MINUTES
CORRECTIONAL MANAGED HEALTH CARE COMMITTEE
March 9, 2010

Chairperson: James D. Griffin, M.D.

CMHCC Members Present: Ben G. Raimer, M.D., William Elger, Gerard Evenwel, Cynthia Jumper, M.D., Lannette Linthicum, M.D., Bryan Collier

CMHCC Members Absent: Elmo Cavin, Desmar Walkes, M.D.

Partner Agency Staff Present: Owen Murray, D. O., Lauren Sheer, Steve Alderman, Anthony Williams, M.D., Scott Reinecke, D.D.S., Billy Horton, D.D.S., Steve Smock, The University of Texas Medical Branch; Cynthia Jumper, M.D., Larry Elkins, Texas Tech University Health Sciences Center; Bobby Lumpkin, George Crippen, R.N., MSN, Rick Thaler, Ron Steffa, Robert Williams, M.D., Texas Department of Criminal Justice; David Nelson, Janice H. Lord, Texas Board of Criminal Justice; Allen Hightower, David McNutt, Lynn Webb, Stephanie Harris, CMHCC Staff.

Others Present: Cathy Corey, Abbott-Institutional Managing; Judy Wilson, concerned citizen

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

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I. Call to Order - **James D. Griffin, M.D.**	Dr. Griffin called the CMHCC meeting to order at 9:00 a.m. then noted that a quorum was present and the meeting would be conducted in accordance with Chapter 551 of the Texas Government Code, the Open Meetings Act.		
II. Recognitions and Introductions - **James D. Griffin, M.D.**	Dr. Griffin acknowledged Mr. David Nelson, Texas Board of Criminal Justice.		
III. Approval of Excused Absence - **James D. Griffin, M.D.**	Dr. Griffin stated that he would now entertain a motion to approve the excused absence of Bryan Collier, who was unable to attend the December 1, 2009 CMHCC meeting due to scheduling conflict.		Dr. Ben Raimer moved to approve Bryan Collier absence from the December 1, 2009 CMHCC meeting, Dr. Linthicum second the motion which prevailed by unanimous vote.

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IV. Approval of Consent Items **- James D. Griffin, M.D.**	Dr. Griffin stated next on the agenda is the approval of the consent items to include the Minutes from the December 1, 2009 CMHCC meeting: TDCJ Health Services Monitoring Report; both UTMB and TTUHSC Medical Director's Report; and the Summary of Joint Committee Activities. He then asked the members if they had any specific consent items(s) to pull out for separate discussion. Hearing no further comments, Dr. Griffin stated that he would now entertain a motion on approving the consent items.		Dr. Ben Raimer moved to approve the consent items as presented at Tab A of the agenda booklet. Mr. Elger seconded the motion. The motion passed by unanimous vote.
V. Executive Director's Report **- Allen Hightower**	Dr. Griffin then called on Mr. Hightower to provide the Executive Director's report. Mr. Hightower noted that the staff has been very busy since our last meeting. We made a presentation to the Texas Department of Criminal Justice Board in regards to our public hearing that was held February 8th in Austin. The LBB, Governor's Office, Lt. Governor's Office and the Speaker's Officer had obviously sent to us as well as other state agencies to identify 5% savings in priority increments. On February 15th the CMHC submitted to TDCJ a plan to reduce the budget 5% for FY10 and FY11. TDCJ submitted this with their proposed reductions to the Legislative Budget Board and the Office of the Governor's Budget Planning and Policy Division. Items identified but not limited to include delay of the Marlin VA facility, delay of purchasing of capital equipment, reduce indirect expenses/hiring freeze, suspend over the counter medications, eliminate dietary services, close the infirmary at UT-Tyler, provide offenders leaving the system with paper prescriptions instead of a 10 day supply, reduce optometry services, and suspend voluntary and routine HIV and Hepatitis C testing. Other actions that would be taken and may have a significant impact on the health care system include: reduce coverage and hours at most TDCJ facilities, modify outpatient staffing, and reductions to dental and mental health services.		

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V. Executive Director's Report (cont.)	On March 8th, the appropriations committee will hear testimony on their interim charge No. 1: monitor the performance of state agencies and institutions, including operating budgets, plans to carry out legislative initiatives, caseload, projections performance measure attainment, implementation of all rider provisions and other matters affecting the fiscal condition of the state. The current revenue outlook, supplemental needs in the current biennium and 5% reduction plans. The CMHCC has been requested to testify. Dr. Griffin thanked Mr. Hightower for his report and asked if there were any questions.	Mr. Evenwel asked if we're cutting back and I assume our partners are cutting back. Are we losing something or are they losing something. How does that work? Mr. Hightower answered that there were two issues at hand. One is the budget we are operating in now we have projected not being able to come in within the amount of the two year appropriation of FY 09 & 10. The second one is all of the state agencies to my knowledge were asked in light of the comptrollers estimation of what would be available to the legislature to appropriate for the next biennium. We're asked to get ahead of the curve and if cuts had to made where the agencies would identify those cuts would come from. That is what Mr. Livingston presented yesterday in behalf of TDCJ and what I presented yesterday in behalf of the committee and the universities of where those cuts would take place if the 5% worked. Ours were in prioritized order being those things that affected direct medical care to the inmates came last within our priority of where we would cut to come within the 5%. It's early before the session to do something like that. But it was probably in my view a good idea to do so because it gives the leadership of the state an opportunity to perhaps say maybe in this agency we would want to take more than 5% in this we have certain legal ramifications if we do not. This gives the leadership and the LBB an opportunity to massage those	

