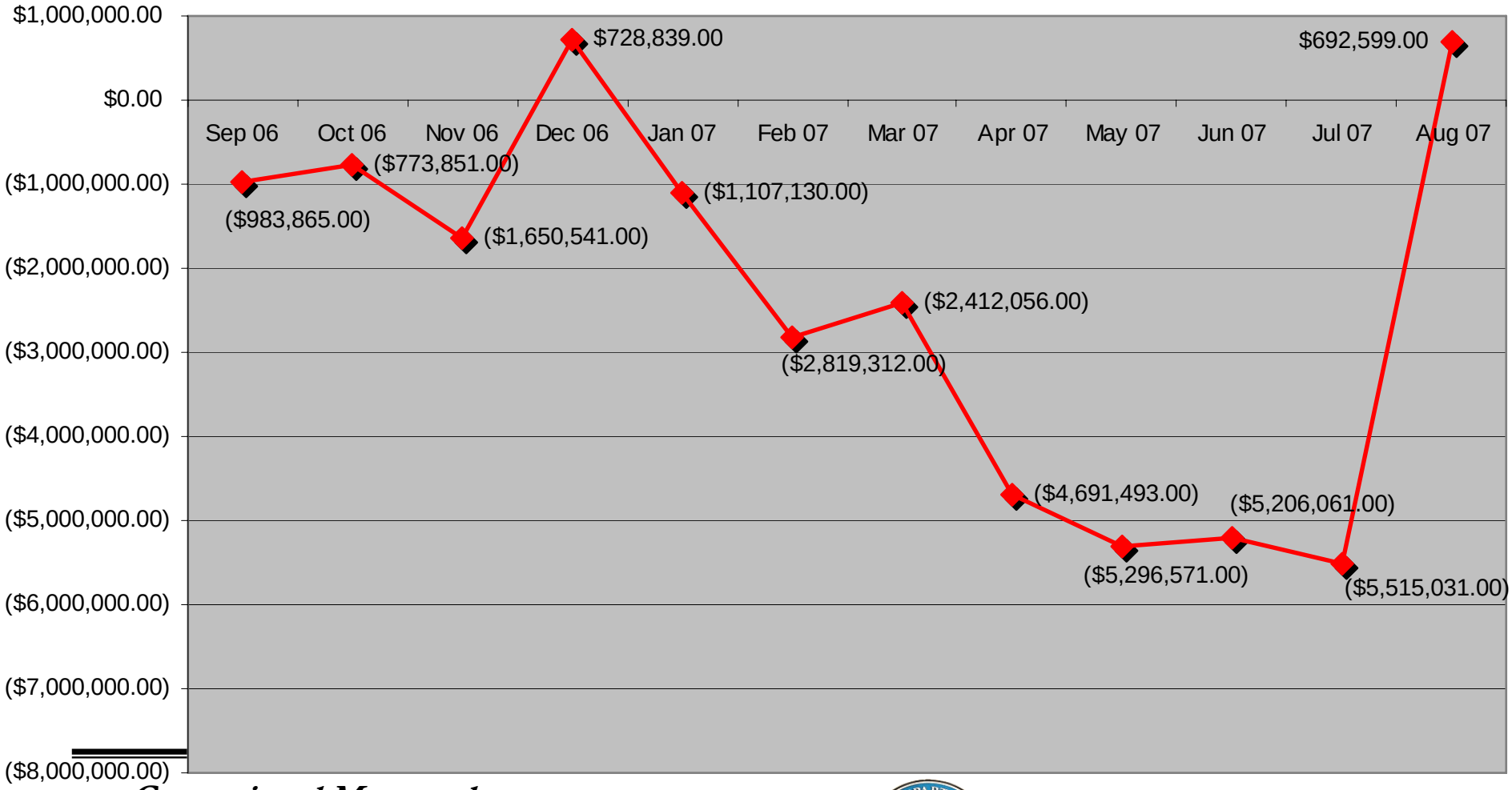
## Statewide Revenue v. Expenses by Month
## FY 2007



## Statewide Loss/Gain by Month
## FY 2007



# Statewide Cumulative Loss/Gain
# FY 2007



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

**As of November 2007**

| Title of Position | CMHC Partner Agency | Vacant Since (mm/yyyy) | Actions Taken to Fill Position |
|---|---|---|---|
| Director Mental Health Services CMC | UTMB CMC | 05/10/2006 | Offer accepted. Hire date February 1, 2008. |
| Clinical Director, Skyview Unit, MHS | UTMB CMC | 03/23/2007 | Filled effective September 1, 2007 |
| Physician I - III | UTMB CMC | 09/01/2006 | Local and national advertising, conferences, currently 18 vacancies system-wide including Hospital Galveston and TYC |
| Mid-Level Practitioners (PA and FNP) | UTMB CMC | 09/01/2006 | Local and national advertising, career fairs, conferences. Currently 18 openings system-wide, concentrated in Beeville and Palestine areas and include Mental Health Services. |

| Title of Position | CMHCC Partner Agency | Vacant Since (mm/yyy) | Actions Taken to Fill Position |
|---|---|---|---|
| PAMIO Mental Health Director | TTUHSC | 10/2005 | Recruitment agencies, National Correctional and Psychiatric Publication advertisements, salary increases. TTUHSC representatives attended Texas Association of Psychiatrist meeting on November 3, 2007 |
| Executive Director | TTUHSC | 03/2007 | Position filled November 8, 2007 |
| Dentist II – Quality & Contract Monitor | TDCJ | 06/2003 | The dentist position was made an agency full-time equivalent position. New dentist to begin working in the Health Services Division on Monday, November 19, 2007. |
| | | | |


# TEXAS DEPARTMENT OF CRIMINAL JUSTICE

# *HEALTH SERVICES DIVISION MEDICAL DIRECTOR'S REPORT*

***Fourth Quarter FY-2007***

***Lannette Linthicum, MD, CCHP-A, FACP***

# TDCJ Medical Director's Report

**Office of Health Services Monitoring (OHSM)**

**Operational Review Audit (ORA)**

- During the fourth quarter of FY-2007, 15 Operational Review Audits were conducted at the following facilities: Baten, Bridgeport, Clements, Clements PAMIO, Clements High Security, Dalhart, Hutchins, Johnston, Jordan, Kegans, Lindsey, Lychner, Mineral Wells, Neal and Plane State Jail. The 15 items most frequently out of compliance follow:

1. Item 5.11 requires Emergency Room Forms (HSM-16), to be filled out completely and legibly to include assessment, intervention, medications administered, disposition and signature. 12 of the 15 facilities were not in compliance with this requirement. The 12 facilities out of compliance were: Baten, Clements, Dalhart, Hutchins, Johnston, Jordan, Kegans, Lindsey, Lychner, Mineral Wells, Neal and Plane. Corrective actions were requested of the 12 facilities, all of which were submitted. The Jordan Facility Corrective Action Plan was approved on 9/28/07. 11 of the 12 facility audits remain open.

2. Item 5.19 requires the medical provider document on the Report of Physical Exam (HSM-4), physical exams annually, on male offenders sixty (60) years of age or older. 12 of the 15 facilities were not in compliance with this requirement. The 12 facilities out of compliance were: Baten, Clements, Clements Pamio, Clements High Security, Dalhart, Hutchins, Johnston, Jordan, Lindsey, Lychner, Mineral Wells and Neal. Corrective actions were requested of the 12 facilities, all of which were submitted. The Jordan Facility Corrective Action Plan was approved on 9/28/07. 11 of the 12 facility audits remain open.

3. Item 6.37 requires pneumococcal vaccine be offered to offenders with certain chronic diseases (e.g., heart disease, emphysema, COPD, diabetes). Note that asthma is not included, unless it is associated with COPD, emphysema or long term systemic steroid use. 12 of the 15 facilities were not in compliance with this requirement. The 12 facilities out of compliance were: Baten, Clements, Clements Pamio, Clements High Security, Dalhart, Hutchins, Johnston, Lindsey, Lychner, Mineral Wells, Neal and Plane. Corrective actions were requested of the 12 facilities, all of which were submitted. 12 of the 12 facility audits remain open.

4. Item 6.07 requires that TB-400 forms (Texas Department of Health-Tuberculosis Elimination Division) to be completed for the following conditions: (1) chemoprophylaxis, (2) identification of a TB suspect case, (3) diagnosis of a case of active TB, and (4) at termination/completion of TB therapy. 11 of the 15 facilities were not in compliance with this requirement. The 11 facilities out of compliance were: Baten, Clements, Clements Pamio, Clements High Security, Dalhart, Hutchins, Jordan, Lychner, Mineral Wells, Neal and Plane. Corrective actions were requested of the 11 facilities, all of which were submitted. The Jordan Facility Corrective Action Plan was approved on 9/28/07. Ten of the 11 facility audits remain open.

5. Item 6.36 requires the influenza vaccine be offered annually to certain chronic disease patients, all offenders over 55 years of age and older, pregnant females after the first trimester and that the vaccinations are documented on the Abstract of Immunization Record (HSM-2). If the vaccination is refused a signed Refusal of Treatment Form (HSM-82) must be placed in the medical record. 11 of the 15 facilities were not in compliance with this requirement. The 11 facilities out of compliance were: Baten, Bridgeport, Clements, Clements Pamio, Clements High Security, Dalhart, Johnston, Lindsey, Lychner, Mineral Wells and Neal. Corrective actions were requested of the 11 facilities, all of which were submitted. 11 of the 11 facility audits remain open.

**Operational Review Audit (ORA) Cont'd.**

6. Item 6.39 requires offenders who have been diagnosed with Methicillin-Resistant Staphylococcus Aureus (MRSA), Diabetes or Human Immunodeficiency Virus (HIV) Infection with an additional diagnosis of Methicillin-Sensitive Staphylococcus Aureus (MSSA), MRSA or Serious MSSA, to be placed on Directly Observed Therapy (DOT). If DOT was not utilized, documentation reflecting compliance checks every forty-eight (48) hours must be present. Ten of the 15 facilities were not in compliance with this requirement. The ten facilities out of compliance were: Baten, Clements, Clements Pamio, Clements High Security, Dalhart, Hutchins, Jordan, Lychner, Neal and Plane. Corrective actions were requested of the ten facilities, all of which were submitted. The Jordan Facility Corrective Action Plan was approved on 9/28/07. Nine of the ten facility audits remain open.

7. Item 5.20 requires physical exams to include a digital rectal exam and fecal occult blood testing; this is to be documented on the Report of Physical Exam (HSM-4), every three years on male offenders 50 to 59 years of age. Nine of the 15 facilities were not in compliance with this requirement. The nine facilities out of compliance were: Baten, Clements, Clements High Security, Dalhart, Hutchins, Johnston, Jordan, Lychner and Neal. Corrective actions were requested of the nine facilities, all of which were submitted. The Jordan Facility Corrective Action Plan was approved on 9/28/07. Eight of the nine facility audits remain open.

8. Item 6.04 requires all offenders receiving Tuberculosis (TB) preventive medication to have the following documentation in the medical record, monthly TB clinic visit, a completed Tuberculosis Patient Monitoring Record (HSM-19), compliance that has been accurately documented and toxicity checks. Nine of the 15 facilities were not in compliance with this requirement. The nine facilities out of compliance were: Baten, Clements, Clements High Security, Dalhart, Jordan, Kegans, Lindsey, Lychner, and Neal. Corrective actions were requested of the nine facilities, all of which were submitted. The Jordan Facility Corrective Action Plan was approved on 9/28/07. Eight of the nine facility audits remain open.

9. Item 6.40 requires Syphilis cases be reported at the time of diagnosis on the Syphilis Monitoring Record (HSM-85) to the Preventive Medicine Department, in addition, the stage must be identified on each report. Nine of the 15 facilities were not in compliance with this requirement. The nine facilities out of compliance were: Baten, Clements, Clements High Security, Dalhart, Hutchins, Johnston, Kegans, Neal and Plane. Corrective actions were requested of the nine facilities, all of which were submitted. Nine of the nine facility audits remain open.

10. Item 5.09 requires the medical record of each offender receiving a therapeutic diet contain the type, duration, and that the order does not exceed 365 days. Eight of the 15 facilities were not in compliance with this requirement. The eight facilities out of compliance were: Baten, Bridgeport, Clements PAMIO, Clements High Security, Dalhart, Hutchins, Johnston and Lychner. Corrective actions were requested of the eight facilities, all of which were submitted. Eight of the eight facility audits remain open.

11. Item 5.10 requires in the medical records of offenders who have been receiving therapeutic diets in excess of seven days, reflect that nutritional counseling has been provided within 30 days, including the diet type and duration. Eight of the 15 facilities were not in compliance with this requirement. The eight facilities out of compliance were: Baten, Bridgeport, Clements High Security, Dalhart, Lychner, Mineral Wells, Neal and Plane. Corrective actions were requested of the eight facilities, all of which were submitted. Eight of the eight facility audits remain open.

**Operational Review Audit (ORA) Cont'd.**

12. Item 5.12 requires all offenders placed in administrative segregation medical record is reviewed and a physical examination is to be completed within 12-hours. Eight of the 15 facilities were not in compliance with this requirement. The eight facilities out of compliance were: Clements, Clements High Security, Dalhart, Hutchins, Jordan, Lychner, Neal and Plane. Corrective actions were requested of the eight facilities, all of which were submitted. The Jordan Facility Corrective Action Plan was approved on 9/28/07. Seven of the eight facility audits remain open.

13. Item 5.14 requires the dated and signed Certification and Record of Segregation Visits form and a current housing list to be attached. Eight of the 15 facilities were not in compliance with this requirement. The eight facilities out of compliance were: Baten, Clements High Security, Dalhart, Hutchins, Johnston, Jordan, Lindsey and Neal. Corrective actions were requested of the eight facilities, all of which were submitted. The Jordan Facility Corrective Action Plans was approved on 9/28/07. Seven of the eight facility audits remain open.

14. Item 6.34 requires the Correctional Managed Health Care Protocol for Chronic Hepatitis C initiated after an offender has two elevated ALT levels which are two times the upper limits of normal over a period of six months or longer. Eight of the 15 facilities were not in compliance with this requirement. The eight facilities out of compliance were: Clements PAMIO, Clements High Security, Dalhart, Kegans, Lindsey, Lychner, Neal and Plane. Corrective actions were requested of the eight facilities, all of which were submitted. Eight of the eight facility audits remain open.

15. Item 6.35 requires if the provider determines treatment is not indicated for Hepatitis C, the reason must be documented in the medical record. Eight of the 15 facilities were not in compliance with this requirement. The eight facilities out of compliance were: Clements PAMIO, Clements High Security, Dalhart, Kegans, Lindsey, Lychner, Neal and Plane. Corrective actions were requested of the eight facilities, all of which were submitted. Eight of the eight facility audits remain open

**Grievances and Patient Liaison Correspondence**

During the fourth quarter of FY-2007 (June, July, and August), the Patient Liaison Program and the Step II Grievance Program received 3,053 correspondences: Patient Liaison Program with 1,359 and Step II Grievance with 1,694. Of the total number of correspondence received, 182 (5.96 percent) Action Requests were generated by the Patient Liaison Program and the Step II Grievance Program.

**Quality Improvement (QI) Access to Care Audits**

During this fourth quarter, the Quality Improvement/Quality Monitoring (QI/QM) staff performed 40 Access to Care audits. The Access to Care audits that were conducted looked at verification of facility information and a random sample conducted by the Office of Health Services Monitoring (OHSM) staff. Of the 40 facilities, representing a total of 360 indicators reviewed, 37 of them fell below the 80 percent threshold representing 10.3 percent. This is a noted decrease from previous quarters.

**Capital Assets Monitoring**

The Capital Assets Contract Monitoring Office audited 13 units during the fourth quarter. These audits are conducted to determine compliance with the Health Services Policy and State Property Accounting (SPA) policy inventory procedures. Audit findings document that 11 of the 13 units audited were within the compliance range: Baten, Clements, Clements PAMIO, Clements High Security, Dalhart, Hutchins, Jordan, Kegans, Lychner, Neal and Plane. The facilities findings of Lindsey and Johnston were not in the acceptable range, corrective action plans were requested from the two facilities.

**Office of Preventive Medicine**

The Preventive Medicine Program monitors the incidence of infectious disease within the Texas Department of Criminal Justice. The following is a summary of this monitoring for the fourth quarter of FY-2007:

- 169 reports of suspected syphilis this quarter compared with 171 in the previous quarter of FY-2007. These figures represent a slight overestimation of actual number of cases, as some of the suspected cases will later turn out to be resolved prior infection rather than new cases.

- 1,285 Methicillin-Resistant Staphylococcus Aureus (MRSA) cases were reported compared to 1,560 during the same quarter of FY-2006.

- There was an average of 21 Tuberculosis (TB) cases under management per month during this quarter, which is the same average of 21 per month during the same quarter of the previous fiscal year.

- Last year of FY-2006, the Office of Preventive Medicine began reporting the activities of the Sexual Assault Nurse Examiner (SANE) Coordinator. This position is funded through the Safe Prisons Program and is trained and certified as a SANE. Although we do not teach the SANE Curriculum because of restrictions imposed by the State Attorney General's Office, the position provides inservice training to unit providers in the performance of medical examination, evidence collection and documentation, and use of the sexual assault kits. 33 training sessions have been held on 28 units so far this year, with 184 medical staff receiving training. This position also audits the documentation and services provided by medical personnel for each sexual assault reported. There have been 414 chart reviews performed for the period of January through August 2007. During the last quarter of FY-2007, three charts were found not in compliance. The area of non-compliance was referral for mental health services. For the 104 alleged assaults in which the perpetrators were known, audits were also conducted on perpetrator charts; all records were compliant for appropriate referrals. From January to May 2007, 89 baseline labs have been drawn on victims/perpetrators. These baseline labs are reviewed monthly for appropriate follow-up. 100 percent compliance has been found to date.

- The number of peer educators decreased from last year because those who are inactive or who have been released were removed from the roster. There are currently programs on 94 of 111 units. Only the Goodman Unit, Private Facilities, and Substance Abuse Facility Program (SAFP) facilities do not have peer education programs at this point.

**Mortality and Morbidity**

There were 100 deaths reviewed by the Mortality and Morbidity Committee during the months of June, July, and August 2007. Of those 100, ten were referred to peer review committees.

| **Peer Review Committee** | **Number of Cases Referred** |
|---|---|
| Physician & Nursing Peer Review | 4 |
| Nursing Peer Review | 1 |
| Physician Peer Review | 2 |
| Allied Mental Health & Nursing Peer Review | 1 |
| Allied Mental Health Peer Review | 2 |
| **Total** | **10** |

**Mental Health Services Monitoring & Liaison**

The following is a summary of the activities performed by the Office of Mental Health Monitoring and Liaison (OMH M&L) during the fourth quarter of FY-2007.

- 81 contacts were made with County Jails identified 200 offenders with immediate mental health needs prior to TDCJ intake.

- The Mental Health/Mental Retardation (MH/MR) history was reviewed for 19,267 offenders brought into TDCJ ID/SJ. Intake facilities were provided with critical mental health data, not otherwise available, for 1,194 offenders.

- 2,467 Texas Uniform Health Status Update forms were reviewed identifying 526 deficiencies (primarily incomplete data).

- 51 offenders were screened for TDCJ Boot Camp.

- 17 Administrative Segregation facilities were visited, 4,160 offenders observed, 1,728 interviewed, and six referred for further evaluation. Access to Care was above 80 percent for all facilities with 14 being 100 percent.

**Clinical Administration**

**Health Services Liaison Utilization Review Monitoring**

During the fourth quarter of FY-2007 ten percent of the combined UTMB and TTUHSC hospital (2,196) and infirmary (472) discharges were audited. The chart below is a summary of the audits showing the number of cases with deficiencies and the percentage.

**Hospital Discharges**

| Month | Unstable Discharges [1] (Cases with deficiencies) | Readmissions [2] (Cases with deficiencies) | Lack documentation (Cases with deficiencies) |
|---|---|---|---|
| June 2007 | 1% | 1% | <1% |
| July 2007 | 3% | <1% | <1% |
| August 2007 | 2% | <1% | <1% |

**Infirmary Discharges**

| Month | Unstable Discharges [1] (Cases with deficiencies) | Readmissions [2] (Cases with deficiencies) | Lack documentation (Cases with deficiencies) |
|---|---|---|---|
| June 2007 | <1% | 0% | 0% |
| July 2007 | <1% | 0% | 0% |
| August 2007 | 0% | 0% | <1% |

Footnotes:

[1] Discharged patient offenders were unable to function in a general population setting.

[2] Discharged patient offenders required emergency acute care or readmission to tertiary level care within a 7 day period.

**Accreditation**

On August 12, 2007, American Correctional Association (ACA) Accreditation hearings were held at the 2007 ACA Summer Conference in Kansas City, Missouri. A total of eight units were presented to the panel of commissioners for initial accreditation: Central, Clemens, Dalhart, Gatesville, Goree, Huntsville, Hutchins, and Jester IV. The Agency now has a total of 72 accredited units, the Baten ISF and Correctional Training Department.

**Research, Evaluation and Development (RED) Group**

The following is a summary of current and pending research projects as reported by the RED Group:

- Health Services Division Active Monthly Medical Research Projects – 15
- Correctional Institution Division Active Monthly Medical Research Projects – 28
- Academic Longitudinal Research Projects – 5
- Academic Research Projects pending approval – 9

**TEXAS CORRECTIONAL OFFICE ON OFFENDERS WITH MEDICAL OR MENTAL IMPAIRMENTS**
**CONTINUITY OF CARE STATISTICAL REPORT**
**FISCAL YEAR 2007**

## I. REFERRALS / SOURCES

A. Offenders Referred by Referral Source

| | | |
|---|---|---|
| Monthly I.T. Data Report | | 2576 |
| Parole Division (HV Placement; ISF) | | 43 |
| BPP Condition "P" | | 513 |
| TCOOMMI - MRIS | | 19 |
| Unit Staff (classification, medical, psych) | | 112 |
| Family/Self | | 0 |
| Regional COC Worker | | 31 |
| OD Field Services | | 5 |
| Health Services Liaison | | 7 |
| Flat/State Jail discharge post card | | 1836 |
| | **TOTAL** | **5142** |

## II. RELEASES BY RELEASE TYPE/DIAGNOSIS

| | | |
|---|---|---|
| Mandatory Supervision | | 1105 |
| Parole | | 1054 |
| Flat Discharge | | 572 |
| State Jail Discharge | | 1286 |
| | **TOTAL** | **4017** |

**Medical**

| | | |
|---|---|---|
| HIV | | 327 |
| Dialysis | | 51 |
| Other | | 46 |
| | **TOTAL** | **424** |

**Psychiatric**

| | | |
|---|---|---|
| Bipolar | | 948 |
| Major Depression | | 1385 |
| Schizophrenia | | 968 |
| Mentally Retarded / other | | 33 |
| BPP imposed "P" | | 259 |
| | **TOTAL** | **3593** |

## III. SAFP RELEASES BY DIAGNOSIS

| | | |
|---|---|---|
| Bipolar | | 213 |
| Major Depression | | 136 |
| Schizophrenia | | 84 |
| Mentally Retarded | | 4 |
| Other | | 3 |
| | **TOTAL** | **440** |

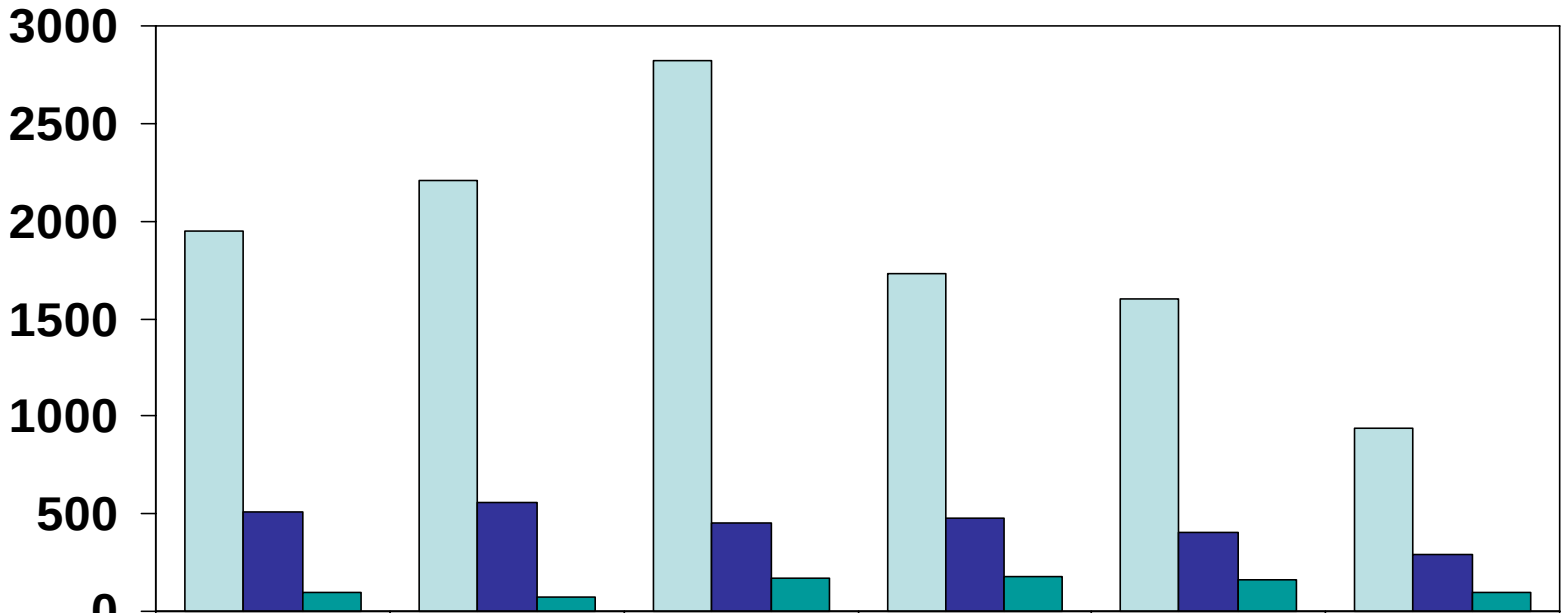
# Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI)