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V. Executive Director's Report (cont.)		numbers and for the leadership how much in the rainy day fund. I think the testimony yesterday from the budget people was that they expected there to be around 8.2 million dollars in the rainy day fund. To what extent the legislature would want to use that and offset the others with budgetary cuts is obviously a policy decision for the legislature to make. Dr. Linthicum asked if the cuts are subject to any discussion because I have some serious concerns. Particularly the dietary services where we only have one dietician in the whole state right now, which is responsible for doing dietary management. And working with the food services department, doing therapeutic diets. Over the counter medications, one which is Tylenol. So we're going to clog up our sick call process with omitting sick calls against Tylenol. That's not a very judicious use of our resources. I'm hoping there will be an opportunity to discuss these issues. Mr. Hightower replied that there will be at the legislature level there is no question that there will be. When they take up the appropriation bill it will be my guess that when they break we'll have an opportunity to speak to a full committee and then when they break up into sub-committees, there are always changes from things that have been laid out in the order of which they are laid out not only will the committee be given an opportunity, so would TDCJ if something had changed to reprioritized one as opposed to another. I think we are way early in the game for it to happen but it's probably a good idea to start the process early. Dr. Linthicum stated even going to a model we're operating now unit medical infirmaries are like outpatient clinics and the hours are 8 to 5. Basically it's not going to work because	

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V. Executive Director's Report (cont.)		of infirmary lines, feeding times, and also after hours at 5:00pm. What we end up with is everybody is being transferred offsite. And offsite cost is going to escalate because you can't expect security or correctional officers to make clinical judgments on step by needs medical attention. There's not health staff onsite to meet their needs, so they are just going to 911 them and take them offsite. These are a few things to think about as we outline the 5% savings. Mr. Hightower replied that Mr. Livingston and his staff are running into similar problems and will take all of these problems into consideration. Dr. Griffin added that there should be a lot of discussion on these issues. He also mentioned that he had listened to some testimony from the Commission on Health and Human services yesterday. And they were basically asked to go back and bring them something different based on his testimony. I think there will be a discussion and the first thing that we should do is actually put an attachment to these minutes with our official submitted list. And then ask our partners, agencies and universities to comment on those specific impacts related to those items so that we can actually get more specific information related to some of those topics as Dr. Linthicum pointed out. Mr. Collier stated that from an agency TDCJ we asked for exceptions for key items and this was one of the items that we asked for. Even though we didn't go thru the 5% scenario on several key areas like prisons, probation &	

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V. Executive Director's Report (cont.)		parole and treatment. This was included in the report for pardons & paroles and entities that are external but really very close to our business. And we are hoping these items will be considered. Dr. Raimer would like to publically thank Mr. Collier and Mr. Livingston for doing that. It was very clear yesterday that they had their cuts outlined in the first part and then their requests was what these other items were on the table that should be exempted The second thing I just wanted to comment that the agencies work so closely together, I think it would be very imperative before any decisions be made that representatives from TDCJ, Dr. Linthicum, Mr. Collier and others and the universities sit down and plan out because it definitely has an impact on both of us any changes that we might do. I'm assuming that would be done and reported back to you. Dr. Murray added actually what the universities had submitted in terms of going thru each area, we went ahead and did exactly that. This is an impact not only to a system but also to additional costs. Ultimately we could get to a 5% number but to the extent there is going to be an additional cost that we couldn't predict could erode into that 5%. So, there is a document out there that we hope the committee has, it really kind of outlines it all. Mr. Hightower added that the way the LBB puts out the budget. It has our Correctional Managed Care budget along with the Parole budget incased in Mr. Collier's budget. The way it's laid out TDCJ goes before us and actually because we are in their strategy we all have to testify at the same time because we are talking about the same manuscript.	

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VI. Performance and Financial Status Report **- David McNutt**	Hearing no further comments, Dr. Griffin called on Mr. McNutt to provide the Performance and Financial Status Report. Mr. McNutt noted that the Performance Dashboard is provided at Tab C page 83 thru 100 of the board agenda. He then reported that through the first quarter FY 2010, the service population 151,551 at the end of this quarter compared to 150,710 for the same time period a year ago which is an increase of 791 or 2% increase. The increase is not so much that TDCJ's population increased, it might have decreased, but they closed out their contracts with the county jails and those people moved back into the system. The aging offenders as you can see over a two year period for the biennium continues to grow, and Mr. McNutt reported that the number of offenders 55+ at the end of first quarter FY2010 was 11,574 as compared to first quarter FY2009 of 10,724 which is an increase of 850 or 7.9% increase. If you look at documents that have been done in the past and Mr. Nelson if you really wanted to know how to cut cost, get rid of the age 55 and older. You can look at a document that TDCJ turned in last year to the legislature as bills were passed and it showed about a $20 million dollar a year savings if you would kick out the non 3G offenders over age 55.	Mr. Elger stated it seems like 50 to 55 population has grown so is 55 and above right or is 50 and above right. Mr. McNutt responded that Dr. Murray had started talking the 50 game. I'm still talking about 55 and that is what we've been reporting. We can go back in the future and start reporting at age 50 or make that a separate report also. Your correct the last few months Dr. Murray has been talking the age 50 plus instead of the age 55 plus. Mr. Elger added that it turns out to be a significant impact on transient cost and what the assumption really is in terms of. Dr, Linthicum adds that in terms of our	

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VI. Performance and Financial Status Report (cont.)	The psychiatric inpatient census remained consistent at the 1,900 bed level which was noted is governed largely by the number of available beds. Through the first quarter of FY 2010, the average number of psychiatric outpatients was 19,744 representing 13% of the service population. Now if you would look at page 88. I know at one time we had members ask about the access to care indicators which are on this page. Mr. McNutt noted that the definitions of the nine access to care indicators are included on page 89 of the agenda packet for reference. He then reported that the medical access to care indicators remained within the 90% - 98% range; the mental health access to care stayed within the 98-100% range; and dental access to care remained consistently between 98% - 100% range. Mr. McNutt continued by stating that the UTMB sector physician vacancy rate for this quarter was 7.04%; mid-level practitioners at 8.46%; RN's at 9.52%; LVN's at 8.11%, dentists at 5.71% and psychiatrists at 10.53% which he noted looked a little better than what was reported for the previous quarter. TTUHSC sector physician vacancy rate for the same quarter averaged at 24.25%; mid-level practitioners at 17.45%; RN's at 21.04%; LVN's at 17.38%; dentists at 16.85%, and psychiatrists at 28.20%. The timeliness in the Medically Recommended Intensive Supervision Program (MRIS) medical summaries for September was 89%, October 95% and November was 92% for the first quarter FY 2010. Mr. McNutt next reported the statewide cumulative loss/gain for the month of September had a net loss of 9 million dollars. The statewide loss/gain by month, we	definition of the geriatric offender, we arbitrally choose a chronological age 55 because the physiological age David reports on 65. So we look at 55 and older, and define that as our geriatric population but within that age group we have 60 then 65.	

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VI. Performance and Financial Status Report (cont.)	gained 2.5 million for the month of September, a little over 3 million in October and 3.3 million in November. Mr. McNutt next reported that the statewide revenue v. expenses by month. You can see where the expense exceeds the revenue by month. September 45.4 million vs. 42.9 million, October 48.1 vs. 45 million and November 46.2 vs. 42.8 million a month. Mr. McNutt next reported TTUHSC cumulative loss/gain 359 thousand thru September, and climbs up to 898,978 dollars thru November. UTMB thru November is 8,076,396 dollars. Mr. McNutt wanted to add on page 88, at one time a board member had requested that we break out the Mental Health Census by gender and we will continue to add this to our agenda. Dr. Griffin thanked Mr. McNutt and asked for any questions or comments.	Dr. Linthicum had a comment about the Mentally Retarded Offender Program has been renamed the Developmental and Disabled Program. Dr. Griffin added that he had a question that Mr. Nelson asked at prior meetings. If you look at page 84 which is the service population and page 100 cumulative loss/gain, there seems to be a disconnect between the service population and losses. Those two don't fluctuate together. Is there a simple way we can report that to leadership? We always get that question that your population is moving but your numbers move as if there weren't people you're taking care of that reflected those dollars. We've been asked that at least two or three times in the last couple of months. There is no variability in that. And to me we have to develop a way we can report that. Mr. McNutt replied that the way the contract	

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VI. Performance and Financial Status Report (cont.)	Dr. Griffin thanked Mr. McNutt for the report then called on Dr. Linthicum to provide the TDCJ Correctional Health Care Vacancy updates. Dr. Linthicum reported that a Contracting Monitoring Nurse was filled our Manager IV Public Health Nurse	is that it's based on a capitation rate but it's based on a variance of 4% either way. But if the question comes up the universities get no more money as long as it's within 4%, if the populations goes down as long as it's within 4% they won't get any less money either. And the contract is written on an actual capitation rate favored by the population variance of 4% either way. The guaranteed a number that we really work the contract off of is one the LBB works with when they made the appropriation. This was a little over 151,000 population. Dr. Raimer commented that it brought up a very good question. I don't know how to answer, but we can think about it. When you go out and start dealing with this population the numbers do go up and down. But it's over 120 different units. So, if you lose 50 prisoners in 20 units you don't automatically throw somebody off there, you still need a nurse in that are whether you have 500 residents or 550. I don't know how to get a handle on this. But it seems unfortunate to tie per member per day like you could actually decrease those expenses, because these are fixed cost. I assume the same thing Bryan Collier would do at TDCJ itself with security officers; you have to have a certain amount of officers. And the same thing with the infirmary weather you have twenty patients or twenty-four patients you have to have a nurse. Dr. Griffin added that it's like the anesthesiology firehouse methodology it doesn't matter if you have a fire or not you have to have a staff. If you have a 4% variance you don't do any change in staff. If you exceed or go below that then there maybe a reasonable assumption to change personnel.	