## Medically Recommended Intensive Supervision (MRIS)

## FY07 Annual Report

***The MRIS program provides for the early parole review and release of certain categories of offenders who are mentally ill, mentally retarded, elderly, terminally ill, long term care or physically handicapped. The purpose of MRIS is to release inmates, who pose minimal public safety risk, from incarceration to more cost effective alternatives.***

# MRIS Data Comparison (by fiscal year)




| | FY 2002 | FY 2003 | FY 2004 | FY 2005 | FY 2006 | FY 2007 |
|---|---|---|---|---|---|---|
| Screened** | 1952 | 2211 | 2821 | 1729 | 1600 | 941 |
| Presented | 510 | 560 | 453 | 475 | 401 | 290 |
| Approved | 97 | 75 | 167 | 174 | 161 | 101 |

**Includes ineligible referrals such as sex offenders, ineligible 3g or inmates with no qualifying medical condition.

# MRIS FY07 Referral Status

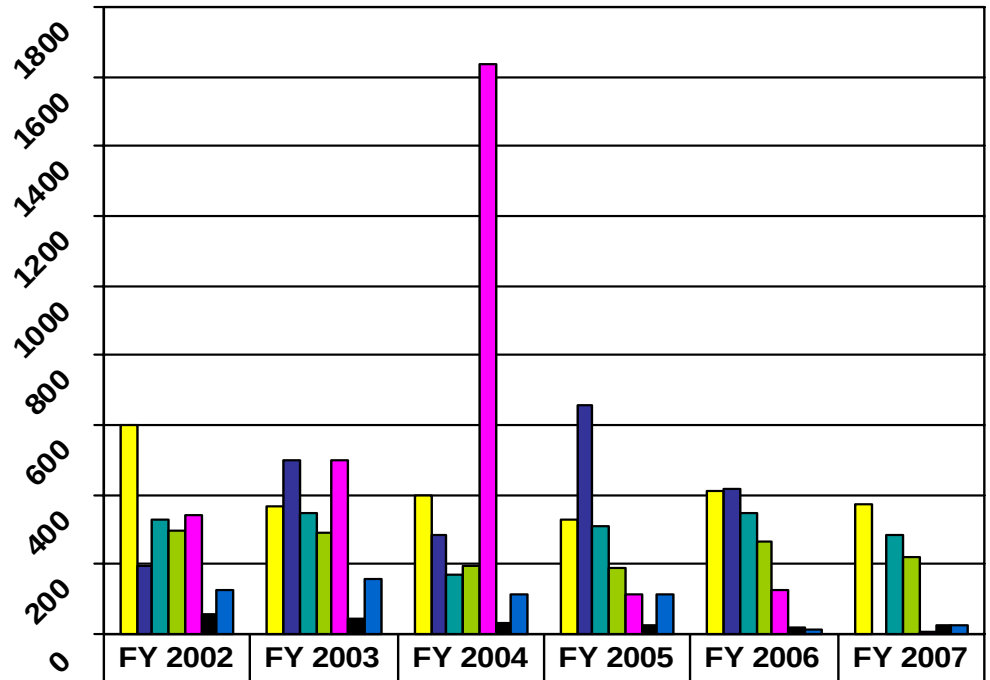
## Eligible

| | |
|---|---|
| Presented to BPP | 290 |
| Clinical Criteria Not Met | 182 |
| Offender Referred to Unit Medical | 127 |
| Deceased Prior to BPP Presentation | 35 |
| Pending Presentation to BPP at close of FY07 | 14 |
| Pending Response from Unit Medical at close of FY07 | 12 |
| Refused MRIS | 6 |
| Active Detainer | 6 |
| Total Eligible Referrals | 672 |

## Ineligible

| | |
|---|---|
| Sex Offender | 179 |
| Parole Approved | 49 |
| Not an Inmate (State Jail or SAFPF) | 26 |
| 3G / Not Long Term Care or Terminally Ill | 15 |
| Total Ineligible Referrals | 269 |

# MRIS Referral Sources (Comparison by fiscal year)




| | FY 2002 Total 1952 | FY 2003 Total 2211 | FY 2004 Total 2821 | FY 2005 Total 1729 | FY 2006 Total 1600 | FY 2007 Total 941 |
|---|---|---|---|---|---|---|
| Unit Medical Staff | 599 | 367 | 395 | 327 | 409 | 372 |
| Data Report | 198 | 502 | 282 | 655 | 414 | 0 |
| Family | 331 | 350 | 169 | 311 | 350 | 286 |
| Offender | 298 | 289 | 197 | 189 | 268 | 223 |
| Re-reviews | 340 | 501 | 1636 | 112 | 126 | 9 |
| Attorney/Advocacy | 58 | 45 | 29 | 23 | 21 | 25 |
| State Agencies | 128 | 157 | 113 | 112 | 12 | 26 |

# MRIS FY07
# Presented to BPP by Diagnosis

| | |
|---|---|
| Terminally Ill | 106 |
| Physically Handicapped | 17 |
| Elderly | 5 |
| Long Term Care | 152 |
| Mentally Ill | 10 |
| Mentally Retarded | 0 |
| Total Presented | 290 |

# MRIS Approval Rates by Diagnosis (Comparison by fiscal year)

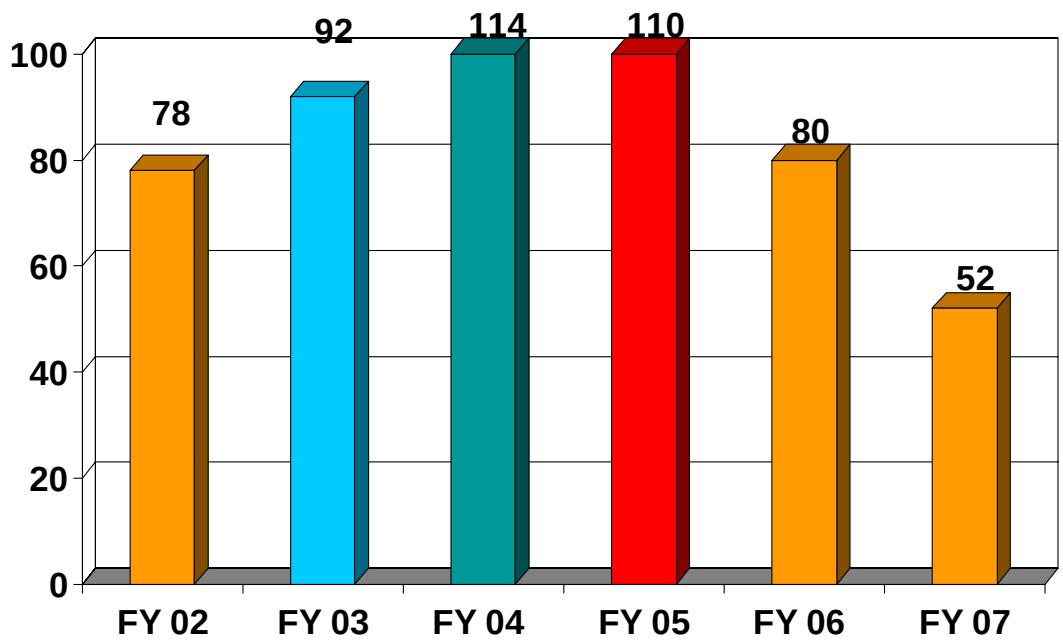
| | FY 2002 | FY 2003 | FY 2004 | FY 2005 | FY 2006 | FY 2007 |
|---|---|---|---|---|---|---|
| Terminally Ill | 54 | 37 | 92 | 79 | 84 | 58 |
| Physically Handicapped | 4 | 6 | 7 | 2 | 0 | 0 |
| Elderly | 9 | 3 | 9 | 2 | 1 | 0 |
| Long Term Care | 29 | 25 | 55 | 90 | 75 | 42 |
| Mentally Ill | 1 | 4 | 4 | 1 | 1 | 1 |
| Mentally Retarded | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total Approvals** | **97** | **75** | **167** | **174** | **161** | **101** |

# Status of FY07 Approved Cases

| | |
|---|---|
| Released | 81 |
| Deceased Prior to Release | 11 |
| Pending Release | 6 |
| MRIS Vote Withdrawn | 3 |
| Total Approved | **101** |

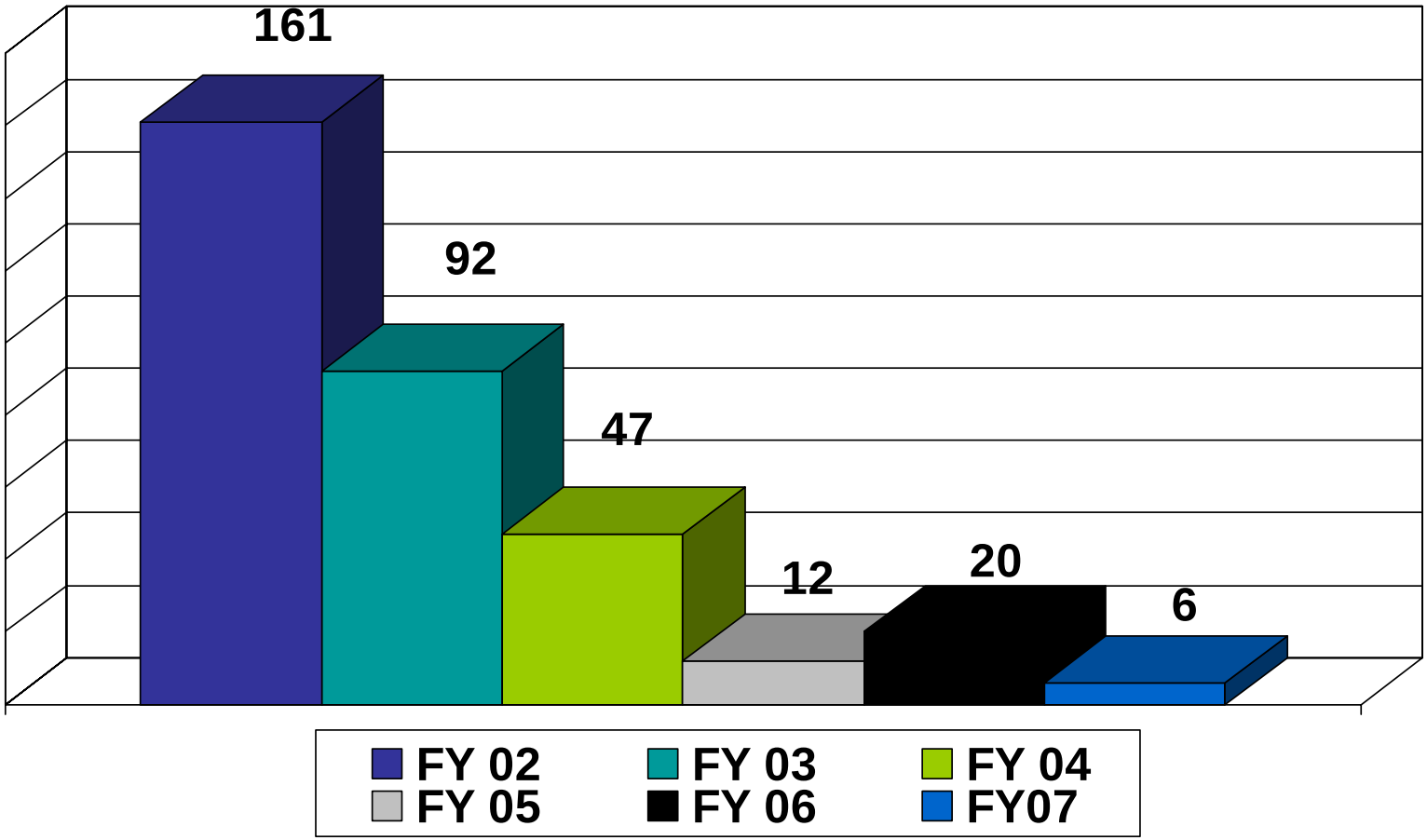
Reflects status of approved cases as of 08/31/2007

# Deaths During the MRIS Process (Comparison by fiscal year)

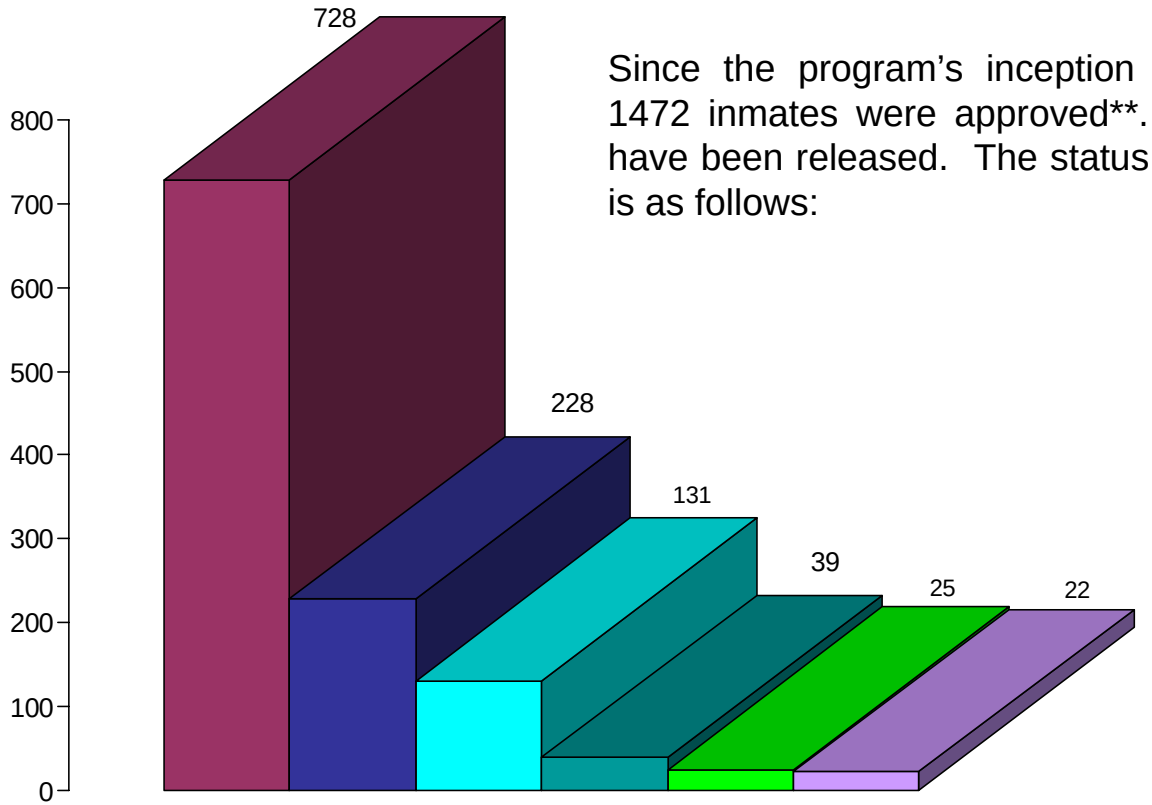



| **FY 07:** | |
|---|---|
| •After Referral ~ Prior to Receipt of MRIS Medical Summary | 0 |
| •After Receipt of MRIS Medical Summary ~ Processing for Presentation to Parole Board | 35 |
| •Pending Parole Panel Decision | 5 |
| •Approved, Pending Placement/Release | 12 |

# Inmate Refusals for MRIS Consideration (Comparison by fiscal year)



# MRIS Total Program Releases to Date




Since the program's inception on December 1, 1991, 1472 inmates were approved**. Of this, 1173 Inmates have been released. The status of these released cases is as follows:

- Deceased Post Release - 62%
- Currently On Supervision - 20%
- Discharged Parole - 11%
- Currently in TDCJ Custody - 3%
- Returned toTDCJ; Departed Other - 2%
- Other (Absconder, Deported, FCI, Other State Custody) - 2%

| | | |
|---|---|---|
| ** | 243 | Deceased Prior to Release |
| | 44 | MRIS Vote Withdrawn Prior to Release |
| | 6 | Approved - Still Pending Release as of 8/31/2007 |
| | 6 | Approved Twice After Returning to Custody |

# Article V Rider
## related to
## TCOOMMI and TDCJ

**74. Medically Recommended Intensive Supervision.** It is the intent of the Legislature that the Texas Department of Criminal Justice (TDCJ) develop an automated report to assist in identifying offenders eligible for medically recommended intensive supervision (MRIS). TDCJ should work with the University of Texas Medical Branch and the Texas Tech University Health Sciences Center to develop uniform diagnosis codes to signal offenders eligible for release on MRIS.

It is also the intent of the Legislature that the TDCJ expedite its screening process for MRIS by requesting an offender's board file at the same time it assigns a caseworker to complete an interview of the offender.

# *An Overview of the System Leadership Council (SLC)*

***For the***
***Correctional Managed Health Care Committee***
***December 4, 2007***

# *A Delegated Authority*

Monitoring and reporting on the quality of health care activities by the University Partners is done by the TDCJ Health Services Division. The results are reported to the CMHCC and the Texas Board of Criminal Justice.

The CMHCC delegated authority and accountability of the Quality Improvement Plan to the SLC.

**SLC Purpose**

To provide a streamlined, integrated, clinically-driven state-of-the-art Quality Improvement Program (QIP) demonstrating that quality activities are consistently and continuously applied/measured and meet or exceed regulatory requirements.

# System Leadership Council (SLC)

- SLC: A multidisciplinary committee composed of clinical and administrative discipline directors who have primary oversight for the health care delivery systems of the Correctional Managed Health Care program. The SLC is responsible for the implementation and oversight of the CMHC quality improvement plan.
- Mission: To monitor Access To Care and Quality of Care through processes of ongoing monitoring and evaluation that assess the adequacy and appropriateness of the care provided and to institute corrective action as needed.
- Meetings are held quarterly in Huntsville.
- The SLC provides reports to the CMHCC at its quarterly meetings.

# *SLC Structure and Composition*

Chairperson: Appointed annually by the presiding chair of the CMHCC.

Members: (**ex-officio** or their designees):

- TDCJ Health Services Division Director
- TTUHSC Executive Medical Director
- UTMB Executive Medical Director
- TTUHSC Director of Mental Health Services
- UTMB Director of Mental Health Services
- TDCJ Health Services Director, Clinical Administration
- TTUHSC Executive Director of Correctional Health
- UTMB Executive Director of Correctional Health
- TDCJ Health Services Chief of Professional Standards
- TTUHSC Director of Quality Improvement

# *SLC Structure and Composition (continued)*

SLC Members (continued):

- Chairperson, Psychology Peer Review Committee
- Pharmacy Director
- Director, Preventive Medicine
- TTUHSC Dental Services Director
- UTMB Dental Services Director
- TDCJ Health Services Director of Clinical Services
- TDCJ Health Services Liaison
- TTUHSC and UTMB Regional Physician
- TTUHSC and UTMB Regional Nurse
- CMHCC Staff Representative

# SLC Quarterly Agenda

- Reports are presented from Champions/Discipline Directors on the nine (9) Access To Care (ATC) Indicators.
- Reports are presented on Continuity of Care Indicators.
- CMHCC staff provide updates.
- TDCJ Health Services presents the Monthly Grievance Exception Report.
- TDCJ Health Services presents a Safe Prisons Update.
- Other pertinent issues related to the provision and monitoring of offender health care are presented (e.g. EMR, sick call requests, Joint Nursing Reports, security issues etc.)

# *SLC Quarterly Agenda (continued)*

During its scheduled quarterly meeting, the SLC will

- Consider and review consolidated quarterly QI reports from all Units.
- Discuss reports on special issues concerning correctional health services.
- Approve the quarterly report for submission to CMHCC.

# SLC Functions

SLC traditional functions include:

- Providing direction and support for the Quality Improvement Plan (QIP).
- Using data collected to identify aspects of care for system-wide improvement.
- Facilitate information flow to the unit medical facilities.
- Provide support and direction to the facility leadership councils.
- Receive/evaluate reports; recommend corrective action.
- Review and evaluate the QIP annually.

# *Access To Care (ATC) Indicators*

- There are nine (9) Access to Care Indicators: Three (3) are **dental**, three (3) are **medical**, and three (3) are **mental health**. The Access to Care Indicators monitor compliance with CMHC policy governing sick call and daily triaging of health care complaints.
- Discipline Directors from UTMB and TTUHSC review consolidated quarterly Access to Care indicator reports from their respective facilities. The discipline director then makes a verbal report to the entire SLC and where deficiencies exist, appropriate corrective action is outlined.

# *SLC Continuity of Care (CoC) Indicators*

- Continuity of Care indicators are developed annually by the SLC.

- SLC members submit indicators for consideration by the committee and these indicators are voted upon at the end of each fiscal year for the ensuing year.

# *Previous SLC (CoC) Indicators*

FY 2006 – (3 indicators)

1. MRSA
2. Medical Orders (pharmacy distribution within 72 hours)
3. No Show Security

FY 2007 – (3 indicators)

1. Antibiotic Medication
2. Updated PULHES
3. Dental X-Ray Focus Study

# *Compliance Actions FY 2006-2007*

| Monitor | Issues | Action |
|---|---|---|
| **ATC Indicators** | Staff Shortages | Recruiting/Retention Strategies |
| | Sick Call Processing | Sick Call Audit; global re-education of nursing staff on SC process |
| | EMR reminders | EMR on-site training for reminders |
| **No Show Security** | Transport (on site appts) | Coordinated and directed effort by Champions with unit wardens at problematic facilities |
| **MRSA** | Obtaining cultures | All units that reported "no draining lesions" were subjected to additional scrutiny and training |
| **Dental X-Ray Focus Study** | Dental X-Ray availability during offender transport | Change in dental transport folder and re-education on x-ray transport process |

# *FY 2008 Compliance Monitoring*

- (9) ATC Indicators
- (4) SLC (Continuity of Care) Indicators
  - Continuity of Care – Updated PULHES
  - Continuity of Care – Post-Op Antibiotic Meds
  - Continuity of Care – CD4/Viral Analysis follow-up
  - Continuity of Care – MRSA on DOT

* Staffing issues: The vast majority of ATC compliance issues noted in FY06-07 were due to staffing shortages. To maintain Access To Care and to provide Quality Care, there must be adequate levels of appropriately trained staff. Difficulty with recruitment and retention of Nursing (and provider) staff in Correctional Health is an issue that will continue to command our attention and vigilance.

## Synopsis of Hepatitis Policy Changes:

1. Entire policy was rewritten and reformatted. It was separated into two documents, one containing the policy requirements, and the other a technical reference that gives background information and serves as a resource for clinical decision making.

2. Adds requirements for baseline testing, chronic care follow-up and criteria to consider antiviral treatment for hepatitis B that are distinct from hepatitis C and follow guidelines of the American Association for the Study of Liver Disease. The criteria for treatment are based on the amount of virus detectable in serum, the ALT level and whether “e” antigen is present. Previous criteria were the same as for hepatitis C and based only on the ALT level.

3. The criteria for considering an offender with hepatitis C for antiviral treatment has changed considerably. The basic criterion is a new indicator, the AST Platelet Ratio Index (APRI) which correlates with fibrosis in the liver. APRI scores below 0.42 will generally not be considered for treatment. Those with scores over 1.2 will be considered for treatment without a liver biopsy. Those with scores in between will have a liver biopsy and be treated according to the findings.

4. Retreatment for hepatitis C may now be considered if an offender relapsed after treatment with standard interferon with or without ribavirin, or who did not respond to standard interferon alone.

5. A new section has been added for management of advanced liver disease. Included in this section is screening for hepatocellular carcinoma by ultrasound every 6 months, considering referral for liver transplant evaluation, instructions to obtain an advance directive, consider for hospice placement and referral for Medically Recommended Intensive Supervision.

6. Two items mentioned in the advanced liver disease section would require further development. One is sheltered housing for patients with end stage liver disease. The other is the Extraordinary Care Review Panel that would review cases being considered for liver transplant evaluation.

This policy is not intended to delineate all aspects of the care of an offender with hepatitis. In particular, the minimal requirements in this policy are intended only to help gather necessary information for a provider to make an appropriate clinical decision about the management of each patient.

**POLICY:** To provide guidance regarding the transmission, clinical management, housing, and work assignment of offenders with Hepatitis A (HAV), Hepatitis B (HBV), and Hepatitis C (HCV).

**PROCEDURES**

I. Hepatitis A

A. Screening
1. Screening with an anti-HAV total antibody test must be done on offenders who are newly diagnosed with HIV or chronic hepatitis B or C.

B. Prevention
1. Encourage good handwashing and good general personal hygiene.
2. Vaccinate susceptible offenders who have HIV infection or chronic liver disease including chronic hepatitis B or chronic hepatitis C.

C. Management of cases
1. Housing
   a. Contact isolation in inpatient settings, until 2 weeks after onset of symptoms, and diarrhea, if any, is resolved.
   b. Outpatients must be assigned to a single cell for two weeks after onset of symptoms or two weeks after diagnosis, if asymptomatic. The cell must undergo cleaning and disinfection after the period of isolation is finished, before any other offender occupies the cell.
2. Work restrictions
   a. Food handlers must be excluded from work until two weeks after onset of symptoms or until resolution of jaundice, whichever is later.

D. Management of contacts
1. All cellmates or dormitory mates (persons sharing toilet facilities) must be tested for anti-HAV total antibody if not already known to be anti-HAV

positive. In addition, sexual contacts and close contacts who shared eating utensils during the infectious period must be identified and tested.
2. Contacts who are anti-HAV antibody negative should receive 0.02 mL/kg of immune globulin IM within 14 days of their last exposure to the case.
3. Contacts who are anti-HAV antibody negative must be excluded from food service work for 8 weeks after their last exposure to the case.
4. If the index case is a food handler, contact the Office of Preventive Medicine immediately for recommendations about management of coworkers and the general offender population.

E. Reporting
1. Acute hepatitis A is required by law to be reported within 7 days.
2. Report to the Office of Preventive Medicine according to procedures in Infection Control Policy Manual B-14.19.