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	applicant declined. Maybe we'll soon be bringing one of our part time physicians to full time.		
VII. Summary of Critical Personnel Vacancies			
- **Lannette Linthicum, M.D. (TDCJ)**	Dr. Griffin thanked Dr. Linthicum for the updates then called on Larry Elkins who is standing in for Dr. DeShields to provide the TTUHSC personnel vacancy updates.		
- Larry Elkins (TTUHSC)	Mr. Elkins reported that Dr. DeShields wanted to report about the PRS (Pharmacy Replacement System) that has been implemented in our first quarter and we will implement the balance of the PRS in the southern region last month. We are happy that we think we are going to hire the psychiatrist for the PAMIO Unit very soon. We offered the Medical Director position to a gentleman from Florida 9 months ago and he is very close in receiving his Texas license. That position has been vacant for six years. Mr. McNutt talked about our vacancies and I don't want to repeat and go into detail. Our nurses' vacancies have increased since the first quarter. We are higher than 25% vacancy rates for nurses in 18 different locations. The situation we are facing in West Texas because we are so scattered in small towns to deal with our nursing shortage. To deal with our nurse shortages we have to deal with recruiting firms. These firms are charging us two to two and half times more than what we pay. For example which UTMB knows Supplemental Healthcare Agency, out of Dallas Fort Worth and they are good at what they do. They bring us a nurse for 13 weeks at a time and then for another 13 weeks and before we know it it's been 52 weeks. But for a RN with some experience they are charging us $110,000 a year and we can hire the same nurse if she would come to work for us for $44,000, so that is two, two and a half times more. So we are facing that and doing the best we can and were hoping that something is going to change not only on the western Texas section but also the State of Texas. We lost another psychiatrist last month so out of ten we have four vacancies. So we are a little excited about this doctor coming from Florida, hopefully he'll be on board in the next two months.		

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VII. Summary of Critical Personnel Vacancies (cont.) - **Owen Murray, D.O., (UTMB)**	Dr. Griffin thanked Mr. Elkins for the update and then called on Dr. Murray. Dr. Murray stated that you saw the numbers and those we're not in that bad of shape. They keep hovering around 10% percent for our providers and a little bit more for our nursing staff. The only loss that we had was Dr. Troy Sybert who was at Hospital Galveston, and we are now without a Chief Medical Officer at Hospital Galveston.	Dr. Griffin asked about Hospice program. Dr. Murray replied that the Hospice program is actually run thru internal medicine. But Troy provided and bridged the gap between our sub-specialist group, the facilities, TDCJ and very experience in a lot of problem solving methodologies. He did a lot of work in what we were discharging out of our hospitals, what we had up in our infirmaries and how we could better make those transitions a little bit smoother. Well miss him he was a good doctor. Dr. Griffin asked if there were any prospects.	
VIII. Wheelchair Policy - **Owen Murray, D.O. (UTMB)**	Dr. Griffin thanked Dr. Murray and went on to the Wheelchair Policy Dr. Murray stated speaking of cautiously optimistic; Dr. Griffin asked if we would talk about what went on with Mr. Comeaux. Mr. Comeaux who spent about a decade plus in a wheelchair and then ultimately left his wheelchair and escaped. I want to thank Dr. Linthicum for putting this hand out together. Just to clarify some things, we've always had a wheelchair policy that has worked very well and efficiently. I don't know quite honestly that would have worked for this individual. He was truly committed to doing his act. Part of the other issue with this individual, we had put him in a wheelchair. There were certainly some medical indications to put him in a wheelchair. But you look back retrospectively you can see some refusal on his part choosing sub-specialty care and some of the diagnostics they were asking for. There were some lose	Dr. Murray replied that given our 5% I think we are going to be cautiously optimistic about pulling someone in.	

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VIII. Wheelchair Policy (cont.)	history of some strokes and some other things. But again his act and his presentation certainly precipitated, I think a reasonably risk management strategy of putting him in a wheel chair. We did attempt a couple of times to move him out which precipitated him to choose to lie in his own feces and create not only an issue for medical and security but also brought in the ACLU. We were dealing with them and this individual and when you paint that picture to an external group, at some point and time you have to make a risk management decision and keeping him in the wheelchair seemed like it was the best decision at that time. Obviously it wasn't necessarily our best decision but looking back our policy was followed and I think it's worth while. We have about 350 offenders in a wheelchair currently in the system. That number goes up and down a little bit. But I think there were some concerns that we had thousands of people wheeling around in TDCJ. And that is not the case. We have a program that evaluates the patients on a daily basis. We also have a full time physiatrist, who is a licensed physician who deals with not only our physically handicap offenders but anybody that will be in a wheelchair. She is going to evaluate them. Part of that evaluation is obviously sub-specialty intervention down in Galveston. Typically seeing a neurologist, orthopedic surgeon and the appropriate sub-specialty to make sure that we can clarify the diagnosis. As well as imaging studies and etc. before we place someone formally and permanently in a wheelchair. Dr. Naik has been with the system for 20 years plus and Dr. Linthicum, Dr. DeShields and myself have a great deal of confidence in her, she is fair, reasonable and has good skills. And she is not one historically to be easily manipulated either way. Again, our policy works the process thru and usually these cases are fairly straight forward the injury is obvious that the history supports. It is these rare cases that you get into where you have some patients who motivated for whatever reason choose to do their time in a wheelchair. And from that standpoint our current policy does address that.		