II. Hepatitis B

A. Screening
1. During the intake medical evaluation, offenders should be asked about risk factors for hepatitis B infection and be screened with a HBsAg test if risk factors are present. Offenders must be screened with an anti-HBs antibody test during the intake medical evaluation unless they have a documented history of previous completed hepatitis B vaccination series or a reliable history of previous hepatitis B infection, to determine whether hepatitis B vaccine must be offered.
2. Every offender who is found to be HIV positive or HCV positive must be screened with anti-HBs antibody, HBsAg and anti-HBc total antibody as part of the baseline evaluation.
3. Chronic hemodialysis patients who have not responded to vaccination must be screened for HBsAg monthly. All hemodialysis patients must be screened for anti-HBs antibody every 6 months. It these patients previously had a protective antibody level that falls below the protective threshold, they should be given a booster dose of hepatitis B vaccine.
4. Pregnant offenders must be screened for hepatitis B surface antigen during the first trimester or at the first prenatal visit, whichever is earlier. They must be screened even if they have been previously tested or have been vaccinated, unless they are already documented to have chronic hepatitis B. Women who continue to have risk factors for infection during their pregnancy must be screened again at the time of delivery.

B. If a patient is found to be HBsAg positive, obtain an anti-HBc IgM antibody test. (Note: do not order an anti-HBc total antibody test as it will not provide the information that is required to establish a diagnosis of acute or chronic infection)
   1. If the anti-HBc IgM is negative, the patient has chronic hepatitis B and should be managed according to the procedures for chronic hepatitis B. The case must be reported within 7 days to the Office of Preventive Medicine as a chronic hepatitis B case.
   2. If the anti-HBc IgM is positive, the patient has acute hepatitis B or was infected with hepatitis B in the recent preceding months.
      a. Report the case within 7 days to the Office of Preventive Medicine as acute hepatitis B.
      b. Elicit contact history for the previous 3 months to determine the source case as well as persons who may be candidates for post-exposure prophylaxis.
      c. Obtain HBsAg and anti-HBs antibody tests in 6 months to document resolution of the infection. If HBsAg remains positive after 6 months the case has become chronic and should be managed according to the procedures for chronic hepatitis B. File a follow-up report with the Office of Preventive Medicine noting that the case is chronic if HBsAg is positive for 6 months or longer.

C. Prevention
   1. Educate staff and offenders about routes of transmission, prevention and early reporting of signs and symptoms of infection.
   2. Discourage high risk behaviors including tattooing, unprotected sex and sharing needles or personal grooming items such as razors, toothbrushes and tweezers.
   3. Vaccinate susceptible offenders as directed in CMHC Infection Control Manual Policy B-14.07.
   4. Identify close contacts (sexual partners and those who share needles) of newly diagnosed cases and offer testing and education to those contacts.
      a. Any sexual contacts within the 2 weeks preceding diagnosis and any needle sharing contacts within 1 week preceding diagnosis who has not previously completed a hepatitis B vaccination series should receive 5 ml of HBIG IM and begin the hepatitis B vaccination series.
      b. Those who have been previously vaccinated should be tested for HBsAg and anti-HBs antibody.

1). If both tests are negative they should receive HBIG if less than 14 days have elapsed since their last sexual exposure or less than 7 days since their last needle exposure to the index case. They should also repeat the hepatitis B vaccine series, regardless of the length of time since their last exposure to the case.
2). If there is not enough time to get the laboratory results before the 14 day or 7 day limit expires, administer HBIG without waiting for the lab results.

D. Procedures for Chronic Hepatitis B
1. These patients must be enrolled in chronic care clinic.
2. Assign mainframe medical alert code 7032.
3. Baseline evaluation includes history, physical assessment and the following laboratory tests:
   a. CBC, albumin, bilirubin, prothrombin time, ALT, AST and alpha fetoprotein.
   b. Anti-HAV antibody tests unless the offender has a history of hepatitis A or is documented to be immune.
   c. Anti-HCV and anti-HIV antibody tests unless previously documented to be positive.
   d. HBeAg, anti-HBe antibody and HBV-DNA.
4. Vaccinate against hepatitis A if susceptible.
5. Patient should be referred to be evaluated for treatment if
   a. HBeAg is positive, HBV-DNA is ≥ 20,000 and ALT ≥ 2 x ULN, or
   b. HBeAg is negative, HBV-DNA is ≥ 2,000 and ALT ≥ 2 x ULN
   c. Consider referring for treatment if HBeAg is positive, HBV-DNA is ≥ 20,000, ALT 1-2 x ULN and patient is over 40.
   d. The presence of cirrhosis is not a contraindication to treatment, and, in fact, makes referral for evaluation for treatment more urgent if cirrhosis is uncompensated.
6. If the patient is not referred for treatment consideration after the baseline evaluation, monitor ALT every 3 months, and HBV-DNA every 6 months for 1 year. If baseline HBeAg was positive, also monitor this test every 6 months.
   a. If, after the initial year of monitoring or thereafter, the patient meets criteria in II.D.5, above, or if they have persistently elevated ALT 1-2 times ULN and either HBeAg positive or HBV-DNA > 2,000, they should be referred for evaluation for treatment.
   b. If the patient is not referred to be evaluated for treatment, continue monitoring the patient as least once per year, clinically and with CBC,

albumin, bilirubin, prothrombin time, ALT, AST, alpha fetoprotein, HBV-DNA and, if the previous HBeAg test was positive, HBeAg.

c. At each chronic care clinic appointment review clinical status and labs to determine if referral to be evaluated for treatment is indicated.
d. Whether treated or not, the following groups of HBsAg+ offender patients are at increased risk for hepatocellular carcinoma (HCC) and should have an abdominal ultrasound test to screen for HCC every 6 months:
   i. Asian males age 40 and older
   ii. Asian females age 50 and older
   iii. Patients with confirmed cirrhosis or lab results suggestive of cirrhosis (compensated or uncompensated)
   iv. Patients with a family history of HCC
   v. Africans over age 20

III. Hepatitis C

A. Screening
1. Offenders should be evaluated for risk factors for hepatitis C and signs or symptoms of liver disease during the intake medical evaluation and offered hepatitis C screening with an anti-HCV antibody test if risk factors or signs or symptoms are present.
2. Offenders diagnosed with chronic hepatitis B or HIV infection must be tested for hepatitis C as part of the baseline evaluation of these conditions.
3. Offenders may be tested for anti-HCV antibody once every 12 months at their request. They do not have to disclose any high risk behavior to qualify for testing.
4. Screening with an anti-HCV antibody test should also be performed after an exposure, according to Infection Control Manual Policy B-14.06, and whenever clinically indicated.

B. Prevention
1. Educate staff and offenders about routes of transmission, prevention and early reporting of signs and symptoms of infection.
2. Discourage high risk behaviors including tattooing, unprotected sex and sharing needles or personal grooming items such as razors, toothbrushes and tweezers.
3. Any identified needle sharing contacts should have an anti-HCV antibody test. If it is negative, repeat the test in 6 months. There is no post-exposure preventive treatment recommended for hepatitis C.

C. Baseline evaluation and initial management of offenders newly identified to be anti-HCV antibody positive.
   1. Offenders who enter TDCJ on treatment for hepatitis C with interferon with or without ribavirin must have that treatment continued unless the provider documents that it must be discontinued for medical reasons.
   2. Take a targeted history to determine the probable date infection was acquired. For example, the date of infection in an injection drug user would be the year he started sharing needles or works. Also obtain history of previous and present alcohol use, co-infections such as HIV or HBV, drug use, symptoms of liver disease, and previous treatment.
   3. Perform a physical examination looking for signs of advanced liver disease, evidence of other causes of liver disease such as Wilson's disease, and extrahepatic manifestations of hepatitis C.
   4. Obtain the following baseline laboratory tests:
      a. CBC with platelet count
      b. Prothrombin time
      c. ALT, AST, alkaline phosphatase, bilirubin, albumin, BUN, creatinine
      d. HIV, anti-HBsAb, anti-HBc total antibody, HBsAg, and anti-HAV total antibody.
   5. Vaccinate the offender against hepatitis B if all hepatitis B serum markers are negative.
   6. Vaccinate against hepatitis A if the anti-HAV test is negative.
   7. Educate the patient about transmission of HCV, his obligation to avoid infecting others, the natural history of HCV infection, effect of alcohol and other hepatotoxins on his disease, etc.
   8. Patients who are HIV positive or HBsAg positive must be referred to a designated clinic or physician to be evaluated for possible treatment of hepatitis C.
   9. Compensated cirrhosis (low albumin but ≥ 3.0, low platelet count but ≥ 70,000, elevated bilirubin but < 2.0, and/or prolonged prothrombin time less than 2 seconds greater than control) is not a contraindication to antiviral treatment. These patients should be evaluated for treatment even if their APRI score is less than 0.42 or if they have only a short time left in the system, as they may be approaching the point where antiviral treatment is contraindicated because of advanced liver disease.
   10. For other patients, if the baseline transaminases and liver function tests are all WNL, consider one or more HCV-RNA, ALT and AST tests over 3-6 months to confirm or rule out current infection. If the ALT and AST results are all WNL and at least two negative HCV-RNA results have been

obtained, that patient can be diagnosed with resolved HCV and discharged from follow-up after appropriate counseling about the possibility of future re-infection if high risk behavior is repeated.

11. If current infection is confirmed by abnormal baseline tests or positive HCV-RNA, calculate the APRI score using the formula below:

    APRI = ((AST/ULN) ÷ (platelet count)) x 100

    Where ULN = upper limit of normal for the AST level and platelet count is in 1,000/$mm^3$

    An APRI score calculator is available on CMCWEB under the Tools submenu.

12. If the APRI is > 0.42 the patient should be considered for referral to a designated clinic or physician to be evaluated for possible treatment of HCV.
    a. Almost all offenders with an APRI score over 0.42 should be referred, but the decision must be individualized. Considerations that may lead to a decision not to refer could include the patient not wanting treatment, presence of a contraindication to the treatment, or presence of comorbidity that is likely to be fatal before hepatitis C becomes symptomatic. This list is not exhaustive.
    b. If a patient with an APRI score > 0.42 is not referred, the rationale for not referring must be documented in the medical record.
13. Although patients with APRI scores ≤ 0.42 generally do not require evaluation for possible treatment, the provider may consider referral if they believe the patient may be a candidate for treatment. Clinical considerations could include
    a. History suggesting that infection was acquired many years previously.
    b. Clinical or laboratory evidence of a failing liver.
    c. Comorbid conditions that might cause elevation of the platelet count or unusually low AST levels, giving an unreliable APRI score.

D. Follow-up after the baseline evaluation
    1. Patients with HCV infection must be enrolled in chronic care clinic and seen at least once every 12 months.
    2. Annual evaluation must include clinical evaluation for signs or symptoms of liver disease and at least the following laboratory tests: AST, bilirubin, albumin, and CBC with platelets.

3. At each annual evaluation the APRI score must be calculated based on the current AST and platelet count and a determination made whether the patient should be referred for evaluation for treatment.
4. If the patient has evidence of compensated or uncompensated cirrhosis, follow-up as indicated under Advanced Liver Disease, below.

E. Retreatment
1. Patients who have responded to therapy with standard interferon with or without ribavirin who relapse after completion of therapy may be considered for retreatment with pegylated interferon and ribavirin.
2. Non-responders to treatment with standard interferon may be considered for retreatment with pegylated interferon and ribavirin.
3. Retreatment is not recommended for non-responders or relapsers who received pegylated interferon and ribavirin.

F. Reporting
1. Anti-HCV positive offenders must be reported to the Office of Preventive Medicine within 7 days.
2. If the patient has had a documented seroconversion to HCV positive, or has clinical signs and symptoms of acute hepatitis or has ALT > 5 times higher than the upper limit of normal, report the case as acute hepatitis C.
3. Enter the mainframe medical alert code 7054 on HCV positive offenders.

IV. Advanced Liver Disease

A. Patients with cirrhosis are in the high risk groups that must be offered influenza and pneumococcal vaccines according to Infection Control Manual Policy B-14.07.

B. Baseline evaluation of patients with cirrhosis includes clinical evaluation for signs or symptoms of hepatic encephalopathy and ascites. Hepatic encephalopathy is a clinical diagnosis and ordinarily, serum ammonia levels are unnecessary. Ammonia levels are often falsely elevated if the serum specimen is not handled properly or is not immediately delivered to the lab. A baseline alpha fetoprotein must be obtained, and the patient should be referred for endoscopy to screen for esophageal varices. If the patient has esophageal varices or ascites consider the use a beta blocker to treat portal hypertension.

C. Patients with compensated or uncompensated cirrhosis should have an abdominal ultrasound every 6 months to screen for hepatocellular carcinoma.

D. Consider referring patients with uncompensated cirrhosis for review by the Extraordinary Care Review Panel (ECRP) for possible referral to be considered for liver transplant. The decision to refer a patient to the ECRP must be made on a case by case basis.

E. For patients with uncompensated cirrhosis, discuss prognosis of their illness and their treatment preferences, obtaining an advance directive when appropriate.

F. Patients with evidence of compensated or uncompensated cirrhosis must be enrolled in chronic care clinic. They must have bilirubin, creatinine, INR, alpha fetoprotein and abdominal ultrasound done every 6 months in addition to any laboratory tests that are clinically indicated.

G. At each chronic care visit, calculate the Model for End-stage Liver Disease (MELD) score. A patient with a MELD score of 30 or greater (associated with a 52% risk of mortality within 3 months) should be referred to a hospice unit if the patient agrees to the conditions of hospice placement, or submitted to the ECRP to be considered for referral to be evaluated for liver transplant if that has not already been done. An individual should not be accepted for or denied hospice care solely on the basis of his/her MELD score, however. The MELD score can be calculated online at:
http://www.unos.org/resources/MeldPeldCalculator.asp?index=98

A MELD score calculator is also available on CMCWEB under the Tools submenu.

The MELD formula is also given below:

Risk Score = 10 * ((.957 * ln(Creat)) + (.378 * ln(Bili)) + (1.12 * ln(INR))) + 6.43

Where
- ln means the natural logarithm (base *e*)
- For any lab values < 1, use the value 1 in the formula
- If creatinine is > 4, use the value 4
- If the patient has been dialyzed 2 or more times in the previous week,

use the value 4 for creatinine
- The risk score should be rounded to the nearest integer
- This formula only applies to adults

H. Every patient with uncompensated cirrhosis should be considered for nomination for Medically Recommended Intensive Supervision (MRIS). The point at which referral should be made is subjective, but at a minimum, patients with a MELD score over 30 or with recurrent ascites, recurrent bleeding esophageal varices or recurrent hepatic encephalopathy should be nominated for MRIS.

I. Patients who are not considered for hospice care or who do not desire hospice may have to be placed in sheltered housing if they are not able to take care of themselves in general population. Carefully consider whether patients with a prior episode of hepatic encephalopathy, bleeding esophageal varices, massive edema or massive ascites should be in sheltered housing [or an ESLD special housing unit if one is created] even if they appear to be able to take care of themselves at the time they are seen.

Infection Control Manual Policy B-14.13 Hepatitis Attachment 1

# Contraindications to Drugs Used in the Treatment of Chronic Hepatitis

Interferon (including pegylated interferon)

Absolute contraindications

- Uncompensated cirrhosis
- Potentially life-threatening non-hepatic disease such as far advanced AIDS, malignancy, severe COPD or severe ASHD
- Uncontrolled autoimmune disorders
- Poorly controlled diabetes
- Uncontrolled hyperthyroidism
- Solid organ transplant
- Ongoing alcohol or injection drug use
- Suicidal ideation or other uncontrolled neuropsychiatric disorder
- Poorly controlled seizure disorder

Relative contrindications

- Neutropenia or thrombocytopenia
- Poorly controlled HIV infection on HAART

Ribavirin

Absolute contraindications

- Previously demonstrated hypersensitivity to the drug
- Pregnancy (during treatment and for 6 months afterward; also applies to partners of males who are treated)
- Hemoglobinopathies and hemolytic or other severe anemias
- Ischemic cardiovascular or cerebrovascular disease
- Renal insufficiency with serum creatinine > 2.0

Adefovir

Absolute contraindication

- Previously demonstrated hypersensitivity to the drug

Relative contraindications

- Renal insufficiency (monitor renal function)
- Inability to continue drug after release
- Potential for hepatomegaly, steatosis and lactic acidosis. Increased risk with obesity, females, prolonged treatment.

Lamivudine

Absolute contraindication

- Previously demonstrated hypersensitivity to the drug

Relative contraindications

- Renal insufficiency (monitor renal function)
- Inability to continue drug after release
- HIV infection (do not use monotherapy against HIV)

Emtricitabine

Absolute contraindication

- Previously demonstrated hypersensitivity to the drug

Relative contraindications

- Potential for hepatomegaly, steatosis and lactic acidosis. Increased risk with obesity, females, prolonged treatment.
- HIV infection (do not use monotherapy against HIV)

Infection Control Manual Policy B-14.13 Hepatitis Attachment 2

# Hepatitis Reporting Form

Name: _____ TDC Number: _____

Facility: _____ UH Number:_____

Diagnosis:

☐ Acute Hepatitis A
☐ Acute Hepatitis B
☐ Acute Hepatitis C

☐ Chronic Hepatitis B
☐ Chronic Hepatitis C

Supporting Data:

Symptoms (acute disease only): Date of Symptom Onset: _____

- ☐ Nausea, vomiting or anorexia
- ☐ Diarrhea
- ☐ Jaundice or icterus
- ☐ Fever, malaise, flu-like symptoms

Lab: (lab tests done are based on clinical considerations and should not be ordered simply to complete this report form. **This form is for reporting purposes only and is not intended as a clinical guideline**)

| Test | Date, if done | Pos | Neg | Not Done or Unknown |
|---|---|---|---|---|
| **Acute Hepatitis A** | | | | |
| Hep A antibody (anti-HAV IgM Ab) | _____ | ☐ | ☐ | ☐ |
| **Hepatitis B** | | | | |
| Hep B surface antigen (HBsAg) | _____ | ☐ | ☐ | ☐ |
| Hep B core antibody (anti-HBc IgM Ab) | _____ | ☐ | ☐ | ☐ |
| Hep B surface antibody (anti-HBs Ab) | _____ | ☐ | ☐ | ☐ |
| **Hepatitis C** | | | | |
| Hep C antibody (anti-HCV Ab) | _____ | ☐ | ☐ | ☐ |
| **Hepatitis D** | | | | |
| Delta hepatitis antibody (anti-HDV Ab) | _____ | ☐ | ☐ | ☐ |

Highest* ALT (SGPT) level: _____ Date: _____

Highest* AST (SGOT) level: _____ Date: _____

* for acute illness only

| Expected Serological Patterns | | | | | |
|---|---|---|---|---|---|
| Acute Hepatitis A | Resolved Hepatitis A (not reportable) | Acute Hepatitis B | Chronic Hepatitis B | Resolved Hepatitis B (not reportable) | Hepatitis C |
| Anti-HAV IgM (+) | Anti-HAV IgM (-)<br>Anti-HAV IgG (+) | HBsAg (+)<br>HbeAg (+)<br>Anti-HBc IgM (+) | HBsAg (+)<br>HBeAg (+ in majority)<br>Anti-HBc total (+)<br>Anti-HBc IgM (-) | HBsAg(-), HBeAg(-)<br>Anti-HBs (usually +)<br>Anti-HBc total (usually +) | Anti-HCV (+) |

Infection Control Manual Policy B-14.13 Hepatitis Attachment 3
Interferon and Ribavirin Dose Modification Guide

Note: this information is adapted from the package insert and is not expected to cover every case. This information does not preclude the exercise of clinical judgment.

| **Hematological Dose Modification Guide*** | | |
|---|---|---|
| **Lab Value** | **Dose Reduction** | **Discontinue When** |
| ANC < 750 | Peginterferon 135 micrograms q week | ANC < 500 |
| Platelets < 50,000 | Peginterferon 90 micrograms q week | Platelets < 25,000 |
| Hemoglobin < 10 ** | Ribavirin 600 mg/day | Hemoglobin < 8.5 ** |
| Hgb 2gm reduction in 4 weeks*** | Ribavirin 600 mg/day | Hgb < 12 after 4 weeks at reduced dosage*** |

* See package insert for details and information on restarting drugs after discontinuation for hematological abnormalities

** Patients with no cardiac disease

*** Patients with stable cardiac disease

ANC = absolute neutrophil count

| **Depression Dose Modification Guide*** | |
|---|---|
| **Depression Severity** | **Dose Reduction** |
| Mild | None |
| Moderate | Peginterferon 135 micrograms q week. May need to reduce dose to 90 micrograms. |
| Severe | Discontinue Peginterferon immediately and refer to psych |

* See package insert for details and information on restarting drugs when discontinued

Increase frequency of clinical evaluations if patient develops depression. Evaluate depression weekly.

| **ALT Dose Modification Guide** | | |
|---|---|---|
| **Lab Value** | **Dose Reduction** | **Discontinue When** |
| ALT > 2x baseline | Peginterferon 135 micrograms q week | Continued ALT increase despite dose reduction, or elevation of bilirubin |

**The information given in this technical reference is not policy. It is intended to assist the provider in making clinical decisions by discussing treatment options and some of the considerations involved in determining the work-up and treatment of viral hepatitis and chronic liver disease.**

## BACKGROUND INFORMATION ON HEPATITIS AND END STAGE LIVER DISEASE

I. Hepatitis A

B. Infectious Agent – hepatitis A virus (HAV), a single strand RNA virus. The virus can persist in the environment for several weeks under ideal conditions. Disinfection of contaminated surfaces with a 1:10 dilution of household bleach or Double-D disinfectant diluted according to directions is effective.

C. Transmission – generally person to person by fecal-oral route. Can also be foodborne or waterborne by contamination from an infected food handler or contamination by raw sewage. High risk groups include men who have sex with men, injection drug users and persons who eat raw shellfish.

D. Diagnostic tests – laboratory confirmation of acute hepatitis A is by serum anti-HAV IgM antibody. Immunity is confirmed by serum anti-HAV total antibody (IgM+IgG). Note that a diagnosis of acute hepatitis A requires the IgM specific test. The total antibody test does not differentiate between acute infection and resolved previous infection.

E. Incubation period – average 4 weeks, range 15-50 days.

F. Infectious period of cases – from 2 weeks before onset of symptoms to 7 days after onset of jaundice or peak elevation of transaminases (approximate).

G. Symptoms – 50% or more of childhood cases are asymptomatic. Adult cases are more likely to be symptomatic, with fever, anorexia, nausea, and abdominal discomfort, followed in a few days by jaundice. Disease is generally self-limited lasting 1-2 weeks. 10-15% of cases may have several episodes of relapsing symptoms over 6-12 months, but chronic infection does not occur. Case-fatality rate is 0.1-0.3%, but is higher in patients over age 50 and those with chronic liver disease.

H. Prevention – hepatitis A vaccine is available. In TDCJ, the very low rate of HAV infection does not warrant hepatitis A vaccination except in patients who

are HIV positive or who have chronic liver disease including hepatitis C or chronic hepatitis B. Hepatitis A can be prevented after exposure by administering immune globulin within 14 days of the exposure. Hepatitis A is also prevented by practicing good personal hygiene, especially hand hygiene.

## II. Hepatitis B

A. Infectious Agent – hepatitis B virus (HBV), a double strand DNA virus. It is able to persist for extended periods in the environment and can be detected in dried blood for several weeks. It remains infectious on environmental surfaces for at least a week. Disinfection of contaminated surfaces with a 1:10 dilution of household bleach or Double-D disinfectant diluted according to directions is effective in inactivating virus on cleaned surfaces, but may not inactivate virus that resides in organic matter such as visible dried blood.

B. Transmission – low infectious dose and typically large amount of virus in the bloodstream make this one of the most easily transmitted of the bloodborne pathogens. Percutaneous or permucosal exposure to blood or other potentially infectious materials (OPIM, see CMHC Policy B-14.5 for definition of OPIM) is the route of infection. HBV is transmitted efficiently through unprotected sexual contact and from mother to infant. Unlike most other bloodborne pathogens, saliva without visible blood is capable of transmitting infection, although no outbreaks have been associated with this. Sharing of toothbrushes and razors has been implicated in transmission. Risk factors for hepatitis B infection include history of injection drug use, history of male on male sex, history of jailhouse tattoos, history of sexually transmitted disease, HCV or HIV infection. Offenders who come from high prevalence areas, including Africa, Eastern Europe, Southeast Asia or the Western Pacific islands are also high risk.

C. Diagnostic tests. HBV surface antigen (HBsAg) indicates current infection and that the patient is infectious. Acute infection is confirmed by a positive HBsAg test with a positive HBV core antibody IgM (anti-HBc IgM) test, while chronic infection is confirmed by a positive HBsAg test and a negative anti-HBc IgM. Chronic infection can also be diagnosed if HBsAg persists for more than 6 months. Total HBV core antibody (anti-HBc total) does not differentiate between acute infection, chronic infection or resolved infection.

HBV surface antibody (anti-HBs) is protective antibody and is seen in resolved infection or in persons who have been vaccinated against hepatitis B.

Anti-HBs is not present in chronic hepatitis B. Vaccinated persons have a positive anti-HBs with a negative anti-HBc total antibody test. Persons with resolved hepatitis B will have a positive anti-HBs and a positive anti-HBc total antibody test.

Anti-HBc antibody persists longer at higher levels than does anti-HBs. Occasionally a person will be seen with a positive anti HBc and all other serum markers of HBV negative. This usually means they had hepatitis B several years previously that has resolved. If they have risk factors of HBV infection and normal liver enzymes this is usually the correct interpretation. If they have normal liver enzymes and no risk factors for HBV the result may be a false positive. An isolated positive anti-HBc result may also be seen in chronic infection if the rate of virus replication is so low that HBsAg is undetectable. This is sometimes seen in HCV-HBV coinfection.

The presence of hepatitis B e antigen (HBeAg) indicates a very high rate of viral replication and a highly infectious patient. HBeAg is not helpful for diagnosis but chronic HBV patients who are HBeAg positive are treated differently than those who are HBeAg negative, and the indications to consider treatment are a little different.

The HBV-DNA test is based on polymerase chain reaction technology. HBV-DNA can remain positive at low levels even in individuals who have serologically recovered from acute HBV infection (i.e., HBsAg has disappeared and anti-HBs is present). The level of 20,000 IU/ml that is currently used as a diagnostic criterion for chronic hepatitis B is an arbitrary value set at the 2000 National Institutes of Health conference on the management of hepatitis B. That value may change in the future as progressive liver disease has been observed in patients with lower levels of HBV-DNA (2,000 – 20,000 IU/mL). Levels of HBV-DNA in the 2,000-20,000 range coupled with evidence of active liver disease (i.e., elevated transaminases or liver function abnormalities) generally warrant further evaluation for treatment.

Interpretation of major hepatitis B serologic test patterns

| HBsAg | Anti-HBs | Anti-HBc IgM | Anti-HBc Total | Interpretation |
|---|---|---|---|---|
| + | – | – | – | Very early infection or 1-2 weeks after first vaccine dose. |
| + | – | + | + | Acute hepatitis B, infectious |
| – | + or – | + | + | Resolving acute infection |
| + | – | – | + | Chronic hepatitis B, infectious |
| – | – | – | – | Never infected or immunized. Susceptible. |
| – | + | – | – | Immunized, never infected. Immune if titer > 10 IU/mL |
| – | + | – | + | Resolved hep B. Immune. |
| – | – | – | + | Several possibilities:<br>1. Lab error<br>2. Remote infection with undetectable anti-HBs; immune<br>3. Chronic infection with undetectable HBsAg (concurrent HCV infection can suppress HBsAg expression); infectious potential is low. |

D. Incubation period – 6 weeks to 6 months

E. Infectious period – for acute cases, from about 3 weeks before the onset of symptoms throughout the course of clinical illness, until HBsAg disappears. For chronic cases, indefinite, as long as HBsAg is positive.

F. Clinical course – childhood cases are more frequently asymptomatic and anicteric. Adult cases are more likely to be symptomatic, with fever, anorexia, nausea, and abdominal discomfort, followed in a few days by jaundice. Acute infection is treated symptomatically and is usually self-limited. Fulminant hepatitis may occur; the case-fatality ratio in patients over 40 is 1 percent. 1-10 percent of acute infections persist and become chronic. Patients with chronic hepatitis B are at risk for hepatocellular carcinoma even in the absence of cirrhosis. HBV infection is the underlying cause of up to 80% of hepatocellular carcinoma cases worldwide. 15-25% of patients with chronic hepatitis B will develop cirrhosis over a period of 10-30 years.

G. Prevention – hepatitis B vaccine is available. Hepatitis B can be prevented after exposure by administering hepatitis B immune globulin (HBIG) within 7 days of a percutaneous exposure (it is preferable to administer HIBG within 24 hours of exposure) or within 14 days of sexual exposure. Hepatitis B is also prevented by avoiding high risk behaviors such as sharing needles or personal grooming items, exposure to blood and other potentially infectious materials, and unsafe sexual practices.

H. Treatment – chronic hepatitis B can be treated with interferon alfa (IFN) or with nucleoside analogs (NA). FDA approved NA available in the United States as of April 2007 include lamivudine, adefovir, entecavir and telbivudine. Several other drugs are in clinical trials so this list is likely to change. NAs are usually administered for an indefinite period until a specific endpoint is reached. For HBeAg positive patients this endpoint is 6 months after the disappearance of HBeAg. For initially HBeAg negative patients treatment may continue for several years, with the endpoint being normalization of ALT levels and undetectable HBV-DNA for one year. One problem with the use of NAs includes the development of drug resistance. Of the drugs available in April, 2007, lamivudine has the highest rate of drug resistance developing during treatment while entecavir has the lowest. Combination therapy has not yet been shown to reduce the risk of resistance. Another problem with NAs is the possibility of a hepatitis flare if the drug is stopped abruptly. This could happen in a patient who is released while on treatment and does not have follow-up in the community.

   If a patient has coinfection with HBV and HIV it is very important that the treatment regimen take into account both infections, as a poorly conceived drug regimen for one infection may adversely impact the ability to treat the other.

   FDA approved interferons for treatment of chronic hepatitis B include interferon alfa 2b and peginteferon alfa 2a. IFN is administered for a defined period that differs for HBeAg positive and HBeAg negative patients. Interferon may cause decompensation in cirrhotic patients and is currently contraindicated in those patients.

   Criteria for consideration for treatment are given in the Hepatitis Policy in sections II.D.5 and II.D.6. Although they are complicated, in general, a HBV-DNA level over 20,000 is considered confirmatory for HBV infection and coupled with ALT levels ≥ 2x ULN, an indication of immediate referral for treatment. These patients will often be treated without a liver biopsy. If the e-

antigen is negative, treatment should be considered if the HBV-DNA is over 2,000 and the ALT is ≥ 2x ULN. However, if the HBV-DNA level is in the 2,000 – 20,000 range, a liver biopsy may be needed before treatment to verify the presence of active liver disease.

After the initial evaluation, if there is evidence of active liver disease (HBV-DNA persistently over 2,000 and ALT levels persistently elevated) then treatment should be considered, but, again, a liver biopsy may be needed to verify active liver disease before treatment is initiated.

I. Contraindications to treatment – see Attachment 1 for contraindications to IFN and other drugs used to treat chronic hepatitis B. In addition to the absolute contraindications, the following relative contraindications should be considered.
   1. If interferon treatment is being considered, evaluate the patient for history of serious mental illness. These patients may need evaluation by a psychologist or psychiatrist prior to treatment. If they have symptoms of mental illness, they should be treated and stabilized before pursuing a work-up for treatment.
   2. Ability to complete treatment before release, or to assure continuation of treatment after release. The latter is particularly important for HBeAg negative offenders for whom long term therapy with a NA is anticipated.
   3. Ongoing substance or alcohol abuse. Inability to abstain during incarceration raises questions about their ability to adhere to the treatment regimen and to abstain from high risk behaviors after their release.
   4. Co-morbidity that may affect life expectancy independent of their chronic hepatitis infection.

III. Hepatitis C

A. Infectious Agent – hepatitis C virus (HCV), an enveloped RNA virus. The virus exists in at least 6 distinct genotypes, with the most common genotype in TDCJ offenders being genotype I. Approximately 70 percent of cases in TDCJ are genotype I and 30 percent genotypes 2 or 3. The virus can persist in the environment for several hours. Although few, if any, disinfectants are registered with the EPA to be virucidal against HCV, a 1:10 dilution of household bleach or properly diluted Double-D disinfectant are effective.

B. Transmission – HCV is a bloodborne pathogen. The most common mode of transmission is through shared needles, such as with injection drug use. There is some evidence that jail tattoos may be responsible for transmission of HCV. Sexual transmission may occur, but it is much less efficient than needle sharing. In the past, HCV was commonly acquired through blood transfusion, but since July, 1992, the test used to screen donated blood has nearly eliminated this mode of transmission in the United States. Risk factors for hepatitis C infection include current or previous injection drug use, unprotected sex with multiple partners, blood transfusion before July 1992, receipt of clotting factor concentrates before 1987, history of chronic hemodialysis, and possibly having a jailhouse or street tattoo. There is evidence that the majority of HCV infections related to injection drug use occur within the first year of beginning to engage in this behavior.

C. Diagnostic Tests – Screening for hepatitis C infection is done by a serum anti-HCV antibody test (EIA). This test does not differentiate between acute, chronic or resolved hepatitis C. Confirmation by an immunoblot (RIBA) test is not required; RIBA should only be ordered in exceptional circumstances. If confirmation of the diagnosis is required, current (acute or chronic) HCV infection can be verified with a HCV-RNA assay. However, confirmation of the diagnosis with HCV-RNA is not required for offenders with risk factors for HCV infection. (Note that a positive HCV-RNA is still required before initiating treatment) A positive HCV-RNA assay is conclusive for current infection, but a single negative result does not rule out infection, as the degree of viremia fluctuates during infection and may be undetectable at times. Chronic infection can be diagnosed by demonstrating persistent viremia or elevation of transaminases over 6 months or longer. If the offender has a clinical history that suggests infection was most likely acquired in the past (for example, injection drug use more than 1 year previously) a diagnosis of chronic infection may be reasonably made at the time of the initial diagnosis of HCV infection.

D. Incubation Period – two to 26 weeks, averaging about 6-7 weeks. ALT elevation usually begins 1-3 months after infection. Anti-HCV antibody may not be present when acute symptoms or the initial rise in ALT occur, but the antibody usually is detectable within 3 months of exposure and infection.

E. Infectious period – patients must be considered infectious unless they have demonstrated persistent normal ALT levels and undetectable HCV-RNA by qualitative testing.

F. Symptoms – most cases of acute HCV infection are asymptomatic or do not have symptoms that would suggest hepatitis. The minority of acute infections that do have symptoms will have those typical of acute hepatitis. 50-85% of acute infections will become chronic. Chronic hepatitis C is generally asymptomatic. Chronic hepatitis C is characterized by fluctuations in viremia and ALT levels.

G. Treatment – In 2007, pegylated interferon and ribavirin in combination is the accepted form of treatment. There are a number of warnings and contraindications to these drugs and the prescriber should be familiar with them. The decision who to treat must be individualized, but currently the best candidates are considered to be those with elevated ALT, positive HCV-RNA and moderate to severe fibrosis (METAVIR or Ludwig-Batts score of 2 or higher) on liver biopsy. Some individuals with advanced liver disease may have normal ALT levels. One must also consider absolute and relative contraindications to treatment, the patient's commitment and consent to pre-treatment evaluation and to treatment, comorbid conditions and other clinical considerations in making a decision about referral for treatment.

H. Retreatment. The chance of achieving a sustained viral response in a patient who initially responded to treatment and then relapsed after completion of therapy may be as high as 40-50 percent if a more effective treatment regimen is used. Patients who relapse after standard interferon with or without ribavirin should be considered for retreatment with pegylated interferon and ribavirin. Retreatment with a longer duration or therapy in patients who relapse after a 12 month course of pegylated interferon and ribavirin is of unproven benefit. Retreatment of non-responders to standard interferon monotherapy with pegylated interferon can achieve SVR in up to 20 percent of patients; response to retreatment of non-responders to standard interferon with ribavirin is only about 10 percent.

I. The APRI (aspartate aminotransferase to platelet ratio index) is the ratio of the AST level, expressed as a percentage of the upper limit of normal, divided by the platelet count in thousands per cubic millimeter. It is somewhat predictive of liver fibrosis but cannot replace the liver biopsy in all cases. An APRI score of less than 0.42 has a 93% predictive value for a Ludwig-Batts score of 0 or 1 on liver biopsy, and a score of over 1.2 has a predictive value of 93% for a Ludwig-Batts score of 2-4. The APRI may be less predictive when there are comorbid conditions other than liver disease that may affect the platelet count or AST level.

An APRI score calculator is available on CMCWEB under the Tools submenu.

IV. Advanced Liver Disease

A. Approximately 10-25 percent of chronic hepatitis C and chronic hepatitis B infections will progress to cirrhosis over a period of 10-30 years. The proportion progressing and the rate of progression may be increased by cofactors such as alcohol ingestion and co-infection.

B. Laboratory evidence suggestive of cirrhosis includes AST/ALT ratio greater than 1, elevated alkaline phosphatase, low albumin level, elevated bilirubin, low platelet count or prolonged prothrombin time. Of course, other conditions can cause some or all of these abnormalities so the laboratory results must be interpreted in the context of the overall clinical picture.

C. Laboratory results consistent with uncompensated cirrhosis are albumin < 3.0, bilirubin > 1.5, platelet count < 70,000, or prothrombin time > 2 seconds longer than control.

D. Clinical evidence of uncompensated cirrhosis includes ascites, history of bleeding esophageal varices and history of hepatic encephalopathy.

E. Each year about 1-4 percent of patients with cirrhosis will progress to end stage liver disease or develop hepatocellular carcinoma.

F. The treatment of choice for liver failure secondary to chronic HCV or HBV infection is liver transplantation. The American Association for the Study of Liver Disease recommends that patients with chronic hepatitis C or chronic hepatitis B be referred for evaluation for liver transplant if they have decompensated cirrhosis. However, the decision to refer to be considered for transplant must be made on a case-by-case basis.

G. Patients with cirrhosis are at risk of developing hepatocellular carcinoma or esophageal varices. There is no consensus on frequency or modality of screening for varices, but recent evidence suggests periodic surveillance for hepatocellular carcinoma is cost-effective in selected patients. These patients include those with cirrhosis related to hepatitis B, hepatitis C or other causes of liver disease, as well as some patients with chronic hepatitis B without evidence of cirrhosis, as listed below:
   1. Asian males age 40 and older

2. Asian females age 50 and older
3. Patients with confirmed cirrhosis or lab results suggestive of cirrhosis (compensated or uncompensated)
4. Patients with a family history of HCC
5. Africans over age 20

H. Patients with ascites are at increased risk for spontaneous bacterial peritonitis. Certain high-risk patients (eg., GI bleed) may benefit from prophylactic antibiotics.

I. Primary treatment for ascites is dietary sodium restriction (2 Gm/day) and diuretics, although the initial presentation of tense ascites may require therapeutic paracentesis followed by salt restriction and diuretics. Some patients may be diuretic resistant and require second line therapy, such as serial therapeutic paracentesis, transjugular intrahepatic portasystemic shunt (TIPS), liver transplant or peritoneovenous shunt. Before concluding a patient is refractory to diuretics, make sure they are following the sodium restriction and are not taking NSAIDS or other drugs that can reduce urinary sodium excretion. If a random spot urine has a sodium/potassium ratio greater than 1 or if a 24 hour urine sodium is less than 78 mmol/day (on diuretics) and the patient is not losing weight, they should be counseled about adhering to the salt restriction.

J. Patients with esophageal varices are at risk for gastrointestinal hemorrhage. Primary prevention of gastrointestinal hemorrhage with beta blockers may be considered for patients with severe liver failure or those who have had endoscopy findings of large esophageal varices. Secondary prevention (i.e., prevention of rebleeding after an initial bleed) may include variceal ligation or sclerotherapy, both of which require multiple sessions to eradicate varices. Non-selective beta blockers used for secondary prevention have comparable rates of rebleeding and survival to sclerotherapy. Portosystemic shunt, including Transjugular Intrahepatic Portosystemic Shunt (TIPS) may also be considered for a patient who has had a GI bleed from esophageal varices.

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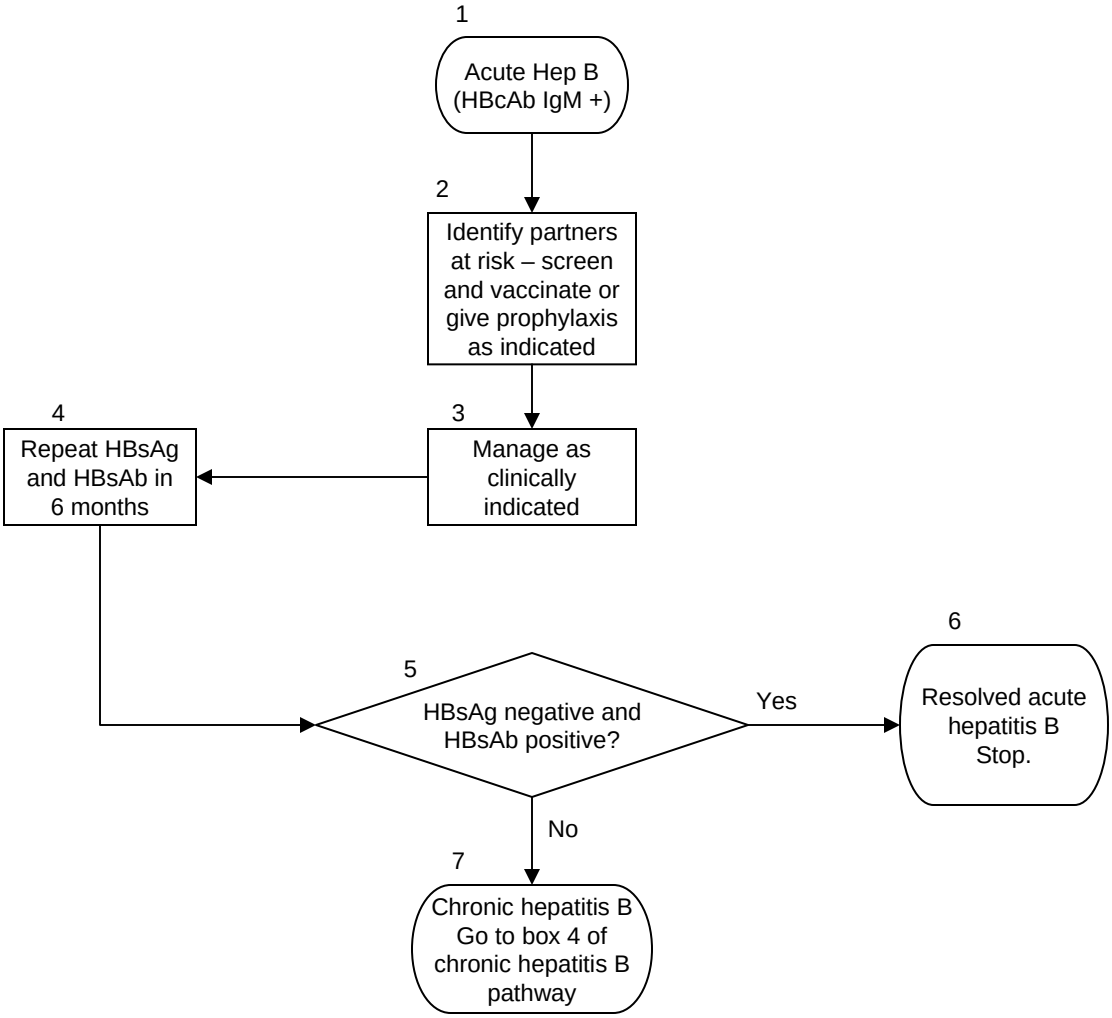
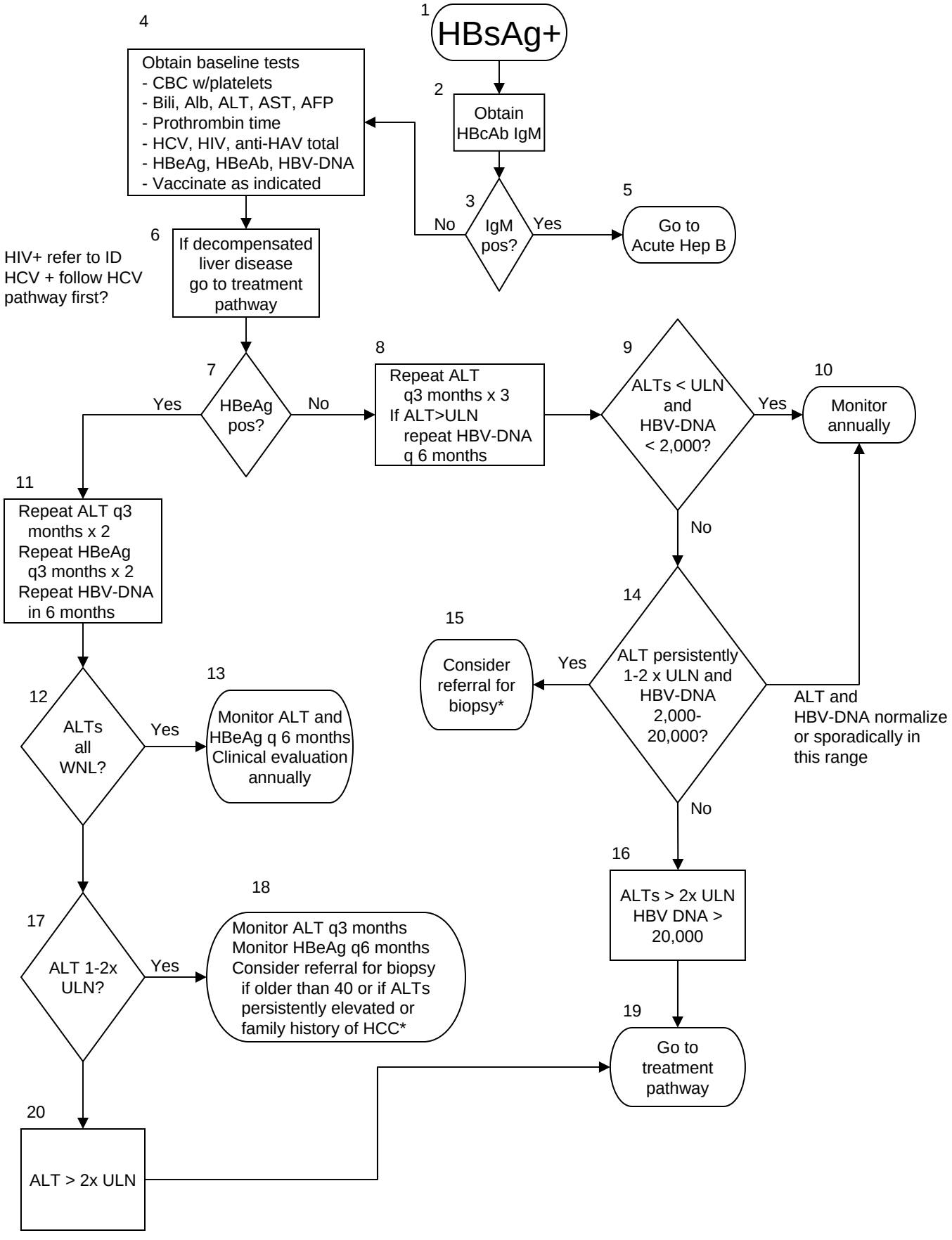
# Acute Hepatitis B



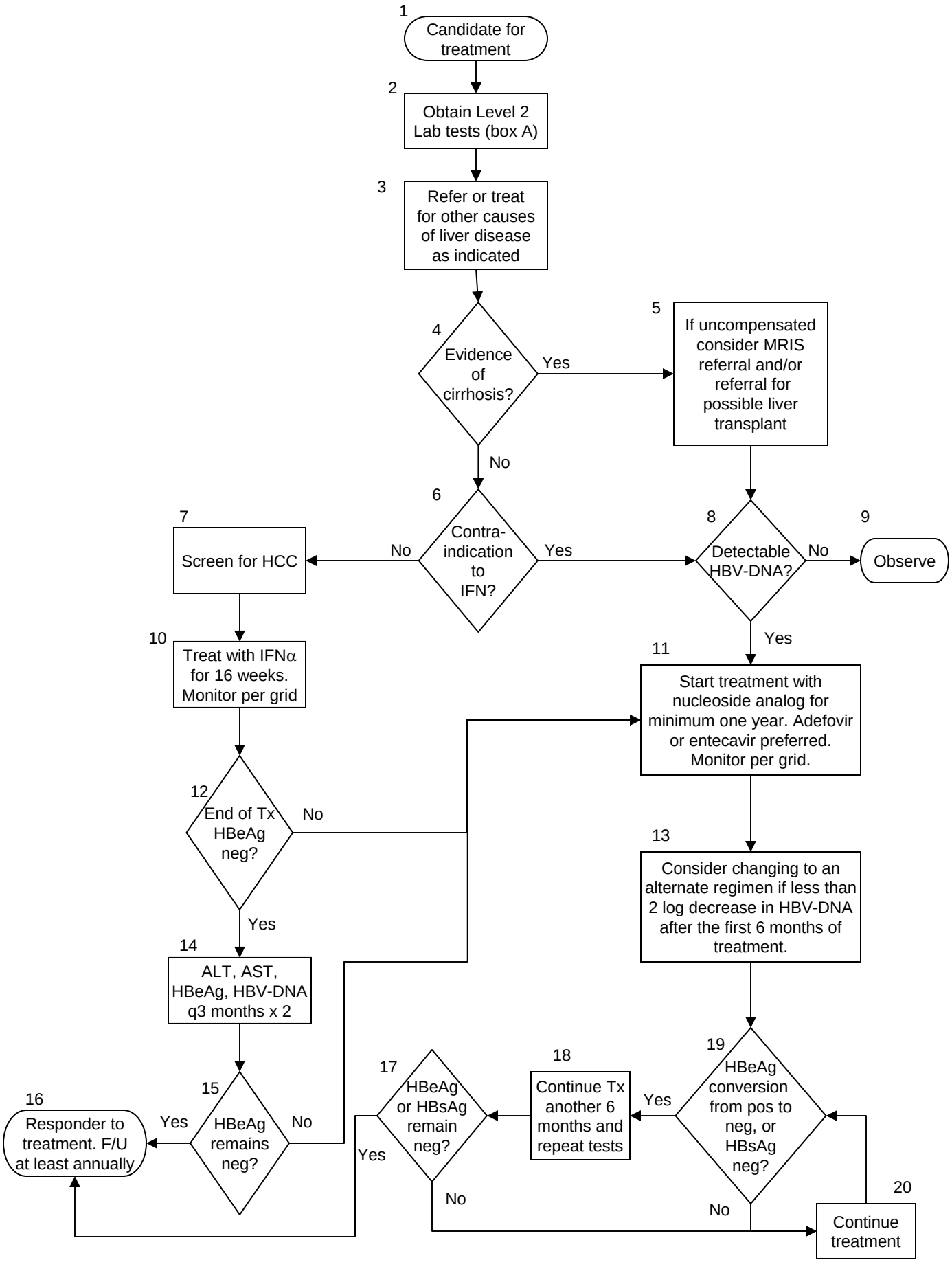
# Chronic Hepatitis B




* Initiate treatment if indicated after biopsy

See also the hepatocellular carcinoma screening pathway, even if patient does not meet criteria for treatment

# Hepatitis B Treatment Pathway



Box A – Level 2 Labs

- Quantitative HBV-DNA
- Abdominal ultrasound
- alpha-fetoprotein
- Alpha-1 antitrypsin
- Ceruloplasmin
- ANA
- CXR and EKG if over 40 or clinically indicated