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VIII. Wheelchair Policy (cont.)	Some of the changes on page 2 is there is a multidisciplinary committee that is composed not only of health services, but security to deal with these particular individuals who are trying to manipulate the system to their advantage. We've done a review of our current policy and we have made some minor revisions. Nothing really significant. Item 3 is really the important thing identifying some facilities that might deal with those individuals like Mr. Comeaux. Both from a healthcare & security perspective in having a facility or unit that will deal with this type of individual it really does take a coordinated effort, because these patients will act so far out in left field it is difficult to continue to educate everybody at multiple facilities and having one place much like our mental health facility that understands this person presentation, limitations and manipulations will make it much easier for us to deal with these types of individuals in the future. And I think ultimately it's a shared responsibility. Dr. Linthicum and I are in complete agreement that when we get to a level where there is that kind of concern that someone is being placed in that kind of environment that she and I and Dr. DeShields are looking over that care and really at the highest level making sure that clinically we feel comfortable with what's going on so that ultimately whatever the outcome is, at least it's been reviewed by everyone and we are all in agreement. Looking back on Comeaux it was such an extended period of time. We did all of this, given his motivation to remain in that chair and the things he was willing to do I don't know honestly if we would have done anything different. Our policy has worked well for the fifteen years that I've been here, the simple changes we will make and then certainly Dr. Linthicum, Dr. DeShields and I will make sure that we have some clinical oversight and review of any cases that get to that level.	Dr. Linthicum noted that they were going to bring in the security side of the house to look at the security issues as well. In terms of housing these offenders, one of the real	

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VIII. Wheelchair Policy (cont.)	Dr. Griffin thanked Dr. Murray and went on to Agenda Item IX TDCJ Rider 83 of SB1, Article V. Mr. Elger reported that he wanted to give an update of	sensitive problems for us when we determine that there is no organic basis or no pathology for why these individuals are refusing to walk. Some of them will go to the extreme of dragging themselves around the unit or crawling on all fours, things like that which are not tolerated well by the other offenders on the unit, they don't understand, they don't have the history, all they see is the offender crawling around the unit. Our committee is going to get with security so they can have their focus and to see how our policies and how we each interact. And then this whole review board which primarily the medical directors will do the final review but we were going to bring in the CID director as well for security review to make sure that housing and classification for these offenders are correct as well. We plan to work more closely together in management. In fact Mr. Comeaux has already filed two grievances up to me demanding his wheelchair back. He's appealed up to the second step. This is an ongoing daily prison operations manager problem. Dr. Griffin asked if there were any questions or comments. Dr. Griffin added that when this issue came to him there were some miss conceptions out there. And I think certainly in the process that develops from these discussions is the distinction between the people who is wheelchair dependant versus the one who is wheelchair bound to facilitate activities of daily living within their prison environment. And I think that in the newspaper they don't make that distinction. Wheelchair means you can't walk, you can't get around and I think that is different from the wheelchair policy.	

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IX. Managed Health Care Appropriation Transfer Between Fiscal Years, Rider 83 of TDCJ Appropriations Article V, 81st Legislature **- William Elger**	the Financial data for CMC. In your handout turn to page 2. The first five months shows a loss of little over 12 million. We've been looking at what the projections might be for the biennium. We've been trying to tighten these numbers up. Turn to page 3 that show the funding shortfall. Well it comes to two principal parts. One is underfunding of what was requested at the last session. And that had two elements to it, one the SAR that was requested. Some of that was not funded and some of it was funded but not added to the base, which put it with a 16 million dollar shortfall. And for the LAR request not all of that was funded that created another 42 million dollar shortfall and together going into the biennium that is approximately a 59 million dollar shortfall. And there is another piece, other unfunded items not in the LAR with a 23 million dollar shortfall for a total projected shortfall for the biennium is 82 million dollars. This does not include any potential deductions from the 5% that we had to do. That turns out for CMC approximately 36 million dollars for the biennium, which turns this number into a non sustainable amount. So that's where we are for the biennium. Mr. Elger adds that the last two pages were intended to illustrate the timing of cash payments here beginning of the quarterly payment. It makes sense sometimes a little bit difficult to see until you get to the end of the year. For example at the beginning of the first quarter, CMC get a payment for the quarter and then its been out their for a quarter but we are spending more than what we received by the quarter so the last part of the first quarter we're short in essence drawing money from other university funds to cover that shortfall.	Dr. Griffin commented that he did not see that and that's one of the big things that are very difficult for us to explain. In first quarter about an average 90 million dollars. Let's say you go forward and you have a 7.6 million dollar deficit. Well your getting another 90 million dollars before services are rendered and it's difficult for individuals that I have conversations with to say where you're using other funds when we fund prior to services rendered fourth quarter. And that's the	

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IX. Managed Health Care Appropriation Transfer Between Fiscal Years, Rider 83 of TDCJ Appropriations Article V, 81st Legislature (cont.)	Mr. Elger commented that was what he is trying to illustrate. On page 4 the green line the very beginning of the quarter we get that quarterly payment. The 80 million dollars comes in there will be expenses for the quarter of 7million dollars. Before we get that next 90 million dollar check we're short approximately 7 million dollars and the only way to fund that is that we basically use the accumulated resources of the university until that next 90 million dollar check comes in. For which if you think of it part of the 90 million dollar goes to pay back the 7 million dollars that we borrowed, so that now you got only 83 million dollars left, another 97 million dollar expenses come in and before you get to that quarterly payment you are short another 7 plus. So the accumulated deficit kind of builds thru the end of the fiscal year because we scored things under the fiscal years bases when they dropped the hammer. Mr. Elger stated the numbers get so big that on a cash basis and the bottom line here is basically the checkbook account in time you can squeeze a little bit around, you don't spend everything. But, it's not much to come up	squeeze point. It's not a question that it's going to happen; it's really a question of timing of these events. Well UTMB is not getting some interest income from this lagging deficit that's building over time. And so that's that parsing question related to a cash flow statement in terms of the entire argument. That's the point that I think when we submit a request again it's about timing not about if you'll do it. What's that trigger point if which it should go forward. Dr. Griffin added that was understood in timing when invoices go out and when payments are received all comes toward the end of the quarter. I guess one of the issues has is based on prior legislative sessions if they don't make you whole then your left holding this irreconcilable difference. But thru the year, the casual statements should be able to be managed in a way where they are not actual funds that come from other sources. Because when we pay versus you have to send checks out to other providers or pharmacy vendors or whatever the case may be.	