If not done in the preceding 6 months:
- ALT, AST, bilirubin, albumin, BUN, creatinine
- CBC, platelets, PT
- T4, TSH
- Fe, TIBC

**Monitoring Schedule on nucleoside analog therapy for hepatitis B**

| Treatment week | **Pre Rx** | **1 2** | **2 4** | **3 6** | **4 8** | **Q 12** | **6 mos. Post Rx** |
|---|---|---|---|---|---|---|---|
| CBC + diff | X | X | X | X | X | X | X |
| PT/PTT | X | X | X | X | X | X | X |
| Liver tests** | X | X | X | X | X | X | X |
| Free T4, T4, TSH | X | X | X | X | X | X | X |
| alpha-fetoprotein (AFP) | X | | X | | X | X | X |
| Creatinine (if on adefovir or tenofovir) | X | X | | | | | |
| HBV-DNA | X | | X | | X | X* | X |
| HBeAg/anti-HBe (if initially HBeAg positive) | X | | X | | X | X* | X |
| HBsAg (if HBeAg neg and HBV-DNA < 2,000) | X | | X | | X | X* | X |

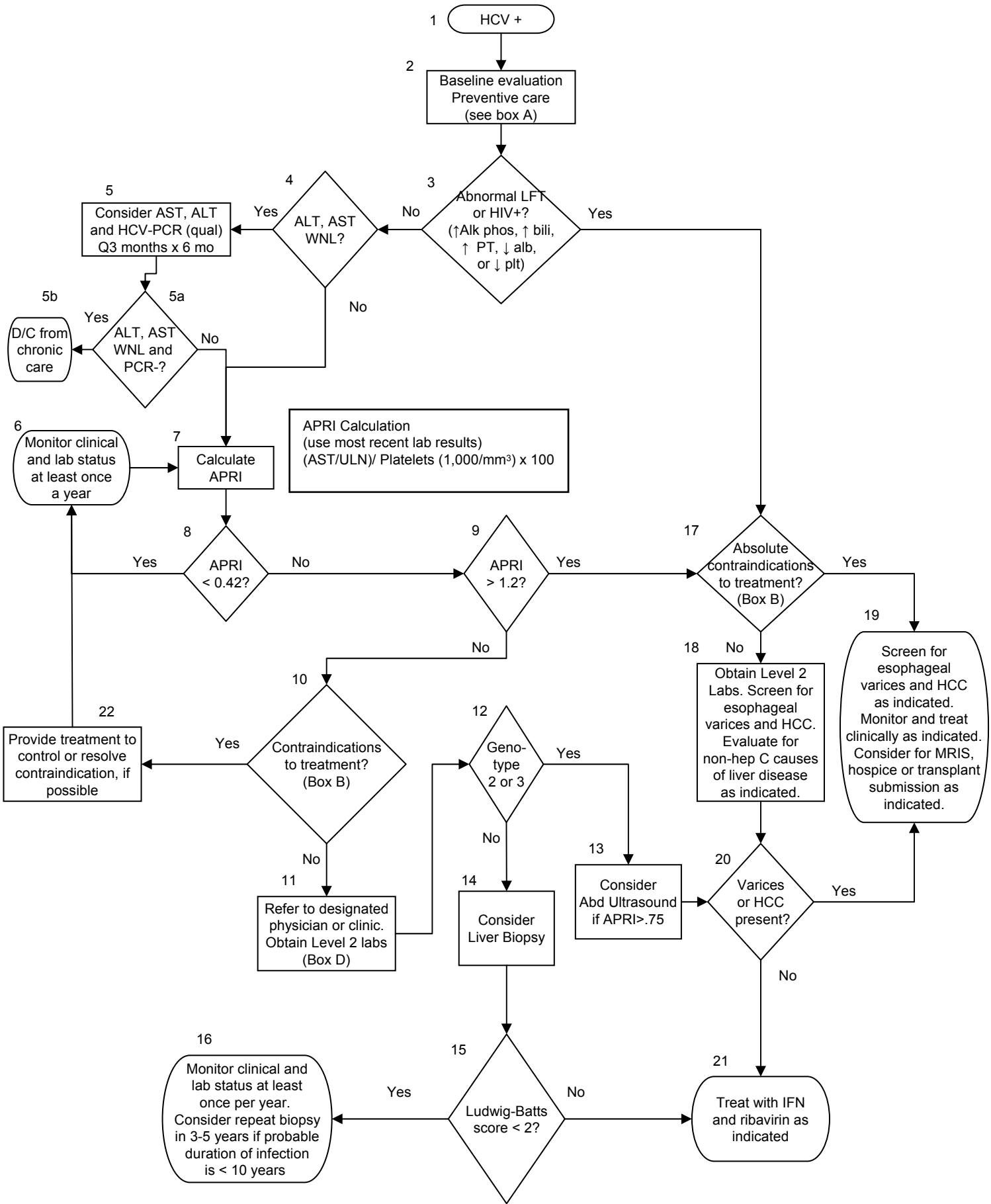
* these tests are done every 24 weeks during treatment

**Monitoring Schedule on IFN alfa**

| Treatment week | **Pre Rx** | 2 | 4 | 8 | **1 2** | 1 6 | **3 mos.Post Rx** | **6 mos.Post Rx** |
|---|---|---|---|---|---|---|---|---|
| CBC + diff | X | X | X | X | X | X | X | X |
| PT/PTT | X | X | X | X | X | X | X | X |
| Liver tests** | X | X | X | X | X | X | X | X |
| Free T4, T4, TSH | X | | | | X | | X | X |
| alpha-fetoprotein (AFP) | X | | | | | | | X |
| HBV-DNA | X | | | | | X | X | |
| HBeAg/anti-HBe (if initially HBeAg positive) | X | | | | | X | X | X |
| HBsAg (if HBeAg neg and HBV-DNA < 2,000) | X | | | | | X | | |
| Beck Depresion Index | X | | X | X | X | X | X | X |

** liver test: ALT, AST, bilirubin (conjugated & unconjugated), albumin, Alkaline phosphatase, LDH

# Hepatitis C Evaluation and Treatment Pathway



# Hepatitis C Evaluation and Treatment Pathway

Box A

Baseline Evaluation
- History and physical
- ALT, AST, Alk Phos, Bili, Alb
- CBC, platelets, PT
- HBsAg, anti-HBs, anti-HAV
- HIV
- BUN/Creatinine

Preventive Care
- Education and counseling
  - Natural history of disease
  - Potential treatments
  - Behaviors to avoid (eg, alcohol)
  - Avoiding transmission
- Vaccination, if indicated
  - Hep B
  - Hep A
- Additional care if cirrhosis present
  - Pneumococcal vaccine
  - Annual influenza vaccination
  - Consider screening for hepatocellular carcinoma and esophageal varices

Box B – Contraindications

Refusal of treatment

Absolute contraindications
- Uncompensated cirrhosis (Box C)
- Life-threatening comorbidity
- Uncontrolled autoimmune disorders
- Poorly controlled diabetes
- Solid organ transplant
- Untreated or uncontrolled hyperthyroidism
- Active suicidal ideation or poorly controlled psychiatric disorder

Additional contraindications for ribavirin
- Pregnancy
- Hemoglobinopathies
- Hemolytic or other severe anemias
- Creatinine > 2

Relative contraindications
- Ischemic cardiovascular or cerebrovascular disease
- Insufficient time left in system to complete work-up and treatment
- Poor compliance with work-up or other treatments
- Evidence of ongoing high risk behavior
- Neutropenia or thrombocytopenia
- Poorly controlled HIV on HAART

Note: Treatable contraindications should be controlled or resolved and the patient reconsidered for treatment

Box C – Evidence of Uncompensated Cirrhosis

- Hepatic encephalopathy
- History of bleeding esophageal varices
- Ascites
- Laboratory abnormalities (but consider other causes of the abnormalities)
  - Platelet count < 70,000
  - Albumin < 3.0
  - Prothrombin time prolonged > 2 sec
  - Bilirubin > 1.5

Box D – Level 2 Labs

- Quantitative HCV-PCR
- HCV genotype
- alpha-fetoprotein
- Alpha-1 antitrypsin
- Ceruloplasmin
- ANA
- CXR and EKG if over 40 or clinically indicated
- Serum pregnancy test if female

If not done in the preceding 6 months:
- ALT, AST, bilirubin, albumin, BUN, creatinine
- CBC, platelets, PT
- T4, TSH
- Fe, TIBC

Hepatitis C Pathway Notes

Notice: The pathway is not intended to cover all clinical situations nor to comprehensively cover the aspects that are included in the pathway. It represents the normal expected level of care. It is understood that each patient is different and the care provided to a particular patient must be individualized. Clinical judgment prevails in patient care; however it is advisable to document the rationale for deviation from the pathway whenever it occurs.

The decision to proceed with the pre-treatment evaluation or to start treatment depends on more than the simplified decision-making criteria used in the pathway. The clinician should also consider co-morbidity, patient desires, patient compliance with other treatments and with the work-up, disciplinary actions that suggest ongoing high-risk behavior, likelihood of completing treatment if the offender is expected to release before completion, etc. No single factor should be the deciding one. For example, one might decide not to proceed with treatment in an offender with 6 months left who is otherwise healthy and is thought to have been infected only for 10 years and who has normal or slightly elevated ALT levels. On the other hand if the offender had only 6 months left, had been infected for 30 years and had mild abnormalities of LFTs, one might initiate treatment even without enough time left to complete it in TDCJ because the liver disease is likely rather advanced. In that case, arranging appropriate follow-up care through TCOOMMI will be important.

Box 2 – baseline evaluation should include the items required by policy and listed in Box A. The history should be directed toward identifying co-factors that may affect clinical decisions, as well as a history of risk behaviors to establish a probable date of infection. In general a longer probable period of infection is associated with a greater likelihood of advanced disease and should weight decision making in the direction of pursuing evaluation for treatment.

Box 3 - LFTs are indicators of liver function as opposed to transaminases which are more reflective of the rate of liver damage. LFTs include bilirubin, prothrombin time and serum albumin. Other tests that may indicate more advanced liver fibrosis are alkaline phosphatase, which is often elevated in cirrhosis, platelet count (decreased in cirrhosis) and the ratio of AST/ALT, which is often greater than 1 in cirrhosis. If these tests are abnormal, or if the patient is coinfected with HIV, they should usually be entered into the pre-treatment evaluation. HIV coinfected offenders should be referred to an Infectious Disease specialist for management of both infections. If they are in the Texas Tech sector they should be transferred to the UTMB sector for care if possible.

Box 5 – If the baseline liver transaminases and LFTs are WNL, the patient may have resolved hepatitis C. Consider repeating ALT, AST and obtaining HCV-PCR (qualitative) 2-3 times over a six month period.

Box 5a, 5b – If all ALTs, ASTs and HCV-PCR are WNL, the patient has resolved hepatitis C and can be discharged from chronic care clinic for this condition.

Box 6 – annual evaluation of patients who are not evaluated for treatment or for whom treatment is deferred after evaluation should include clinical evaluation for signs of progressive liver disease. Minimal laboratory studies should include an AST level and platelet count so that an APRI score can be calculated. If the APRI score is greater than or equal to 0.42 or if there is reason to believe that the APRI score is unreliable, the clinician should consider proceeding with the pre-treatment work-up. If a patient has had a liver biopsy with a Ludwig-Batts score less than 2, and the duration of illness suggests their disease is slowly progressive, it may be appropriate to postpone a repeat evaluation for treatment for 3-5 years. See the discussion for box 20 for more details.

Box 7 – the aspartate aminotransferase (AST) to platelet ratio index (APRI) is calculated by dividing the AST level by the upper limit of normal, and then dividing the result by the platelet count in thousands/$mm^3$. That result is then multiplied by 100 to arrive at the APRI score. The APRI is somewhat predictive of liver fibrosis but cannot replace the liver biopsy in all cases. An APRI score of less than 0.42 has a 93% predictive value for a Ludwig-Batts score of 0 or 1 on liver biopsy, and a score of over 1.2 has a predictive value of 93% for a Ludwig-Batts score of 2-4. The APRI may be less predictive when there are conditions other than liver disease that may affect the platelet count or AST level. Realizing that the predictive values of the chosen cutoff scores are less than 100, the clinician may find situations when they will choose to proceed with the pre-treatment evaluation with a lower APRI score, or not proceed with a higher score.

Box 8 – In general, patients with an APRI score less than 0.42 do not need to be considered for treatment. However, refer to the discussion for Box 7 to consider times when the APRI score might be elevated or depressed for reasons related to coexisting morbidity and might not be reflective to the status of liver fibrosis. In addition, the APRI score may be over 0.42 with normal ALT levels. While there may be times when treatment is indicated even with normal ALT levels, there is currently no consensus on the need to biopsy and evaluate for treatment if the ALT levels are consistently normal. If a decision is made to proceed with a work-up with normal ALT levels and an APRI score over 0.42, chronic HCV infection should be confirmed first with one or more HCV-PCR tests.

Box 9 – Generally, patients with an APRI score over 1.2 should be considered for treatment without a liver biopsy. 93% of these patients will have a Ludwig-Batts score of 2 or higher if they were biopsied. If there is reason to believe the APRI score is not an accurate indicator of liver fibrosis, the provider may wish to consider a liver biopsy before making a decision on a treatment recommendation. Patients with an APRI score between 0.42 and 1.2 should usually be considered for liver biopsy before determining a recommendation about treatment.

Box 10 and Box 22 – If the patient has any absolute contraindications to treatment, an attempt should be made to correct those that can be altered, and then proceed with the pre-treatment evaluation if they no longer have an absolute contraindication. Absolute and relative contraindications are listed in Box B. If one or more relative contraindications are present, the provider must weigh the benefits and risks of treatment.

Some of the factors to consider are how advanced or rapidly progressing the liver disease is, the severity of the condition causing the relative contraindication, interest in treatment on the part of the patient, and understanding by the patient of the potential risks. In addition, the likelihood of completing adequate treatment must be considered for each patient on an individual basis.

Box 11 – If a patient has an APRI score between 0.42 and 1.2 and no clear-cut contraindications for treatment, they should be referred to the designated physician or clinic that will continue the pre-treatment work-up and make a recommendation for treatment. At this point, level 2 labs (quantitative HCV-PCR and genotype should be done, as well as alpha fetoprotein, alpha-1 antitrypsin, ceruloplasmin, and ANA. ALT, AST, bilirubin, albumin, PT, CBC with platelets, BUN, creatinine, T4, TSH, iron, TIBC, and ferritin should be obtained if not already done in the preceding 6 months. CXR and EKG should be obtained of patients over 40 or if otherwise clinically indicated. Serum pregnancy test if female)

Box 12 –About 30% of cases in TDCJ are genotypes 2/3. In general, response to treatment in genotypes 2/3 is relatively good, and it is cost-effective and clinically appropriate to consider treatment without a liver biopsy in these patients, unless the laboratory findings suggest the possibility of co-morbid liver disease.

Box 13 – If a liver biopsy is not being done, consider abdominal ultrasound if the APRI score is over 0.75.

Box 14 – If genotype other than 2/3, or if other indications exist, consider liver biopsy prior to making a treatment recommendation.

Box 15 – In the Unites States, the Ludwig-Batts score is a common way to describe liver biopsies based on the amount of fibrosis. Ludwig-Batts scores are given on a 0-4 scale and correlate with the METAVIR score that is widely used in Europe and is frequently seen in the scientific literature. Although treatment is usually not recommended if the Ludwig-Batts score is 0 or 1, each case must be considered individually.

Box 16 – If the Ludwig-Batts score is less than 2, treatment is usually not indicated. If the probable duration of infection is over 10 years and the Ludwig-Batts score is this low, the patient is probably a slow-progressor, and the timing of a repeat biopsy should be considered on an individual basis. If the probable duration of infection is less than 10 years, a repeat biopsy should be considered in 3-5 years to assess status and rate of disease progression.

Box 21 – If the Ludwig-Batts score is 2 or greater, treatment is usually indicated. However, the clinician should consider relative contraindications, co-morbidity, patient desires, etc., in making a treatment recommendation.

Box 17 – If the APRI score is over 1.2, the likelihood that the patient has fibrosis corresponding to a Ludwig-Batts score of 2 or higher is 93%. These patients may be considered for treatment without liver biopsy if treatment is not contraindicated. See also discussion for Boxes 10 and 22. Level 2 labs should be obtained at this point.

Box 18 – If no uncorrectable absolute contraindications to treatment exist, and correctable contraindications have been addressed, obtain level 2 labs and screen for esophageal varices. At a minimum, an abdominal ultrasound should be done, but endoscopy to rule out large varices may be considered.

Box 19 – If absolute contraindications to treatment exist and cannot be corrected, screen for varices and hepatocellular carcinoma as clinically indicated. Consider submitting the patient for Medically Recommended Intensive Supervision, and for submission to be considered for liver transplant. Calculate the Model for End-stage Liver Disease (MELD) score. A score of 30 or higher has a predicted 3-month mortality of 50%. These patients should be referred to the hospice program if they are willing and are not being considered for liver transplant. Other patients may be suitable for hospice care; the MELD score should not be the sole determining factor. Consider whether patients with hepatic encephalopathy or massive ascites or edema should be in an extended care facility or other special care setting.

Box 20 – If esophageal varices or hepatocellular varices are present, these problems should be addressed, but treatment for hepatitis C is generally contraindicated. If the conditions are not present, treatment for hepatitis C should be considered (Box 21)

# Monitor Grid

**Monitoring Schedule on Peg-IFN alfa-2a and Ribavirin: HCV genotypes 1 & 4**

| Treatment week | **Pre Rx (wk 0)** | 2 | 4 | 8 | **12*** | 16 | 20 | **24*** | 28 | 32 | 36 | 40 | 44 | **48*** | **6 mos. Post Rx*** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CBC + diff | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X |
| PT/PTT | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Liver tests** | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Free T4, T4, TSH | X | | | | X | | | X | | | X | | | X | X |
| alpha-fetoprotein (AFP) | | | | | | | | X | | | | | | X | X |
| **HCV (quantitative PCR)** | | | | | **X** | | | | | | | | | | |
| **HCV (qualitative PCR)** | | | | | | | | **X** | | | | | | **X** | **X** |
| Beck Deprresion Index | X | | X | X | X | X | | X | | | X | | | X | X |
| Urine pregnancy test (F) | X | | | | X | | | X | | | X | | | X | X |
| TCC (wks) [UTMB only] | | | (6) | (10) | (16) | | (22) | (28) | | | (38) | | (46) | (54) | (7 mos.post Rx) |

**Monitoring Schedule on Peg-IFN alfa-2a and Ribavirin: HCV genotype 2 & 3**

| Treatment week | **Pre Rx (wk 0)** | 2 | 4 | 8 | **12*** | 16 | 20 | **24*** | **6 mos.Post Rx*** |
|---|---|---|---|---|---|---|---|---|---|
| CBC + diff | X | X | X | X | X | X | X | X | X |
| PT/PTT | X | X | X | X | X | X | X | X | X |
| Liver tests** | X | X | X | X | X | X | X | X | X |
| Free T4, T4, TSH | X | | | | X | | | X | X |
| alpha-fetoprotein (AFP) | | | | | | | | X | X |
| **HCV (quantitative PCR)** | | | | | **X** | | | | |
| **HCV (qualitative PCR)** | | | | | | | | **X** | **X** |
| Beck Deprresion Index | X | | X | X | X | X | | X | X |
| Urine pregnancy test (F) | X | | | | X | | | X | X |
| TCC (wks) [UTMB only] | | | (6) | (10) | (16) | | (22) | (28) | (7 mos.post Rx) |

** liver test: ALT, AST, bilirubin (conjugated & unconjugated), albumin, Alkaline phosphatase, LDH
* It is **very important** to do PCRs on schedule, treatment decision and response are based on the PCR results

# Correctional Managed Health Care

# Monthly Report

# July 2007

**September 2006 – July 2007**

## Summary

The purpose of this report is to provide updated and accurate information on the costs of the correctional health care program. This monthly report summarizes activity for the month of July, 2007. Following this narrative are the supporting financial and statistical tables.

### *Background*

During Fiscal Year 2007, approximately $375.8 million within the TDCJ appropriation has been allocated for funding correctional health care services. This funding included:

- $313.2M in general revenue appropriations in strategy C.1.8 (Managed Health Care, medical services)
- $17.5M in supplemental appropriations from HB10
- $43.1M in general revenue appropriations in strategy C.1.7. (Psychiatric Care).
- $2.0M in general revenue funding from C.3.1 (Contract Prisons/Private State Jails) provided by TDCJ for the addition of health services for the privately-operated facilities to the CMHCC service population. This transfer of responsibility from the private prison operators to the CMHCC resulted in a net savings to the TDCJ appropriations.

Of this funding, $375.2M (99.8%) was allocated for health care services provided by UTMB and TTUHSC and $584.9K (0.2%) for the operation of the Correctional Managed Health Care Committee.

In addition to the above funding, UTMB and TTUHSC also receive partial reimbursement for certain benefit payments through other appropriations made for that purpose. These payments are made directly to the university providers. Benefit reimbursement amounts and expenditures are included in the reported totals provided by the universities.

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## *Report Highlights*

### Population Indicators

- Through July of this fiscal year, the correctional health care program remained essentially stable in the overall offender population served by the program. The average daily population served through July of FY 2007 was 151,811. This average was slightly higher than the average through July FY 2006 of 151,255, an increase of 556 (0.4%). Even though the overall population was relatively stable, the number of offenders age 55 and over has continued to steadily increase.
  - Consistent with the trend for the last several years, the number of offenders in the service population aged 55 or older has continued to rise at a faster rate than the overall population. Through July of FY 2007, the average number of older offenders in the service population was 9762. Through this same month a year ago (FY 2006), the average number of offenders age 55 and over was 8906. This represents an increase of 856 or about 9.6% more older offenders than a year ago.
  - The overall HIV+ population has remained relatively stable throughout the last three years and continued to remain so through this month, averaging 2,580(or about 1.7% of the population served).
  - Two mental health caseload measures have also remained relatively stable:
    - The average number of psychiatric inpatients within the system was 2,010 through July of FY 2007, a slight increase from 1,988 through July of FY 2006.
    - Through the month of July FY 2007, the average number of mental health outpatients was 20,330 representing 13.4% of the service population.

### Health Care Costs

- Overall health costs through July of FY 2007 totaled $391.0M.
  - UTMB's total revenue through the month was $311.0M. Their expenditures totaled $311.1M, resulting in a net loss of less than $0.1M. On a per offender per day basis, UTMB earned $7.75 in revenue and expended $7.75.
    - TTUHSC's total revenue through the month was $74.4M. Expenditures totaled $79.9M, resulting in a net loss of $5.5M. On a per offender per day basis, TTUHSC earned $7.05 in revenue, but expended $7.57 resulting in a shortfall of $0.52 per offender per day.

Examining the health care costs in further detail indicates that of the $391.0M in expenses reported through July:

- Onsite services (those medical services provided at the prison units) comprised $187.2M representing about 47.9% of the total health care expenses:
- Pharmacy services totaled $37.8M representing approximately 9.7% of the total expenses:
- Offsite services (services including hospitalization and specialty clinic care) accounted for $116.6M or 29.7% of total expenses:
- Mental health services totaled $35.8M or 9.2% of the total costs:
- Indirect support expenses accounted for $13.5M and represented 3.5% of the total costs.

The total cost per offender per day for all health care services statewide through July of FY 2007 was $7.71, an increase (1.4%) from $7.60 for July of FY 2006. However, when benchmarked against the average cost per offender per day for the prior four fiscal years of $7.53, the cost has increased slightly higher (2.3%).

- For UTMB, the cost per offender per day was $7.75, slightly higher than the average cost per day for the last four fiscal years of $7.66.
- For TTUHSC, the cost per offender per day was $7.58, significantly higher than the average cost per day for the last four fiscal years of $7.05.
- Differences in cost between UTMB and TTUHSC relate to the differences in mission, population assigned and the acuity level of the offender patients served.

### *Reporting of Fund Balances*

- A review of revenues and expenditures for FY 2007 indicates that UTMB reports a total shortfall of $22,145 through the month. TTUHSC reports a total shortfall of $5,492,886 through this month.

- A summary analysis of the ending balances, revenue and payments through July for all CMHCC fund accounts is also included in this report. That summary indicates that the net balance on all accounts held by the CMHCC on July 31, 2007 was $280,105.72.

### *Financial Monitoring*

Detailed transaction level data from both providers is being tested on a monthly basis to verify reasonableness, accuracy, and compliance with policies and procedures. All corrective actions requested in prior months have been completed and verified as agreed by UTMB and TTUHSC. The results of the detail transaction testing performed on TTUHSC's and UTMB's financial information for the month of June 2007 found all tested transactions to be verified. Transaction testing for the month of July 2007 is in progress.

### *Concluding Notes*

The combined *shortfall* for the university providers through July of FY 2007 is $5,515,031. 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 2007 Budget Allocations***

## *Distribution of Funds*

| Allocated to | FY 2007 |
|---|---|
| **University Providers** | |
| **The University of Texas Medical Branch** | |
| Medical Services | $273,775,733 |
| Mental Health Services | $25,619,350 |
| Subtotal UTMB | $299,395,083 |
| **Texas Tech University Health Sciences Center** | |
| Medical Services | $63,433,828 |
| Mental Health Services | $12,337,000 |
| Subtotal TTUHSC | $75,770,828 |
| SUBTOTAL UNIVERSITY PROVIDERS | $375,165,911 |
| **Correctional Managed Health Care Committee** | $584,909 |
| **TOTAL DISTRIBUTION** | **$375,750,820** |

## *Source of Funds*

| Source | FY 2007 |
|---|---|
| **Legislative Appropriations** | |
| SB 1, Article V, TDCJ Appropriations | |
| Strategy C.1.8. Managed Health Care | $313,174,719 |
| Strategy C.1.7 Psychiatric Care | $43,094,589 |
| Strategy C.3.1. Contract Prisons/Private St. Jails* | $1,981,512 |
| HB 10 Supplemental Appropriations | $17,500,000 |
| **TOTAL** | **$375,750,820** |

*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.

Table 2
FY 2007
Key Population Indicators
Correctional Health Care Program

| Indicator | Sep-06 | Oct-06 | Nov-06 | Dec-06 | Jan-07 | Feb-07 | Mar-07 | Apr-07 | May-07 | Jun-07 | Jul-07 | Population Year to Date Avg. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Avg. Population Served by CMHC: | | | | | | | | | | | | |
| UTMB State-Operated Population | 108,444 | 108,358 | 108,500 | 108,214 | 107,951 | 108,255 | 108,465 | 108,459 | 108,727 | 108,770 | 108,511 | 108,423 |
| UTMB Private Prison Population* | 11,802 | 11,817 | 11,807 | 11,809 | 11,812 | 11,797 | 11,819 | 11,811 | 11,795 | 11,798 | 11,768 | 11,803 |
| UTMB Total Service Population | 120,246 | 120,174 | 120,307 | 120,022 | 119,763 | 120,052 | 120,283 | 120,271 | 120,522 | 120,568 | 120,279 | 120,226 |
| TTUHSC Total Service Population | 31,520 | 31,568 | 31,700 | 31,639 | 31,612 | 31,596 | 31,571 | 31,620 | 31,570 | 31,491 | 31,544 | 31,585 |
| CMHC Service Population Total | 151,766 | 151,742 | 152,007 | 151,662 | 151,375 | 151,648 | 151,854 | 151,891 | 152,092 | 152,059 | 151,824 | 151,811 |
| Population Age 55 and Over | | | | | | | | | | | | |
| UTMB Service Population Average | 7,704 | 7,760 | 7,832 | 7,862 | 7,967 | 8,035 | 8,053 | 8,100 | 8,197 | 8,197 | 8,224 | 7,994 |
| TTUHSC Service Population Average | 1,704 | 1,721 | 1,743 | 1,754 | 1,753 | 1,778 | 1,782 | 1,802 | 1,807 | 1,792 | 1,820 | 1,769 |
| CMHC Service Population Average | 9,408 | 9,481 | 9,575 | 9,616 | 9,720 | 9,813 | 9,835 | 9,902 | 10,004 | 9,989 | 10,044 | 9,762 |
| HIV+ Population | 2,679 | 2,706 | 2,679 | 2,693 | 2,507 | 2524 | 2523 | 2512 | 2516 | 2529 | 2509 | 2,580 |
| Mental Health Inpatient Census | | | | | | | | | | | | |
| UTMB Psychiatric Inpatient Average | 1,037 | 1,034 | 1,039 | 1,014 | 1,038 | 1,042 | 1,036 | 1,041 | 1,060 | 1060 | 1057 | 1,042 |
| TTUHSC Psychiatric Inpatient Average | 960 | 971 | 964 | 981 | 986 | 980 | 966 | 961 | 953 | 963 | 970 | 969 |
| CMHC Psychiatric Inpatient Average | 1,997 | 2,005 | 2,003 | 1,995 | 2,024 | 2,022 | 2,002 | 2,002 | 2,013 | 2,023 | 2,027 | 2,010 |
| Mental Health Outpatient Census | | | | | | | | | | | | |
| UTMB Psychiatric Outpatient Average | 15,648 | 16,654 | 15,426 | 15,278 | 15,741 | 15,544 | 16,310 | 16,951 | 16,520 | 16,252 | 16,652 | 16,089 |
| TTUHSC Psychiatric Outpatient Average | 4,557 | 4,807 | 4,333 | 3,947 | 4,101 | 4,064 | 3,779 | 4,323 | 4,481 | 4,178 | 4,089 | 4,242 |
| CMHC Psychiatric Outpatient Average | 20,205 | 21,461 | 19,759 | 19,225 | 19,842 | 19,608 | 20,089 | 21,274 | 21,001 | 20,430 | 20,741 | 20,330 |

# Table 3
# Summary Financial Report: Medical Costs
# Fiscal Year 2007 - through July 31, 2007 (Sept 2006- July 2007)

Days in Year: 334

| | Medical Services Costs | | | Medical Cost Per Day Calculations | | |
|---|---|---|---|---|---|---|
| | **UTMB** | **TTUHSC** | **TOTAL** | **UTMB** | **TTUHSC** | **TOTAL** |
| **Population Served** | **120,221** | **31,589** | **151,810** | | | |
| **Revenue** | | | | | | |
| Capitation Payments | $252,123,547 | $58,972,134 | $311,095,681 | $6.28 | $5.59 | $6.14 |
| State Reimbursement Benefits | $30,844,546 | $2,981,209 | $33,825,755 | $0.77 | $0.28 | $0.67 |
| Other Misc Revenue | $254,898 | $0 | $254,898 | $0.01 | $0.00 | $0.01 |
| **Total Revenue** | **$283,222,991** | **$61,953,343** | **$345,176,334** | **$7.05** | **$5.87** | **$6.81** |
| **Expenses** | | | | | | |
| **Onsite Services** | | | | | | |
| Salaries | $108,794,079 | $8,943,591 | $117,737,670 | $2.71 | $0.85 | $2.32 |
| Benefits | $27,476,026 | $2,155,219 | $29,631,245 | $0.68 | $0.20 | $0.58 |
| Operating (M&O) | $14,993,113 | $1,210,519 | $16,203,632 | $0.37 | $0.11 | $0.32 |
| Professional Services | $0 | $2,459,472 | $2,459,472 | $0.00 | $0.23 | $0.05 |
| Contracted Units/Services | $0 | $18,936,477 | $18,936,477 | $0.00 | $1.79 | $0.37 |
| Travel | $876,635 | $63,988 | $940,623 | $0.02 | $0.01 | $0.02 |
| Electronic Medicine | $0 | $194,960 | $194,960 | $0.00 | $0.02 | $0.00 |
| Capitalized Equipment | $1,078,244 | $0 | $1,078,244 | $0.03 | $0.00 | $0.02 |
| **Subtotal Onsite Expenses** | $153,218,097 | $33,964,226 | $187,182,323 | $3.82 | $3.22 | $3.69 |
| **Pharmacy Services** | | | | | | |
| Salaries | $3,584,222 | $1,038,880 | $4,623,102 | $0.09 | $0.10 | $0.09 |
| Benefits | $1,100,046 | $61,477 | $1,161,523 | $0.03 | $0.01 | $0.02 |
| Operating (M&O) | $2,004,036 | $554,394 | $2,558,430 | $0.05 | $0.05 | $0.05 |
| Pharmaceutical Purchases | $23,046,538 | $6,412,650 | $29,459,188 | $0.57 | $0.61 | $0.58 |
| Professional Services | $0 | $0 | $0 | $0.00 | $0.00 | $0.00 |
| Travel | $19,082 | $12,704 | $31,786 | $0.00 | $0.00 | $0.00 |
| **Subtotal Pharmacy Expenses** | $29,753,924 | $8,080,105 | $37,834,029 | $0.74 | $0.77 | $0.75 |
| **Offsite Services** | | | | | | |
| University Professional Services | $12,683,752 | $914,950 | $13,598,702 | $0.32 | $0.09 | $0.27 |
| Freeworld Provider Services | $13,241,153 | $11,816,880 | $25,058,033 | $0.33 | $1.12 | $0.49 |
| UTMB or TTUHSC Hospital Cost | $66,113,913 | $8,736,300 | $74,850,213 | $1.65 | $0.83 | $1.48 |
| Estimated IBNR | $2,367,361 | $707,814 | $3,075,175 | $0.06 | $0.07 | $0.06 |
| **Subtotal Offsite Expenses** | $94,406,179 | $22,175,944 | $116,582,123 | $2.35 | $2.10 | $2.30 |
| **Indirect Expenses** | $8,379,574 | $3,639,325 | $12,018,899 | $0.21 | $0.34 | $0.24 |
| **Total Expenses** | **$285,757,774** | **$67,859,600** | **$353,617,374** | **$7.12** | **$6.43** | **$6.97** |
| **Operating Income (Loss)** | **($2,534,783)** | **($5,906,257)** | **($8,441,040)** | **($0.06)** | **($0.56)** | **($0.17)** |

# Table 3 (Continued)
# Summary Financial Report: Mental Health Costs
# Fiscal Year 2007 through July 31, 2007 (Sept 2006- July 2007)

Days in Year: 334

| | Mental Health Services Costs | | | Mental Health Cost Per Day Calculations | | |
|---|---|---|---|---|---|---|
| | UTMB | TTUHSC | TOTAL | UTMB | TTUHSC | TOTAL |
| **Population Served** | **120,140** | **31,603** | **151,743** | | | |
| **Revenue** | | | | | | |
| Capitation Payments | $23,443,460 | $10,363,367 | $33,806,827 | $0.58 | $0.98 | $0.67 |
| State Reimbursement Benefits | $4,376,816 | $2,109,385 | $6,486,201 | $0.11 | $0.20 | $0.13 |
| Other Misc Revenue | $0 | $0 | $0 | $0.00 | $0.00 | $0.00 |
| **Total Revenue** | **$27,820,276** | **$12,472,752** | **$40,293,028** | **$0.69** | **$1.18** | **$0.80** |
| **Expenses** | | | | | | |
| **Mental Health Services** | | | | | | |
| Salaries | $18,906,725 | $8,646,562 | $27,553,287 | $0.47 | $0.82 | $0.54 |
| Benefits | $4,648,083 | $2,231,208 | $6,879,291 | $0.12 | $0.21 | $0.14 |
| Operating (M&O) | $743,545 | $146,348 | $889,893 | $0.02 | $0.01 | $0.02 |
| Professional Services | $0 | $338,830 | $338,830 | $0.00 | $0.03 | $0.01 |
| Contracted Units/Services | $0 | $0 | $0 | $0.00 | $0.00 | $0.00 |
| Travel | $131,051 | $19,081 | $150,132 | $0.00 | $0.00 | $0.00 |
| Electronic Medicine | $0 | $0 | $0 | $0.00 | $0.00 | $0.00 |
| Capital Expenditures | $35,658 | $0 | $35,658 | $0.00 | $0.00 | $0.00 |
| **Subtotal Mental Health Expenses** | $24,465,062 | $11,382,029 | $35,847,091 | $0.61 | $1.08 | $0.71 |
| | | | | | | |
| **Indirect Expenses** | $842,576 | $677,352 | $1,519,928 | $0.02 | $0.06 | $0.03 |
| | | | | | | |
| **Total Expenses** | **$25,307,638** | **$12,059,381** | **$37,367,019** | **$0.63** | **$1.14** | **$0.74** |
| | | | | | | |
| **Operating Income (Loss)** | **$2,512,638** | **$413,371** | **$2,926,009** | **$0.06** | **$0.04** | **$0.06** |

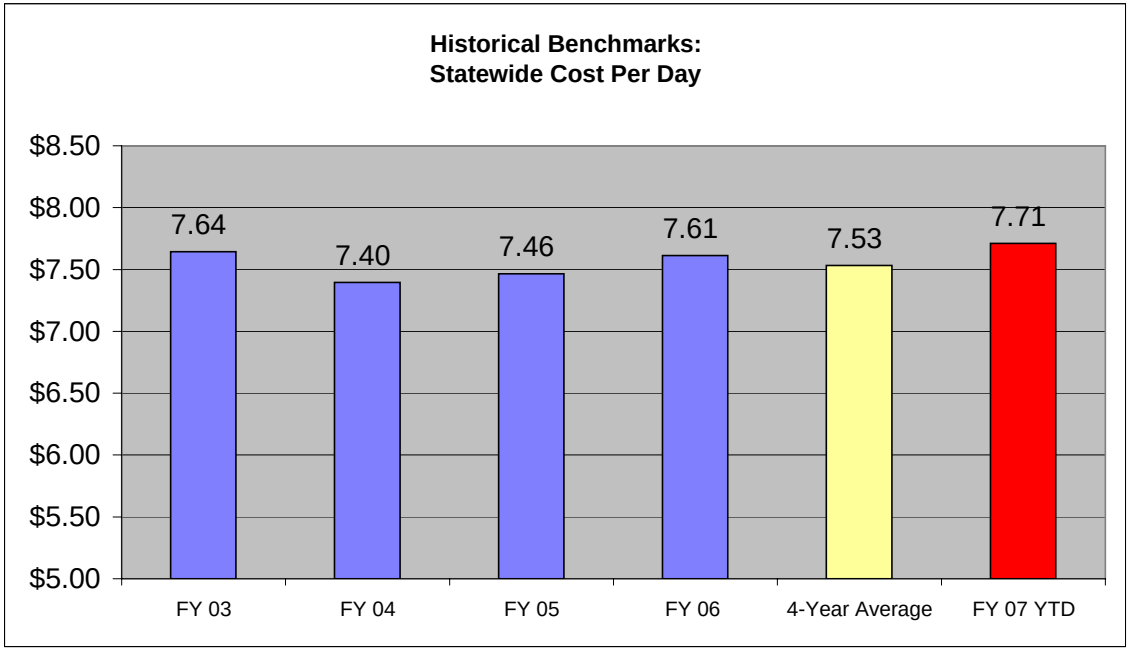
## All Health Care Summary

| | All Health Care Services | | | Cost Per Offender Per Day | | |
|---|---|---|---|---|---|---|
| | UTMB | TTUHSC | TOTAL | UTMB | TTUHSC | TOTAL |
| Medical Services | $283,222,991 | $61,953,343 | $345,176,334 | $7.06 | $5.87 | $6.81 |
| Mental Health Services | $27,820,276 | $12,472,752 | $40,293,028 | $0.69 | $1.18 | $0.80 |
| **Total Revenue** | **$311,043,267** | **$74,426,095** | **$385,469,362** | **$7.75** | **$7.05** | **$7.61** |
| Medical Services | $285,757,774 | $67,859,600 | $353,617,374 | $7.12 | $6.43 | $6.98 |
| Mental Health Services | $25,307,638 | $12,059,381 | $37,367,019 | $0.63 | $1.14 | $0.74 |
| **Total Expenses** | **$311,065,412** | **$79,918,981** | **$390,984,393** | **$7.75** | **$7.57** | **$7.71** |
| | | | | | | |
| **Operating Income (Loss)** | **($22,145)** | **($5,492,886)** | **($5,515,031)** | **($0.00)** | **($0.52)** | **($0.11)** |

**Table 4**
**Comparison of Total Health Care Costs**

| | FY 03 | FY 04 | FY 05 | FY 06 | 4-Year Average | FY 07 YTD |
|---|---|---|---|---|---|---|
| **Population** | | | | | | |
| UTMB | 105,525 | 113,729 | 119,322 | 119,835 | 114,603 | 120,226 |
| TTUHSC | 31,041 | 31,246 | 31,437 | 31,448 | 31,293 | 31,585 |
| Total | 136,566 | 144,975 | 150,759 | 151,283 | 145,896 | 151,811 |
| | | | | | | |
| **Expenses** | | | | | | |
| UTMB | $300,912,092 | $313,875,539 | $330,672,773 | 336,934,127 | 320,598,633 | 311,065,412 |
| TTUHSC | $80,079,315 | $78,548,146 | $80,083,059 | 83,467,550 | 80,544,518 | 79,918,981 |
| Total | $380,991,407 | $392,423,685 | $410,755,832 | 420,401,677 | 401,143,150 | 390,984,393 |
| | | | | | | |
| **Cost/Day** | | | | | | |
| UTMB | $7.81 | $7.56 | $7.59 | $7.70 | $7.66 | $7.75 |
| TTUHSC | $7.07 | $6.89 | $6.98 | $7.27 | $7.05 | $7.58 |
| **Total** | **$7.64** | **$7.40** | **$7.46** | **$7.61** | **$7.53** | **$7.71** |

* Expenses include all health care costs, including medical, mental health, and benefit costs.
NOTE: The calculation for FY 04 has been adjusted from some previous reports to correctly account for leap year



## Table 5
## Ending Balances July 31, 2007

| | Beginning Balance September 1, 2006 | Net Activity FY 2007 | Ending Balance July 31, 2007 |
|---|---|---|---|
| CMHCC Operating Funds | $79,112.92 | $39,224.39 | $118,337.31 |
| CMHCC Medical Services | $734,417.59 | ($589,249.63) | $145,167.96 |
| CMHCC Mental Health | $527,107.07 | ($510,506.62) | $16,600.45 |
| **Ending Balance All Funds** | **$1,340,637.58** | **($1,060,531.86)** | **$280,105.72** |

**SUPPORTING DETAIL**

| **CMHCC Operating Account** | |
|---|---|
| Beginning Balance | $79,112.92 |
| **FY 2006 Funds Lapsed to State Treasury** | ($79,112.92) |
| **Revenue Received** | |
| 1st Qtr Payment | $146,227.25 |
| 2nd Qtr Payment | $146,227.25 |
| 3rd Qtr Payment | $146,227.25 |
| 4th Qtr Payment | $146,227.25 |
| Interest Earned | $2,687.41 |
| Subtotal Revenue | $587,596.41 |
| **Expenses** | |
| Salary & Benefits | ($424,551.10) |
| Operating Expenses | ($44,708.00) |
| **Subtotal Expenses** | **($469,259.10)** |
| **Net Activity thru this Qtr** | **$39,224.39** |
| **Total Fund Balance CMHCC Operating** | **$118,337.31** |

**SUPPORTING DETAIL**

| **CMHCC Capitation Accounts** | **Medical Services** | **Mental Health** |
|---|---|---|
| Beginning Balance | $734,417.59 | $527,107.07 |
| **FY 2006 Funds Lapsed to State Treasury** | ($734,417.59) | ($527,107.07) |
| **Revenue Detail** | | |
| **1st Qtr Payment from TDCJ** | $84,302,390.25 | $9,489,087.50 |
| **2nd Qtr Payment from TDCJ** | $84,302,390.25 | $9,489,087.50 |
| **3rd Qtr Payment from TDCJ** | $84,302,390.25 | $9,489,087.50 |
| **4th Qtr Payment from TDCJ** | $84,302,390.25 | $9,489,087.50 |
| **Interest Earned** | $145,167.61 | $13,425.55 |
| **Revenue Received** | **$337,354,728.61** | **$37,969,775.55** |
| **Payments to UTMB** | | |
| 1st Qtr Payment to UTMB | ($68,256,415.50) | ($6,384,115.10) |
| 2nd Qtr Payment to UTMB | ($67,506,345.00) | ($6,317,100.00) |
| 3rd Qtr Payment to UTMB | ($69,006,486.00) | ($6,457,480.00) |
| 4th Qtr Payment to UTMB | ($69,006,486.00) | ($6,457,480.00) |
| **Subtotal UTMB Payments** | **($273,775,732.50)** | **($25,616,175.10)** |
| **Payments to TTUHSC** | | |
| 1st Qtr Payment to TTUHSC | ($15,815,009.21) | ($3,075,800.00) |
| 2nd Qtr Payment to TTUHSC | ($15,641,217.90) | ($3,042,000.00) |
| 3rd Qtr Payment to TTUHSC | ($15,988,800.52) | ($3,109,600.00) |
| 4th Qtr Payment to TTUHSC | ($15,988,800.52) | ($3,109,600.00) |
| **Subtotal TTUHSC Payments** | **($63,433,828.15)** | **($12,337,000.00)** |
| **Total Payments Made thru this Qtr** | **($337,209,560.65)** | **($37,953,175.10)** |
| **Net ActivityThrough This Qtr** | **($589,249.63)** | **($510,506.62)** |
| **Total Fund Balance** | **$145,167.96** | **$16,600.45** |


# Correctional Managed Health Care

# Quarterly Report
# FY 2007 Fourth Quarter

**September 2006 – August 2007**

## Summary

This report is submitted in accordance with Rider 46, page V-20, Senate Bill 1, 79th Legislature, Regular Session 2005. The report summarizes activity through the fourth quarter of FY 2007. Following this summary are individual data tables and charts supporting this report.

### *Background*

During Fiscal Year 2007, approximately $375.8 million within the TDCJ appropriation has been allocated for funding correctional health care services. This funding included:

- $313.2M in general revenue appropriations in strategy C.1.8 (Managed Health Care, medical services)
- $17.5M in supplemental appropriations from HB10
- $43.1M in general revenue appropriations in strategy C.1.7. (Psychiatric Care).
- $2.0M in general revenue funding from C.3.1 (Contract Prisons/Private State Jails) provided by TDCJ for the addition of health services for the privately-operated facilities to the CMHCC service population. This transfer of responsibility from the private prison operators to the CMHCC resulted in a net savings to the TDCJ appropriations.

Of this funding, $375.2M (99.8%) was allocated for health care services provided by UTMB and TTUHSC and $584.9K (0.2%) for the operation of the Correctional Managed Health Care Committee.

In addition to the regular appropriations listed above, a total of $12.9M in supplemental appropriations for the FY 2006-07 Biennium was approved by the 80th Legislature. These funds were distributed to UTMB and TTUHSC in August of 2007 and are included in the revenues outlined in this report.

UTMB and TTUHSC receive partial reimbursement for certain benefit payments through other appropriations made for that purpose. These payments are made directly to the university providers. Benefit reimbursement amounts and expenditures are included in the reported totals provided by the universities.

## *Report Highlights*

**Population Indicators**

- Through the fourth quarter of this fiscal year, the correctional health care program remained essentially stable in the overall offender population served by the program. The average daily population served through the fourth quarter of FY 2007 was 151,813. Through this same quarter a year ago (FY 2006), the average daily population was 151,284, an increase of 529 (0.4%). While overall growth was relatively stable, the number of offenders age 55 and over has continued to steadily increase.
  - Consistent with the trend for the last several years, the number of offenders in the service population aged 55 or older has continued to rise at a faster rate than the overall population. Through the fourth quarter of FY 2007, the average number of older offenders in the service population was 9,789. Through this same quarter a year ago (FY 2006), the average number of offenders age 55 and over was 8,937. This represents an increase of 852 or about 9.5% more older offenders than a year ago.
  - The overall HIV+ population has remained relatively stable throughout the last two years and continued to remain so through this quarter, averaging 2,573 (or about 1.7% of the population served).
  - Two mental health caseload measures have also remained relatively stable:
    - The average number of psychiatric inpatients within the system was 2,008 through the fourth quarter of FY 2007, as compared to 1,991 through the same quarter a year ago (FY 2006). The inpatient caseload is limited by the number of available inpatient beds in the system.
    - Through the fourth quarter of FY 2007, the average number of mental health outpatients was 20,387 representing 13.4% of the service population.

**Health Care Costs**

- Overall health costs through the fourth quarter of FY 2007 totaled $430.0M. This amount was below the overall revenues earned by the university providers by $0.7M or 0.2%.
  - UTMB's total revenue through the quarter was $343.6M. Their expenditures totaled $342.9M, resulting in a net gain of $0.7M. On a per offender per day basis, UTMB earned $7.83 in revenue and expended $7.82 resulting in a gain of $0.01 per offender per day.
  - TTUHSC's total revenue through the fourth quarter was $87.1M. Expenditures totaled $87.1M, resulting in a net loss of $51,423. On a per offender per day basis, TTUHSC earned $7.55 in revenue, but expended $7.56 resulting in a shortfall of $0.01 per offender per day.
- Examining the health care costs in further detail indicates that of the $430.0M in expenses reported through the fourth quarter of the year:
  - Onsite services (those medical services provided at the prison units) comprised $205.3M representing about 47.7% of the total health care expenses:
    - Of this amount, 77.9% was for salaries and benefits and 22.1% for operating costs.
  - Pharmacy services totaled $41.9M representing approximately 9.7% of the total expenses:
    - Of this amount 15.1% was for related salaries and benefits, 6.9% for operating costs and 78.0% for drug purchases.
  - Offsite services (services including hospitalization and specialty clinic care) accounted for $129.2M or 30.0% of total expenses:
    - Of this amount 76.0% was for estimated university provider hospital, physician and professional services; and 24.0% for Freeworld (non-university) hospital, specialty and emergency care.
  - Mental health services totaled $39.3M or 9.1% of the total costs:
    - Of this amount, 95.8% was for mental health staff salaries and benefits, with the remaining 4.2% for operating costs.
  - Indirect support expenses accounted for $14.4M and represented 3.3% of the total costs.

- The total cost per offender per day for all health care services statewide through the fourth quarter of FY 2007 was $7.76. The average cost per offender per day for the prior four fiscal years was $7.53.
    - For UTMB, the cost per offender per day was $7.81. This is slightly higher than the average cost per offender per day for the last four fiscal years of $7.66.
    - For TTUHSC, the cost per offender per day was $7.56, significantly higher than the average cost per offender per day for the last four fiscal years of $7.05.
    - 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 fourth quarter of FY 2007 indicates that offenders aged 55 and over had a documented encounter with medical staff almost three times as often as those under age 55.
    - An examination of hospital admissions by age category found that through this quarter of the fiscal year, hospital costs received to date for charges incurred this fiscal year for offenders over age 55 totaled approximately $3,326 per offender. The same calculation for offenders under age 55 totaled about $614. In terms of hospitalization, the older offenders were utilizing health care resources at a rate more than four times higher than the younger offenders. While comprising about 6.4% of the overall service population, offenders age 55 and over account for more than 27% of the hospitalization costs received to date.
    - A third examination of dialysis costs found that, proportionately, older offenders are represented more than three times more often in the dialysis population than younger offenders. Dialysis costs continue to be significant, averaging about $19K per patient per year. Providing medically necessary dialysis treatment for an average of 194 patients through the fourth quarter of FY2007 cost $3.7M.

**Drug Costs**

- Total drug costs through the fourth quarter of FY 2007 totaled $32.4M.
    - Pharmaceutical costs related to HIV care continue to be the largest single component of pharmacy expenses.
        - Through this quarter, $14.8M in costs (or $1.2M per month) for HIV antiretroviral medication costs were experienced. This represents 45.7% of the total drug cost during this time period.
        - Expenses for psychiatric drugs are also being tracked, with approximately $1.8M being expended for psychiatric medications through the third quarter, representing 5.6% of the overall drug cost.
        - Another pharmacy indicator being tracked is the cost related to Hepatitis C therapies. These costs were $1.3M and represented about 4.0% of the total drug cost.