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IX. Managed Health Care Appropriation Transfer Between Fiscal Years, Rider 83 of TDCJ Appropriations Article V, 81st Legislature (cont.)	with the numbers. So that's the challenge that were looking at the size of these deficits are more than UTMB can play banker for. When you add that to the revolving building other capital outflows we have to do that we have to try to get reimbursed for after the fact. We combine these two events we get into a situation. Dr. Griffin asked for any questions or comments.	Dr. Raimer stated that what this needs is a long term solution and what we are talking about is a short term solution. Some discussion I believe Mr. Hightower did incur behind the scenes yesterday about that with some others that we need to figure out a better financing mechanism for this so that these deficits do not accrue into one of the universities budget or anybody else's budget for that matter. Today's request that we have discussed in the last meeting is simply activating of our spend forward authority that allow us to close out this year with a minimum deficit in these accounts. And depend on the next session for us to recoup our SAR. Dr. Griffin added that there was a list of items that were imbedded in the last meeting. What is the status of those and how do they impact those numbers. Are there any things that can be done from an operational stand point? This is the one sanction legislative maneuver that the committee is to request from the leadership. Or there any other management related issues to impact these numbers as well because I think that is important. You just move things from one part to another. Dr. Murray stated that Dr. Griffin saw their list. I think the only thing we would have is those dollars that were given for merit increases for our staff. And that is really about it, unless we are going to un-employ people then that list kind of stands as its the only the thing we can do from a management standpoint to augment these losses. We certainly have gone ahead and held back on	

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IX. Managed Health Care Appropriation Transfer Between Fiscal Years, Rider 83 of TDCJ Appropriations Article V, 81st Legislature (cont.)		our FY10 salary increases that we've discussed at the end of the year. We've not done that, we've brought that to the table for discussion, given the 5% and everything else. We put all of that into that as well. We are acting on some of those right now given this 5% reduction. We need about 5 million dollars for salary increases for staff, market adjustments. It doesn't help the situation because we're going to roll into the next year and two years down on market adjustments for our staff. Mr. Nelson asked to be reminded of what was done at the last meeting. I believe it was a proposal to do several things. One was to go forward with the spend forward provisions. There was another proposal with regard to using capital expenditure, budget items for non capital expense. And then there was another proposal that I remember about reducing the patient care of the services with regard to Hepatitis B, C, and HIV testing. I know that there were two or three other things that I can't recall, but those are some of the major things that impacted spending decisions and deficit numbers. I know there had not been a motion at this point yet with regard to the spend forward provision, but let me just kind of try to get myself reacquainted and Janice acquainted with this. What are ya'll going to do about the proposed use of capital funds for non capital funds. Mr. McNutt asked Dr. Griffin if he could address this and that it was in reference to the letter based on Mr. Cavin's request sent to the LBB. I have the response back on that. This was prior to the 5% cut, so a lot of that is going to be taken and will fall into 5% reduction. Here is the letter to John O'Brien, Director, LBB dated December 8, 2009. The funding for Correctional Managed Health Care	

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IX. Managed Health Care Appropriation Transfer Between Fiscal Years, Rider 83 of TDCJ Appropriations Article V, 81st Legislature (cont.)		(CMHC) is in the Texas Department of Criminal Justice (TDCJ) Appropriations, Article V, Senate Bill 1 of the 81st Legislature. It is appropriated under C.1.7 Psychiatric Care and C.1.8 Managed Health Care. Funding is then allocated to the university providers based on a capitated rate. The University of Texas Medical Branch (UTMB) has addressed the Correctional Managed Health Care Committee and informed them that they are projecting a significant shortfall for FY2010 and FY2011. UTMB has proposed several steps that would reduce the projected shortfalls. A question arises whether or not it would be permissible for TUMB to proceed with two of these proposals: 1. Defer non-committed capital purchases; 2. Defer administration of FY2010 merit raises. Both of the above items were partially funded by the 81st Legislature as exceptional items. And the answer from Susan Dow, Budget Analyst, with the LBB is: As discussed during meetings with UTMB and subsequent phone conversations with UTMB and CMHCC, we still have questions concerning UTMB's projected shortfalls. For this reason, we will not consider at this time any redirection of appropriations from the uses for which they were appropriated. We will, however, inform the Legislature of all the options proposed by UTMB. We do not believe there is a problem with temporarily deferring the items in your proposal, but we will not request legislative approval to use the funds for other purposes until we have a better understanding of UTMB's projected shortfalls and review actual expenditures during fiscal year 2010. The bottom line is they don't mind you deferring but you couldn't redirect at that particular time. In my opinion a lot of that has	

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IX. Managed Health Care Appropriation Transfer Between Fiscal Years, Rider 83 of TDCJ Appropriations Article V, 81st Legislature (cont.)	Dr. Griffin then asked Mr. Elger if he had a motion.	been taken over by the 5% because you show it in the 5% reduction if they choose to take that option and reduce our appropriations by 5%. As Mr. Collier said that is Item 25 in TDCJ's reply in asking for an exemption, but we don't know the answer yet. There were some further discussions between Dr. Raimer, Dr. Griffin, and Mr. McNutt. Dr. Griffin asked if any further discussion. Mr. Nelson excused himself but he didn't listen close enough at the beginning of your motion. The use of the funds as Dr. Raimer mention the unfunded carry over deficit from previous biennium's and the 12 million dollars that remains a hole in your budget. Wanted to make sure that your not proposing that any of this 18 million or 20 million that's going to be spend forward be used to pay for the deficit carry over from 2007, 2008. This money is	Mr. Elger noted, Mr. Chairman, at this time, as per SB1, Article V, TDCJ Rider 83, Page V-28, I would like to make a motion for the Correctional Managed Health Care Committee to seed approval from the Governor and the Legislative Budget Board to transfer funds from fiscal year 2011 to 2010. The motion would be to move $18 million for UTMB and the authority to move $2 million for TTUHSC at a later date if TTUHSC determines the need exist. The Correctional managed Health Care Committee staff is instructed to assist with whomever necessary in completion of the transfer. Dr. Jumper seconded the motion.

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IX. Managed Health Care Appropriation Transfer Between Fiscal Years, Rider 83 of TDCJ Appropriations Article V, 81st Legislature (cont.)		only going to be used from deficit that had occurred since September 1, 2009, is that correct. Mr. Elger responded that was correct. Dr. Raimer also confirmed that was correct. He also added that some of those expenses could be related to Hurricane Ike in 2009. We are looking at other avenues with the State to seek if there were programs that may involve federal dollars. So we're actually trying to be a good player with the state to not depend on the state to find us resources. I did receive some information yesterday that's moving along. More discussion with Mrs. Lord, Dr. Raimer and Dr. Linthicum was heard on whether the employees of Hospital Galveston were paid during Hurricane Ike. It was explained that services were not provided at the hospital for a short time. The patients were disbursed to other hospitals for treatment and treated as off-site treatment. This years budget, little of any of that budget overruns are from Hurricane Ike. Hospital Galveston came back on board around January 1st or 3rd. Dr. Griffin added that it was his understanding that the staff was kept on at full pay. No one was furloughed or released from service from the university and everyone continued to receive a check. Dr. Linthicum said that Hospital Galveston was shut down. Dr. Griffin said he wasn't talking about the facility; he was talking about the people that run the facility. Dr, Linthicum said no they weren't there. Dr. Murray added that once the hospital	

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IX. Managed Health Care Appropriation Transfer Between Fiscal Years, Rider 83 of TDCJ Appropriations Article V, 81st Legislature (cont.)		closed down, they tried to improve services at the Carole Young facility. We opened up nursing positions to bring some of the displaced hospital employees who were really not part of the CMC budget; they are at UTMB's expense. That is the only move we made after the hospital shut down was to bring some of those nurses over to the facility to ramp up the level of care that we might have been able to provide there. Dr. Griffin added that there were people that were fired because of the hurricane. Dr. Raimer stated that there were almost 3,000. Dr. Griffin said that they did not receive a check and that needs to be clear, because it does not show up anywhere in terms of accounting issues.	Now I'll restate the motion that has been seconded, pursuant to SB1, Article V, TDCJ Rider 83, that we move $18 million for UTMB and the authority to move $2 million for TTUHSC at a later date if TTUHSC determines the need exist. And ask the state leadership for that permission. The process being the LBB, The Governor's Office and CMHCC. Those are the three individuals that it has to go thru. The motion passed by unanimous vote.
	Dr. Griffin asked if there were any further questions or comments on this motion.	Additional discussions were had Dr. Griffin asked that in anticipation of this request that UTMB work very closely with the committee staff in terms of the structure of make sure all the points of the narrative be put forth. I think some of the things that Dr.	

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		Raimer has shared with us need to be in that. Because that's one document, they are going to read very closely where in a legislative cycle there are thousands of pages that are moved. But this document will be read by the top leadership of the state. And so it's a chance to get that singular quiet moment for your message to get thru.	
X. Medical Director's Reports - **Owen Murray, D.O. (UTMB)** - **Larry Elkins (TTUHSC)** - **Lannette Linthicum, M.D. (TDCJ)** - **Operational Review Audit** - **Grievances and Patient Liaison** - **Quality Improvement Access to Care Audits** - **Capital Assets Monitoring**	Dr. Griffin then called on Dr. Murray for the medical director's report. Dr. Murray noted that he voted his time to Dr. Horton who will be doing a dental presentation. And that he didn't anything else to add from what he presented earlier. Mr. Elkins also did not have anything else to add from what he reported earlier. My report is on pages 104 – 142. During the fourth quarter of FY 2009, Dr. Linthicum reported that eight facilities were audited and those results are available on pages 104 & 105 of the agenda packet. She then reported that the Grievances and Patient Liaison Program and the Step II Grievance Program received a total of 3,021 correspondences. Of the total number of correspondences received, 415 or 13.74% action requests were generated. Quality Improvement / Quality Monitoring staff performed 34 access to care audits for this quarter. A total of 306 indicators were reviewed and 11indicators fell below the 80% threshold. The Capital Assets Contract Monitoring Office audited eight units during this quarter and these audits are conducted to determine compliance with the Health Services Policy and State Property Accounting policy inventory procedures. Audit findings concluded the eight units audited were within the compliance range.		