## *Reporting of Fund Balances*

- In accordance with Rider 46, page V-20, Senate Bill 1, 79th Legislature, Regular Session 2005, both the University of Texas Medical Branch and Texas Tech University Health Sciences Center are required to report if they hold any monies in reserve for correctional managed health care. UTMB reports that they hold no such reserves and report a total gain of $748,022 through the year end. TTUHSC reports that they hold no such reserves and report a total shortfall of $51,423.

- A summary analysis of the ending balances, revenue and payments through the fourth quarter for all CMHCC accounts is included in this report. That summary indicates that the ending balance on all CMHCC accounts on August 31, 2007 was $35,601.16. In accordance with Rider 69, TDCJ Appropriations, Senate Bill 1, 79$^{th}$ Legislature, the CMHCC end of year balance will be returned to TDCJ for return to the State General Revenue Fund.

### *Financial Monitoring*

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

The testing of detail transactions performed on TTUHSC's financial information for August 2007 is pending requested information. The testing of detail transactions performed on TTUHSC's financial information for May through July 2007 resulted in findings as follows:

- Supplies were incorrectly expensed to Professional Organization Dues account
- Employee travel expense forms were incorrectly completed
- Split-funded employee's Continuing Education expenses were charged entirely to TDCJ account

Per correspondence with TTUHSC, the items have been corrected.

The testing of detail transactions performed on UTMB's financial information for August 2007 is pending requested information. The testing of detail transactions performed on UTMB's financial information for May through July 2007 resulted in findings as follows:

- Lack of adequate backup documentation for Telecom department allocation to TDCJ account
- Incorrect mapping of sick and vacation leave
- Expenses being charged to "Prizes and Awards" account due to an incorrect Purchase Order
- Non-TDCJ United Parcel Services charges expensed to TDCJ account

Per correspondence with UTMB, these items have been corrected.

### *Concluding Notes*

The combined operating gain for the university providers through the fourth quarter of FY 2007 is $692,599. The university providers are continuing to monitor their expenditures closely, while seeking additional opportunities to reduce costs in order to minimize any operating losses.

## *Listing of Supporting Tables and Charts*

**Table 1**

***Correctional Managed Health Care***

***FY 2007 Budget Allocations***

## *Distribution of Funds*

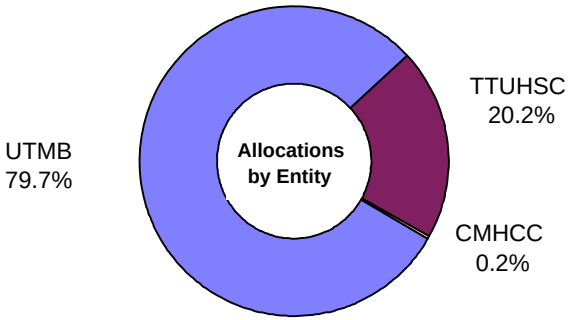
| Allocated to | FY 2007 |
|---|---|
| **University Providers** | |
| **The University of Texas Medical Branch** | |
| Medical Services | $273,775,733 |
| Mental Health Services | $25,619,350 |
| Subtotal UTMB | $299,395,083 |
| **Texas Tech University Health Sciences Center** | |
| Medical Services | $63,433,828 |
| Mental Health Services | $12,337,000 |
| Subtotal TTUHSC | $75,770,828 |
| SUBTOTAL UNIVERSITY PROVIDERS | $375,165,911 |
| **Correctional Managed Health Care Committee** | $584,909 |
| **TOTAL DISTRIBUTION** | **$375,750,820** |

## *Source of Funds*

| Source | FY 2007 |
|---|---|
| **Legislative Appropriations** | |
| SB 1, Article V, TDCJ Appropriations | |
| Strategy C.1.8. Managed Health Care | $313,174,719 |
| Strategy C.1.7 Psychiatric Care | $43,094,589 |
| Strategy C.3.1. Contract Prisons/Private St. Jails* | $1,981,512 |
| HB 10 Supplemental Appropriations | $17,500,000 |
| **TOTAL** | **$375,750,820** |

**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 2007
# Key Population Indicators
# Correctional Health Care Program

| Indicator | Sep-06 | Oct-06 | Nov-06 | Dec-06 | Jan-07 | Feb-07 | Mar-07 | Apr-07 | May-07 | Jun-07 | Jul-07 | Aug-07 | Population Year to Date Avg. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Avg. Population Served by CMHC:** | | | | | | | | | | | | | |
| UTMB State-Operated Population | 108,444 | 108,358 | 108,500 | 108,214 | 107,951 | 108,255 | 108,465 | 108,459 | 108,727 | 108,770 | 108,511 | 108,552 | 108,434 |
| UTMB Private Prison Population* | 11,802 | 11,817 | 11,807 | 11,809 | 11,812 | 11,797 | 11,819 | 11,811 | 11,795 | 11,798 | 11,768 | 11,786 | 11,802 |
| UTMB Total Service Population | 120,246 | 120,174 | 120,307 | 120,023 | 119,763 | 120,051 | 120,284 | 120,270 | 120,522 | 120,568 | 120,279 | 120,337 | 120,235 |
| TTUHSC Total Service Population | 31,520 | 31,568 | 31,700 | 31,639 | 31,612 | 31,596 | 31,571 | 31,620 | 31,570 | 31,491 | 31,544 | 31,499 | 31,578 |
| **CMHC Service Population Total** | **151,766** | **151,742** | **152,007** | **151,662** | **151,375** | **151,648** | **151,855** | **151,890** | **152,092** | **152,059** | **151,824** | **151,837** | **151,813** |
| **Population Age 55 and Over** | | | | | | | | | | | | | |
| UTMB Service Population Average | 7,704 | 7,760 | 7,832 | 7,862 | 7,967 | 8,035 | 8,053 | 8,100 | 8,197 | 8,197 | 8,224 | 8,256 | 8,016 |
| TTUHSC Service Population Average | 1,704 | 1,721 | 1,743 | 1,754 | 1,753 | 1,778 | 1,782 | 1,802 | 1,807 | 1,792 | 1,820 | 1,828 | 1,774 |
| **CMHC Service Population Average** | **9,408** | **9,481** | **9,575** | **9,616** | **9,720** | **9,813** | **9,835** | **9,902** | **10,004** | **9,989** | **10,044** | **10,084** | **9,789** |
| **HIV+ Population** | **2,679** | **2,706** | **2,679** | **2,693** | **2,507** | **2,524** | **2,523** | **2,512** | **2,516** | **2,529** | **2,509** | **2,499** | **2,573** |
| **Mental Health Inpatient Census** | | | | | | | | | | | | | |
| UTMB Psychiatric Inpatient Average | 1,037 | 1,034 | 1,039 | 1,014 | 1,038 | 1,042 | 1,036 | 1,041 | 1,060 | 1,060 | 1,057 | 1,047 | 1,042 |
| TTUHSC Psychiatric Inpatient Average | 960 | 971 | 964 | 981 | 986 | 980 | 966 | 961 | 953 | 963 | 970 | 935 | 966 |
| **CMHC Psychiatric Inpatient Average** | **1,997** | **2,005** | **2,003** | **1,995** | **2,024** | **2,022** | **2,002** | **2,002** | **2,013** | **2,023** | **2,027** | **1,982** | **2,008** |
| **Mental Health Outpatient Census** | | | | | | | | | | | | | |
| UTMB Psychiatric Outpatient Average | 15,648 | 16,654 | 15,426 | 15,278 | 15,741 | 15,544 | 16,310 | 16,951 | 16,520 | 16,252 | 16,652 | 16,617 | 16,133 |
| TTUHSC Psychiatric Outpatient Average | 4,557 | 4,807 | 4,333 | 3,947 | 4,101 | 4,064 | 3,779 | 4,323 | 4,481 | 4,178 | 4,089 | 4,395 | 4,255 |
| **CMHC Psychiatric Outpatient Average** | **20,205** | **21,461** | **19,759** | **19,225** | **19,842** | **19,608** | **20,089** | **21,274** | **21,001** | **20,430** | **20,741** | **21,012** | **20,387** |

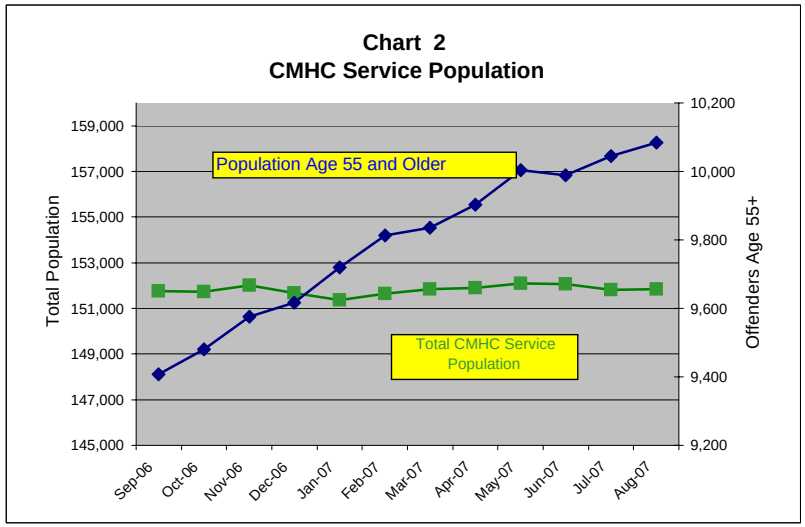


Chart 2
CMHC Service Population
Total Population
Offenders Age 55+
Population Age 55 and Older
Total CMHC Service Population
159,000
157,000
155,000
153,000
151,000
149,000
147,000
145,000
10,200
10,000
9,800
9,600
9,400
9,200
Sep-06
Oct-06
Nov-06
Dec-06
Jan-07
Feb-07
Mar-07
Apr-07
May-07
Jun-07
Jul-07
Aug-07

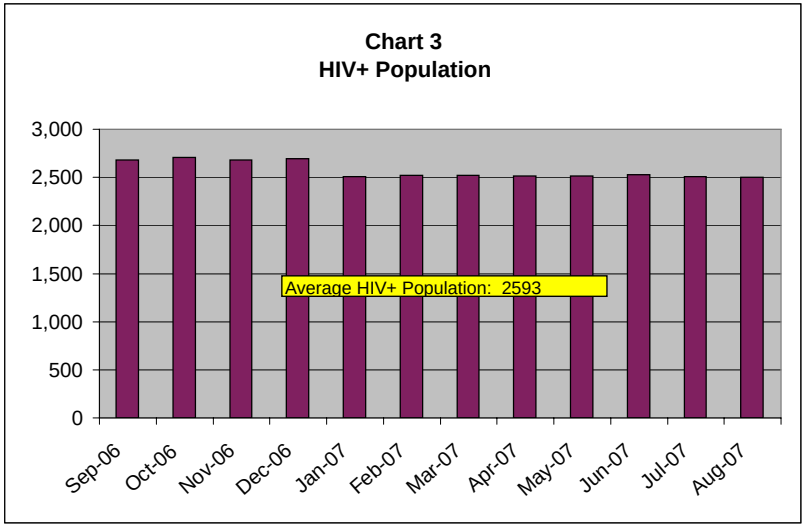


Chart 3
HIV+ Population
Average HIV+ Population: 2593
3,000
2,500
2,000
1,500
1,000
500
0
Sep-06
Oct-06
Nov-06
Dec-06
Jan-07
Feb-07
Mar-07
Apr-07
May-07
Jun-07
Jul-07
Aug-07

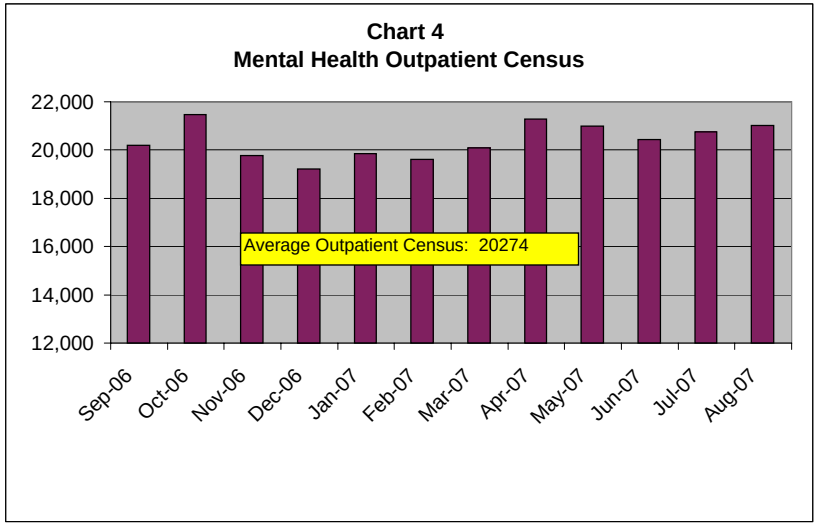


Chart 4
Mental Health Outpatient Census
Average Outpatient Census: 20274
22,000
20,000
18,000
16,000
14,000
12,000
Sep-06
Oct-06
Nov-06
Dec-06
Jan-07
Feb-07
Mar-07
Apr-07
May-07
Jun-07
Jul-07
Aug-07

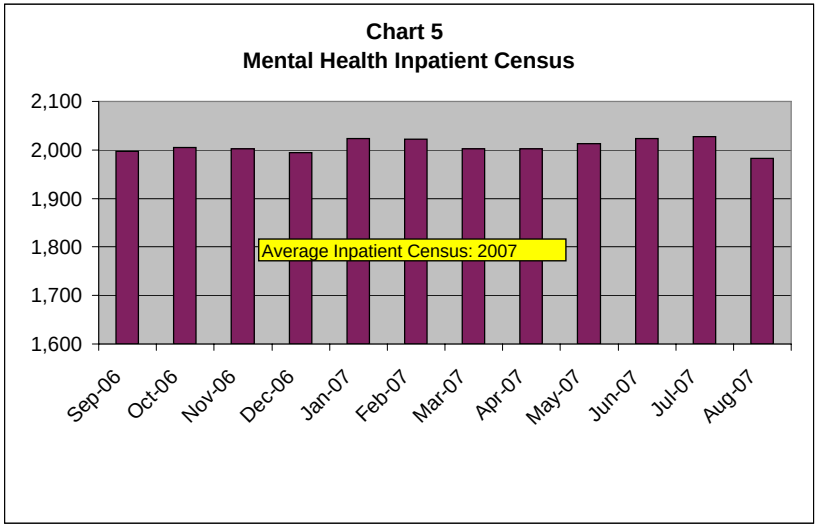


Chart 5
Mental Health Inpatient Census
Average Inpatient Census: 2007
2,100
2,000
1,900
1,800
1,700
1,600
Sep-06
Oct-06
Nov-06
Dec-06
Jan-07
Feb-07
Mar-07
Apr-07
May-07
Jun-07
Jul-07
Aug-07

# Table 3
# Summary Financial Report: Medical Costs
# Fiscal Year 2007 through Quarter 4 (Sep 2006 - August 2007)

Days in Year: 365

| | Medical Services Costs | | | Medical Cost Per Day Calculations | | |
|---|---|---|---|---|---|---|
| | **UTMB** | **TTUHSC** | **TOTAL** | **UTMB** | **TTUHSC** | **TOTAL** |
| **Population Served** | **120,183** | **31,600** | **151,783** | | | |
| **Revenue** | | | | | | |
| Capitation Payments* | $279,152,072 | $70,243,828 | $349,395,900 | $6.36 | $6.09 | $6.31 |
| State Reimbursement Benefits | $33,763,123 | $3,250,235 | $37,013,358 | $0.77 | $0.28 | $0.67 |
| Non-Operating Revenue | $286,030 | $0 | $286,030 | $0.01 | $0.00 | $0.01 |
| **Total Revenue** | **$313,201,225** | **$73,494,063** | **$386,695,288** | **$7.14** | **$6.37** | **$6.98** |
| **Expenses** | | | | | | |
| **Onsite Services** | | | | | | |
| Salaries | $117,889,753 | $9,788,933 | $127,678,686 | $2.69 | $0.85 | $2.30 |
| Benefits | $30,026,861 | $2,354,690 | $32,381,551 | $0.68 | $0.20 | $0.58 |
| Operating (M&O) | $18,119,681 | $1,348,449 | $19,468,130 | $0.41 | $0.12 | $0.35 |
| Professional Services | $0 | $2,523,202 | $2,523,202 | $0.00 | $0.22 | $0.05 |
| Contracted Units/Services | $0 | $20,693,306 | $20,693,306 | $0.00 | $1.79 | $0.37 |
| Travel | $1,005,512 | $72,250 | $1,077,762 | $0.02 | $0.01 | $0.02 |
| Electronic Medicine | $0 | $244,546 | $244,546 | $0.00 | $0.02 | $0.00 |
| Capitalized Equipment | $1,218,743 | $19,337 | $1,238,080 | $0.03 | $0.00 | $0.02 |
| **Subtotal Onsite Expenses** | $168,260,550 | $37,044,713 | $205,305,263 | $3.84 | $3.21 | $3.71 |
| **Pharmacy Services** | | | | | | |
| Salaries | $3,915,126 | $1,134,398 | $5,049,524 | $0.09 | $0.10 | $0.09 |
| Benefits | $1,210,090 | $66,267 | $1,276,357 | $0.03 | $0.01 | $0.02 |
| Operating (M&O) | $2,255,717 | $586,028 | $2,841,745 | $0.05 | $0.05 | $0.05 |
| Pharmaceutical Purchases | $25,598,924 | $7,046,680 | $32,645,604 | $0.58 | $0.61 | $0.59 |
| Professional Services | $0 | $0 | $0 | $0.00 | $0.00 | $0.00 |
| Travel | $20,284 | $16,574 | $36,858 | $0.00 | $0.00 | $0.00 |
| **Subtotal Pharmacy Expenses** | $33,000,141 | $8,849,947 | $41,850,088 | $0.75 | $0.77 | $0.76 |
| **Offsite Services** | | | | | | |
| University Professional Services | $13,764,374 | $1,028,844 | $14,793,218 | $0.31 | $0.09 | $0.27 |
| Freeworld Provider Services | $14,957,929 | $13,493,971 | $28,451,900 | $0.34 | $1.17 | $0.51 |
| UTMB or TTUHSC Hospital Cost | $73,823,963 | $9,573,230 | $83,397,193 | $1.68 | $0.83 | $1.51 |
| Estimated IBNR | $2,552,700 | $0 | $2,552,700 | $0.06 | $0.00 | $0.05 |
| **Subtotal Offsite Expenses** | $105,098,966 | $24,096,045 | $129,195,011 | $2.40 | $2.09 | $2.33 |
| **Indirect Expenses** | $8,763,836 | $3,971,521 | $12,735,357 | $0.20 | $0.34 | $0.23 |
| **Total Expenses** | **$315,123,493** | **$73,962,226** | **$389,085,719** | **$7.18** | **$6.41** | **$7.02** |
| **Operating Income (Loss)** | **($1,922,268)** | **($468,163)** | **($2,390,431)** | **($0.04)** | **($0.04)** | **($0.04)** |

* NOTE: Revenue amounts include supplemental funding provided in August 2007 per HB 15, 80th Legislature.

# Table 3 (Continued)
# Summary Financial Report: Mental Health Costs
# Fiscal Year 2007 through Quarter 4 (Sep 2006 - August 2007)

Days in Year: 365

| | Mental Health Services Costs | | | Mental Health Cost Per Day Calculations | | |
|---|---|---|---|---|---|---|
| | UTMB | TTUHSC | TOTAL | UTMB | TTUHSC | TOTAL |
| **Population Served** | **120,182** | **31,600** | **151,782** | | | |
| **Revenue** | | | | | | |
| Capitation Payments | $25,619,350 | $11,327,000 | $36,946,350 | $0.58 | $0.98 | $0.67 |
| State Reimbursement Benefits | $4,783,243 | $2,274,953 | $7,058,196 | $0.11 | $0.20 | $0.13 |
| Other Misc Revenue | $0 | $0 | $0 | $0.00 | $0.00 | $0.00 |
| **Total Revenue** | **$30,402,593** | **$13,601,953** | **$44,004,546** | **$0.69** | **$1.18** | **$0.79** |
| **Expenses** | | | | | | |
| **Mental Health Services** | | | | | | |
| Salaries | $20,687,131 | $9,450,084 | $30,137,215 | $0.47 | $0.82 | $0.54 |
| Benefits | $5,078,475 | $2,425,973 | $7,504,448 | $0.12 | $0.21 | $0.14 |
| Operating (M&O) | $890,330 | $185,976 | $1,076,306 | $0.02 | $0.02 | $0.02 |
| Professional Services | $0 | $357,559 | $357,559 | $0.00 | $0.03 | $0.01 |
| Contracted Units/Services | $0 | $0 | $0 | $0.00 | $0.00 | $0.00 |
| Travel | $160,265 | $25,401 | $185,666 | $0.00 | $0.00 | $0.00 |
| Electronic Medicine | $0 | $0 | $0 | $0.00 | $0.00 | $0.00 |
| Capitalized Equipment | $38,888 | $0 | $38,888 | $0.00 | $0.00 | $0.00 |
| **Subtotal Mental Health Expenses** | $26,855,089 | $12,444,993 | $39,300,082 | $0.61 | $1.08 | $0.71 |
| | | | | | | |
| **Indirect Expenses** | $881,214 | $740,220 | $1,621,434 | $0.02 | $0.06 | $0.03 |
| | | | | | | |
| **Total Expenses** | **$27,736,303** | **$13,185,213** | **$40,921,516** | **$0.63** | **$1.14** | **$0.74** |
| | | | | | | |
| **Operating Income (Loss)** | **$2,666,290** | **$416,740** | **$3,083,030** | **$0.06** | **$0.04** | **$0.06** |

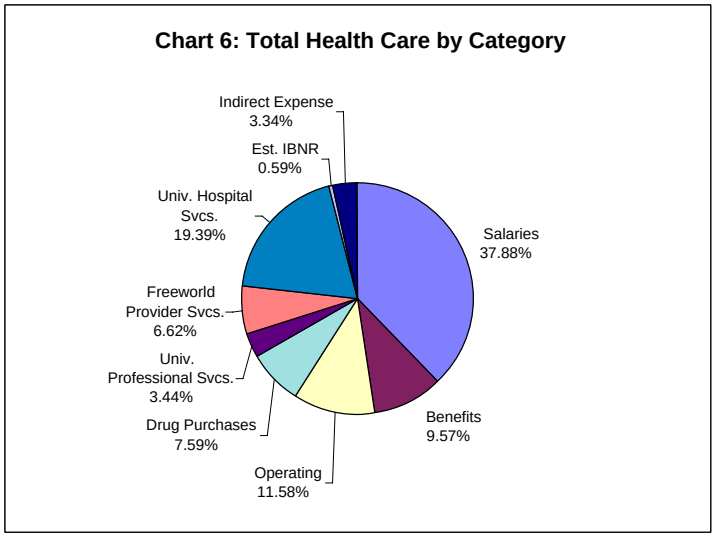
## All Health Care Summary

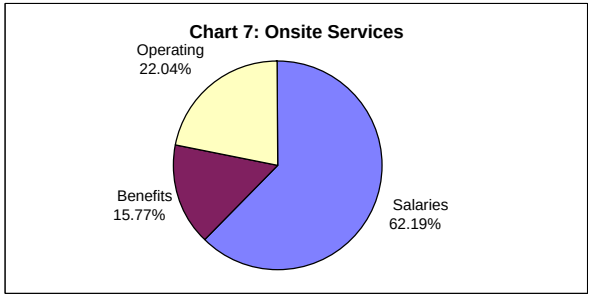
| | All Health Care Services | | | Cost Per Offender Per Day | | |
|---|---|---|---|---|---|---|
| | UTMB | TTUHSC | TOTAL | UTMB | TTUHSC | TOTAL |
| Medical Services | $313,201,225 | $73,494,063 | $386,695,288 | $7.14 | $6.37 | $6.98 |
| Mental Health Services | $30,402,593 | $13,601,953 | $44,004,546 | $0.69 | $1.18 | $0.79 |
| **Total Revenue** | **$343,603,818** | **$87,096,016** | **$430,699,834** | **$7.83** | **$7.55** | **$7.77** |
| Medical Services | $315,123,493 | $73,962,226 | $389,085,719 | $7.18 | $6.41 | $7.02 |
| Mental Health Services | $27,736,303 | $13,185,213 | $40,921,516 | $0.63 | $1.14 | $0.74 |
| **Total Expenses** | **$342,859,796** | **$87,147,439** | **$430,007,235** | **$7.82** | **$7.56** | **$7.76** |
| | | | | | | |
| **Operating Income (Loss)** | **$744,022** | **($51,423)** | **$692,599** | **$0.02** | **($0.00)** | **$0.01** |

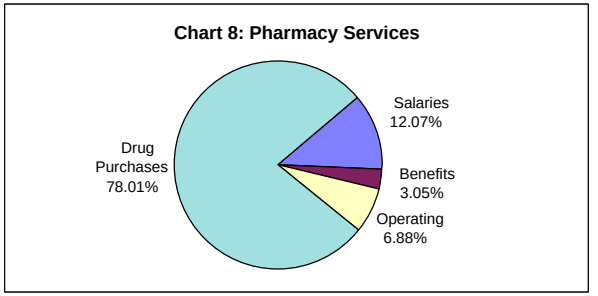
**Note: In FY 2007 Revenue Includes Supplemental Appropriations from HB15, 80th Legislature 2007.**

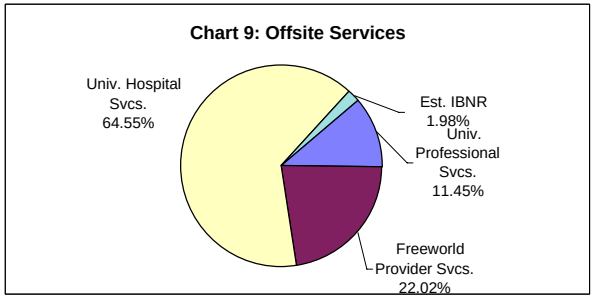
# Table 4
# FY 2007 4th Quarter
# UTMB/TTUHSC EXPENSE SUMMARY

| Category | Expense | Percent of Total |
|---|---|---|
| **Onsite Services** | **$205,305,263** | **47.74%** |
| Salaries | $127,678,686 | |
| Benefits | $32,381,551 | |
| Operating | $45,245,026 | |
| **Pharmacy Services** | **$41,850,088** | **9.73%** |
| Salaries | $5,049,524 | |
| Benefits | $1,276,357 | |
| Operating | $2,878,603 | |
| Drug Purchases | $32,645,604 | |
| **Offsite Services** | **$129,195,011** | **30.04%** |
| Univ. Professional Svcs. | $14,793,218 | |
| Freeworld Provider Svcs. | $28,451,900 | |
| Univ. Hospital Svcs. | $83,397,193 | |
| Est. IBNR | $2,552,700 | |
| **Mental Health Services** | **$39,300,082** | **9.14%** |
| Salaries | $30,137,215 | |
| Benefits | $7,504,448 | |
| Operating | $1,658,419 | |
| **Indirect Expense** | **$14,356,791** | **3.34%** |
| **Total Expenses** | **$430,007,235** | **100.00%** |



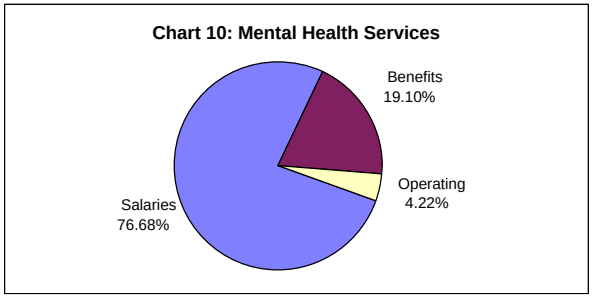



**Table 5**
**Comparison of Total Health Care Costs**

| | FY 03 | FY 04 | FY 05 | FY 06 | 4-Year Average | FYTD 07 1st Qtr | FYTD 07 2nd Qtr | FYTD 07 3rd Qtr | FYTD 07 4th Qtr |
|---|---|---|---|---|---|---|---|---|---|
| **Population** | | | | | | | | | |
| UTMB | 105,525 | 113,729 | 119,322 | 119,835 | 114,603 | 120,242 | 120,094 | 120,182 | 120,235 |
| TTUHSC | 31,041 | 31,246 | 31,437 | 31,448 | 31,293 | 31,596 | 31,606 | 31,600 | 31,578 |
| Total | 136,566 | 144,975 | 150,759 | 151,283 | 145,896 | 151,838 | 151,700 | 151,782 | 151,813 |
| **Expenses** | | | | | | | | | |
| UTMB | $300,912,092 | $313,875,539 | $330,672,773 | $336,934,127 | 320,598,633 | 83,691,562 | 167,279,377 | $253,758,870 | $342,859,796 |
| TTUHSC | $80,079,315 | $78,548,146 | $80,083,059 | $83,467,550 | 80,544,518 | 21,709,909 | 43,276,611 | $65,197,089 | $87,147,439 |
| Total | $380,991,407 | $392,423,685 | $410,755,832 | $420,401,677 | 401,143,150 | 105,401,471 | 210,555,988 | 318,955,959 | $430,007,235 |
| **Cost/Day** | | | | | | | | | |
| UTMB | $7.81 | $7.56 | $7.59 | $7.70 | $7.66 | $7.65 | $7.70 | $7.73 | $7.81 |
| TTUHSC | $7.07 | $6.89 | $6.98 | $7.27 | $7.05 | $7.55 | $7.56 | $7.56 | $7.56 |
| **Total** | **$7.64** | **$7.40** | **$7.46** | **$7.61** | **$7.53** | **$7.63** | **$7.67** | **$7.70** | **$7.76** |

365

* Expenses include all health care costs, including medical, mental health, and benefit costs.
NOTE: The FY04 calculation has been adjusted from previous reports to correctly account for leap year

**Chart 11: UTMB Cost Per Day**

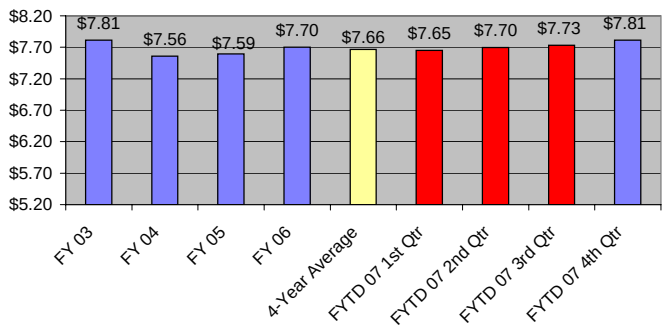



**Chart 12: TTUHSC Cost Per Day**

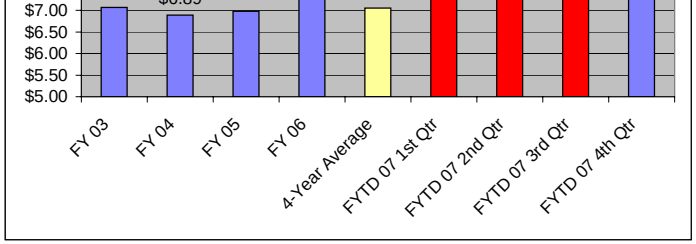
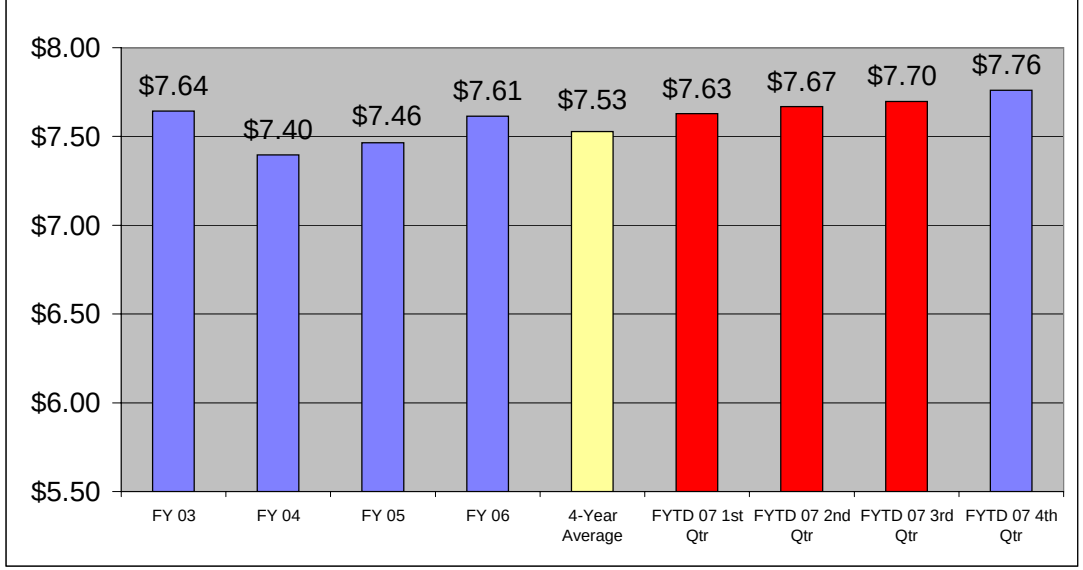



**Chart 13: STATEWIDE Cost Per Day**



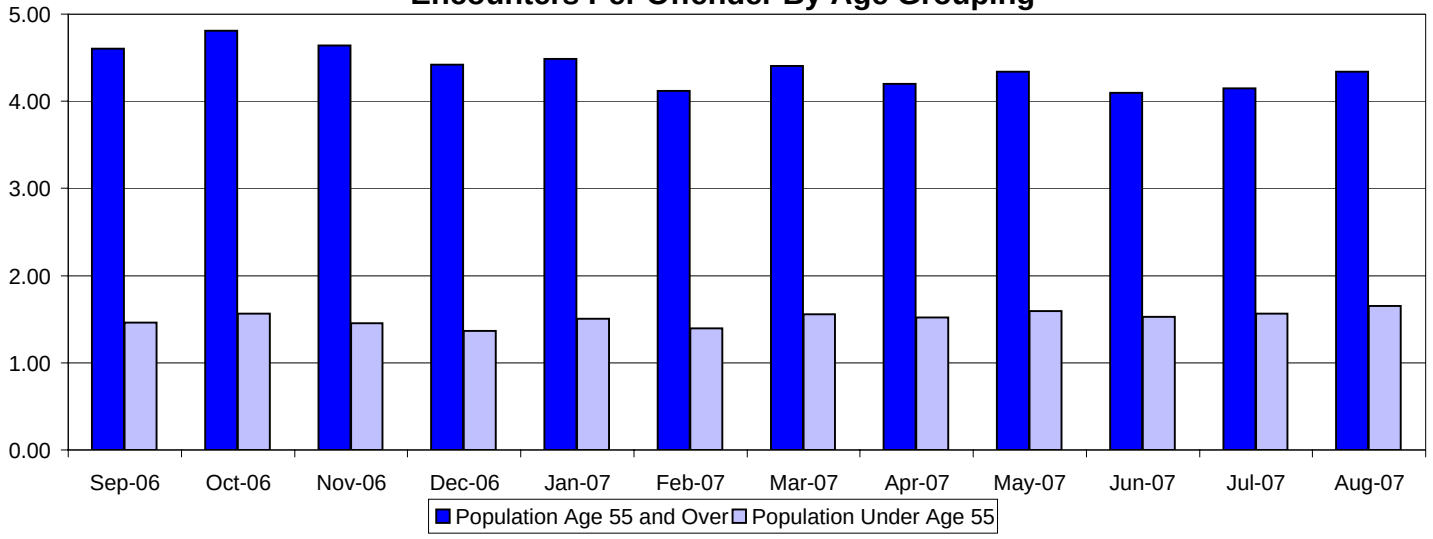
# Table 6
## Medical Encounter Statistics* by Age Grouping

12

| Month | Encounters | | | Population | | | Encounters Per Offender | | |
|---|---|---|---|---|---|---|---|---|---|
| | Age 55 and Ove | Under Age 55 | Total | Age 55 and Ove | Under Age 55 | Total | Age 55 and Ove | Under Age 55 | Total |
| Sep-06 | 35,470 | 164,841 | 200,311 | 7,704 | 112,542 | 120,246 | 4.60 | 1.46 | 1.67 |
| Oct-06 | 37,313 | 175,603 | 212,916 | 7,760 | 112,414 | 120,174 | 4.81 | 1.56 | 1.77 |
| Nov-06 | 36,330 | 163,877 | 200,207 | 7,832 | 112,475 | 120,307 | 4.64 | 1.46 | 1.66 |
| Dec-06 | 34,724 | 153,479 | 188,203 | 7,862 | 112,161 | 120,023 | 4.42 | 1.37 | 1.57 |
| Jan-07 | 35,734 | 168,184 | 203,918 | 7,967 | 111,796 | 119,763 | 4.49 | 1.50 | 1.70 |
| Feb-07 | 33,081 | 156,441 | 189,522 | 8,035 | 112,016 | 120,051 | 4.12 | 1.40 | 1.58 |
| Mar-07 | 35,448 | 174,541 | 209,989 | 8,053 | 112,231 | 120,284 | 4.40 | 1.56 | 1.75 |
| Apr-07 | 33,996 | 170,160 | 204,156 | 8,100 | 112,170 | 120,270 | 4.20 | 1.52 | 1.70 |
| May-07 | 35,572 | 178,841 | 214,413 | 8,197 | 112,325 | 120,522 | 4.34 | 1.59 | 1.78 |
| Jun-07 | 33,612 | 171,723 | 205,335 | 8,197 | 112,371 | 120,568 | 4.10 | 1.53 | 1.70 |
| Jul-07 | 34,098 | 174,863 | 208,961 | 8,224 | 112,055 | 120,279 | 4.15 | 1.56 | 1.74 |
| Aug-07 | 35,835 | 184,790 | 220,625 | 8,256 | 112,081 | 120,337 | 4.34 | 1.65 | 1.83 |
| Average | 35,101 | 169,779 | 204,880 | 8,016 | 112,220 | 120,235 | 4.38 | 1.51 | 1.70 |

*Detailed data available for **UTMB** Sector only (representing approx. 79% of total population). Includes all medical and dental onsite visits. Excludes mental health vi

## Chart 14
## Encounters Per Offender By Age Grouping



# Table 7
# FY 2007 4th Quarter
# Offsite Costs* To Date by Age Grouping

| Age Grouping | Cost Data | Total Population | Total Cost Per Offender |
|---|---|---|---|
| Age 55 and Over | $32,554,532 | 9,789 | $3,325.54 |
| Under Age 55 | $87,134,464 | 142,024 | $613.52 |
| **Total** | **$119,688,996** | **151,813** | **$788.40** |

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

**Chart 15**
**Hospital Costs to Date Per Offender**
**by Age Grouping**

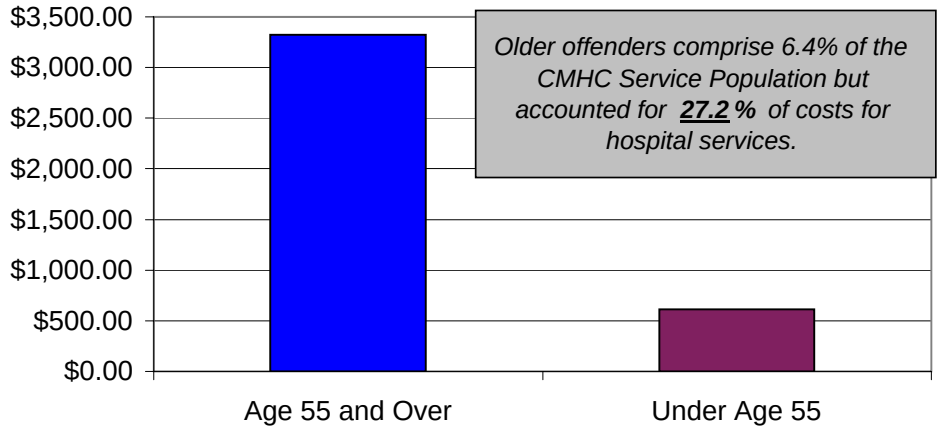
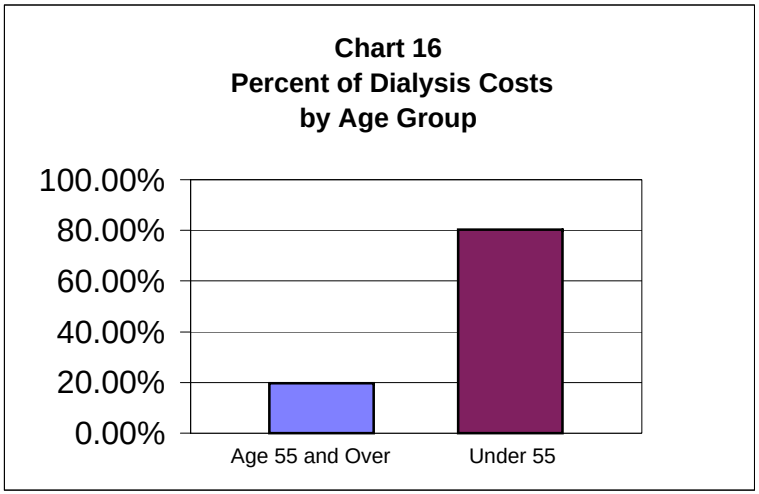
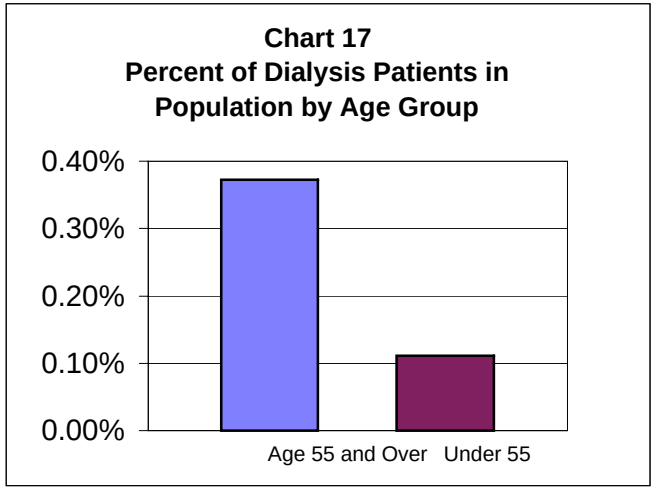


**Table 8**
**Through FY 2007 4th Quarter**
**Dialysis Costs by Age Grouping**

| 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 | $732,415 | 19.61% | 9,789 | 6.45% | 37 | 0.37% |
| Under Age 55 | $3,003,399 | 80.39% | 142,024 | 93.55% | 157 | 0.11% |
| **Total** | **$3,735,814** | **100.00%** | **151,813** | **100.00%** | **194** | **0.13%** |

***Projected Avg Cost Per Dialysis Patient Per Year:*** $19,274

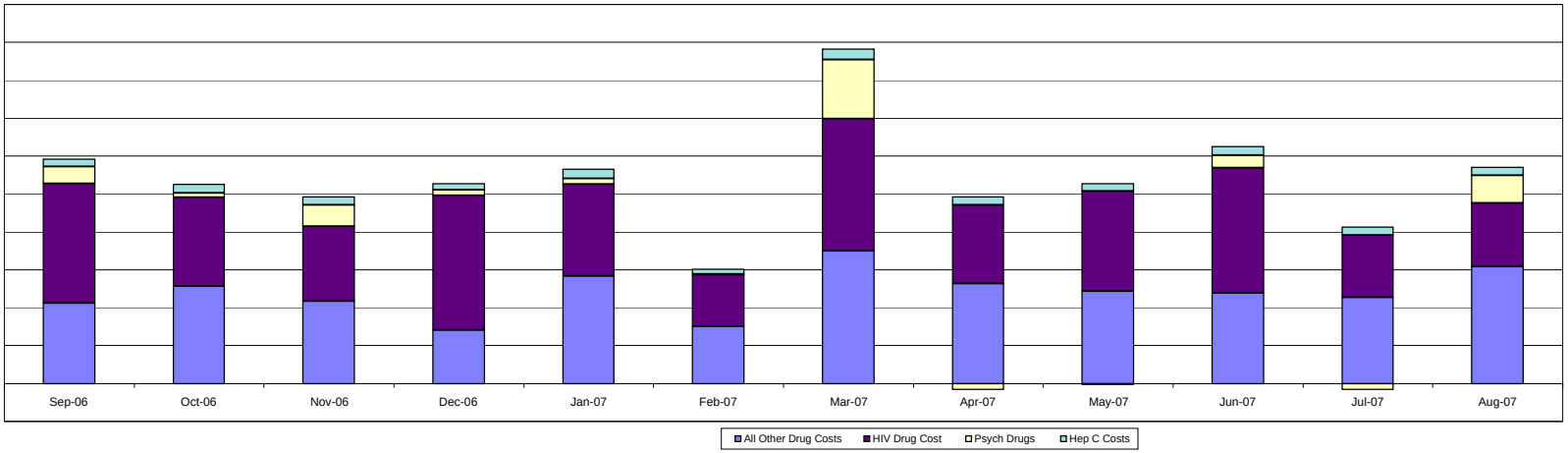


## Table 9
## Selected Drug Costs FY 2007

| Category | Sep-06 | Oct-06 | Nov-06 | Dec-06 | Jan-07 | Feb-07 | Mar-07 | Apr-07 | May-07 | Jun-07 | Jul-07 | Aug-07 | Total Year-to-Date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ***Total Drug Costs*** | $2,958,564 | $2,628,306 | $2,459,070 | $2,632,161 | $2,828,844 | $1,510,740 | $4,410,403 | $2,375,497 | $2,613,704 | $3,121,687 | $1,980,058 | $2,850,860 | $32,369,894 |
| ***HIV Medications*** | | | | | | | | | | | | | |
| HIV Drug Cost | $1,578,626 | $1,164,261 | $991,471 | $1,775,787 | $1,210,128 | $684,041 | $1,742,017 | $1,040,807 | $1,313,587 | $1,656,351 | $825,092 | $835,883 | $14,818,051 |
| HIV Percent of Cost | 53.36% | 44.30% | 40.32% | 67.46% | 42.78% | 45.28% | 39.50% | 43.81% | 50.26% | 53.06% | 41.67% | 29.32% | 45.78% |
| ***Psychiatric Medications*** | | | | | | | | | | | | | |
| Psych Drug Cost | $224,093 | $57,584 | $276,291 | $77,353 | $78,472 | $2,219 | $776,570 | -$88,297 | -$19,477 | $159,246 | -$87,226 | $364,834 | $1,821,664 |
| Psych Percent of Cost | 7.57% | 2.19% | 11.24% | 2.94% | 2.77% | 0.15% | 17.61% | -3.72% | -0.75% | 5.10% | -4.41% | 12.80% | 5.63% |
| ***Hepatitis C Medications*** | | | | | | | | | | | | | |
| Hep C Drug Cost | $99,021 | $119,692 | $107,789 | $79,371 | $122,653 | $72,988 | $141,829 | $110,256 | $99,645 | $116,012 | $108,652 | $110,288 | $1,288,195 |
| Hep C Percent of Cost | 3.35% | 4.55% | 4.38% | 3.02% | 4.34% | 4.83% | 3.22% | 4.64% | 3.81% | 3.72% | 5.49% | 3.87% | 3.98% |
| ***All Other Drug Costs*** | $1,056,822 | $1,286,768 | $1,083,519 | $699,650 | $1,417,591 | $751,493 | $1,749,988 | $1,312,731 | $1,219,949 | $1,190,078 | $1,133,540 | $1,539,855 | $14,441,985 |

**Chart 18**
**Drug Costs by Selected Categories**



## Table 10
## Ending Balances 4th Qtr FY 2007

| | Beginning Balance September 1, 2006 | Net Activity FY 2007 | Ending Balance August 31, 2007 |
|---|---|---|---|
| CMHCC Operating Funds | $79,112.92 | ($56,133.52) | $22,979.40 |
| CMHCC Medical Services | $734,417.59 | ($721,838.13) | $12,579.46 |
| CMHCC Mental Health | $527,107.07 | ($527,064.77) | $42.30 |
| **Ending Balance All Funds** | **$1,340,637.58** | **($1,305,036.42)** | **$35,601.16** |

**SUPPORTING DETAIL**

| **CMHCC Operating Account** | |
|---|---|
| Beginning Balance | $79,112.92 |
| **FY 2006 Funds Lapsed to State Treasury** | ($79,112.92) |
| **Revenue Received** | |
| 1st Qtr Payment | $146,227.25 |
| 2nd Qtr Payment | $146,227.25 |
| 3rd Qtr Payment | $146,227.25 |
| 4th Qtr Payment | $146,227.25 |
| Interest Earned | $2,919.86 |
| Subtotal Revenue | $587,828.86 |
| **Expenses** | |
| Salary & Benefits | ($451,336.71) |
| Operating Expenses | ($124,394.08) |
| Transfer Pandemic Flu Amendment | ($68,231.59) |
| **Subtotal Expenses** | **($643,962.38)** |
| **Net Activity thru Year End** | **($56,133.52)** |
| **Total Fund Balance CMHCC Operating** | **$22,979.40** |

**SUPPORTING DETAIL**

| **CMHCC Capitation Accounts** | **Medical Services** | **Mental Health** |
|---|---|---|
| Beginning Balance | $734,417.59 | $527,107.07 |
| **FY 2006 Funds Lapsed to State Treasury** | ($734,417.59) | ($527,107.07) |
| **Revenue Detail** | | |
| **1st Qtr Payment from TDCJ** | $84,302,390.25 | $9,489,087.50 |
| **2nd Qtr Payment from TDCJ** | $84,302,390.25 | $9,489,087.50 |
| **3rd Qtr Payment from TDCJ** | $84,302,390.25 | $9,489,087.50 |
| **4th Qtr Payment from TDCJ** | $84,302,390.25 | $9,489,087.50 |
| **Supplemental Payment from TDCJ** | $12,940,619.00 | $0.00 |
| **Interest Earned** | $157,747.07 | $13,467.85 |
| **Revenue Received** | **$350,307,927.07** | **$37,969,817.85** |
| **Payments to UTMB** | | |
| 1st Qtr Payment to UTMB | ($68,256,415.50) | ($6,384,115.10) |
| 2nd Qtr Payment to UTMB | ($67,506,345.00) | ($6,317,100.00) |
| 3rd Qtr Payment to UTMB | ($69,006,486.00) | ($6,457,480.00) |
| 4th Qtr Payment to UTMB | ($69,006,486.00) | ($6,457,480.00) |
| Supplemental Payment to UTMB | ($5,140,619.00) | $0.00 |
| Pandemic Flu Amendment | ($145,167.96) | ($16,600.45) |
| **Subtotal UTMB Payments** | **($279,061,519.46)** | **($25,632,775.55)** |
| **Payments to TTUHSC** | | |
| 1st Qtr Payment to TTUHSC | ($15,815,009.21) | ($3,075,800.00) |
| 2nd Qtr Payment to TTUHSC | ($15,641,217.90) | ($3,042,000.00) |
| 3rd Qtr Payment to TTUHSC | ($15,988,800.52) | ($3,109,600.00) |
| 4th Qtr Payment to TTUHSC | ($15,988,800.52) | ($3,109,600.00) |
| Supplemental Payment to TTUHSC | ($7,800,000.00) | $0.00 |
| **Subtotal TTUHSC Payments** | **($71,233,828.15)** | **($12,337,000.00)** |
| **Total Payments Made thru this Qtr** | **($350,295,347.61)** | **($37,969,775.55)** |
| **Net ActivityThrough This Qtr** | **($721,838.13)** | **($527,064.77)** |
| **Total Fund Balance** | **$12,579.46** | **$42.30** |