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X. Medical Director's Reports (cont.) - **Office of Public Health**	Dr. Linthicum next reported that the Office of Preventive Medicine monitors the incidence of infectious diseases for TDCJ. For the first quarter of FY 2010, there were 165 cases of suspected syphilis; 549 Methicillin-Resistant Staphylococcus Aureus (MRSA) cases were reported compared to 327 during the same quarter of FY 2009. There was an average of 24 Tuberculosis (TB) cases under management per month during this quarter, compared to an average of 23 per month during the first quarter of the FY 2009. Dr. Linthicum then stated that the Office of Preventive Medicine's Sexual Assault Nurse Examiner (SANE) Coordinator provided five training sessions, attended by six facilities with 34 medical staff trained. Currently, Peer Education Programs are available at 108 of the 112 facilities housing CID offenders.		
- **Mortality and Morbidity**	The Mortality and Morbidity Committee reviewed 103 deaths. Of those 103 deaths, 8 were referred to peer review committees and 1 was referred to utilization review.		
- **Mental Health Services Monitoring**	The Mental Health Services Monitoring and Liaison with County Jails identified 49 offenders with immediate mental health needs prior to TDCJ intake. Dr. Linthicum added that the MHMR history was reviewed for 19,530 offenders brought into TDCJ-ID/SJ. Intake facilities were provided with critical mental health data, not otherwise available for 2,724 offenders. 3,105 Texas Uniform Health Status Update forms were reviewed which identified 891 deficiencies. There were 276 offenders with high risk factors (very young, old, or long sentences) transferring into the Correctional Institution Division interviewed which resulted in 19 referrals. During the first quarter of FY 2010, 21 Administrative Segregation facilities were audited, 4,136 offenders were observed, 2,581 of them interviewed, and 6 offenders referred to the university providers for further		

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	evaluation. We are also very involved now in the Special Need Substance Abuse Felony Punishment Program (SAFP). The staff in my office is actually looking at all offenders discharged from Special Needs SAFP facilities and we are coordinating between the university providers and offender for the rehabilitation program services.		
X. Medical Director's Reports (cont.) - **Clinical Administration**	During the first quarter of FY 2010, 10 percent of the combined UTMB and TTUHSC hospital and infirmary discharges were audited. The breakout of the summary of the audits is provided at page 108- 109 of the agenda packet. We continue to have some issues with documentation but it has really much improved over the years. Then a few that were unstable discharges had to be returned		
- **Accreditation**	Dr. Linthicum next reported that there were no ACA accreditations during this quarter.	Dr. Raimer said that he knew that Dr. Linthicum had done a lot nationally on the issues of prison sexual assaults. How do the Texas numbers compare to other states.	
- **Biomedical Research Projects**	Dr. Linthicum concluded by stating that the Biomedical Research Projects summary shoes that we have 8 projects and one that is pending. The Correctional Institutions Division has 31 research projects and 6 pending.	Dr. Linthicum answered that actually the ombudsman's office that keeps all those stats. If you look at the SANE Coordinator in my report for the first quarter for FY2010 on page 106, it shows that here have been 172 chart reviews of allegations. Dr. Raimer asked if she was pleased with the results. Dr. Linthicum replied that she was and that they had a Safe Prisons Program that is really multi disciplinary, lots of collaboration with the security side, the ombudsman, health service, mental health staff, program staff, etc. So I think as a system, we are light years ahead of a lot of systems. Dr. Griffin asked if that was federal and has it had any impact on these numbers or is that something that will impact these numbers.	

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X. Medical Director's Reports (cont.)		Dr. Linthicum answered that it has because a lot of our programming has been based on what's come out of Career and other conventions. Mr. Nelson had a question on operational review audits and unbearably there are units that do not comply and what do you do following the audit to get them in compliance and ensure that they will stay in compliance. Dr. Linthicum replied that at the last meeting she had brought in samples of their corrective action process. Dr. Linthicum proceeded to discuss the process in further discussions with Mr. Nelson, Mrs. Lord, and Mrs. Lord also asked about H1N1. Dr. Griffin asked Dr. Linthicum to add in the briefest concise way a permanent attachment to her report that talks about the Corrective Action Plan. Because if you ever see this apart from that, there's always a distant all these things what are they doing. Just a one page attachment that when we see these things, this is the process because if any singular individual sees this for the first time they can see the basics of this plan.	
XI Joint Work Group Committee Overview: Dental Work Group **- Billy Horton, D.D.S.**	Dr. Horton stated that his presentation began on page 112 of the agenda packet. They have three Committee Membership Dental Directors which are; TDCJ, Dr. Hirsch, TTUHSC, Dr. Tucker and himself for UTMB. They also have UTMB Associate Dr. Reinecke, district dental directors, specialty coordinators, Manager, Dental Hygiene Program, Pam Myers, RDH and others that are invited when applicable. The Dental Work Group Committee is scheduled to meet every two months. The System Dental Directors and TDCJ Dental Director will be meeting quarterly on the same day as the System Leadership Council. In addition to that we touch base at least once a week. Our main Committee Functions are; provide oversight		

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XI Joint Work Group Committee Overview: Dental Work Group (cont.)	of the Dental Program to assure quality and humane care is provided at reasonable costs, policy review and revision, clinical audit reports: TDCJ Operational Review and Dental Quality of Care Audits, ACA accreditation findings and reports, University Quality Assurance Audits and Monthly Audits of each facility. Policy/Process Change: based on scientific and professional advancement/recommendations, literature review of professional journals, recommendation/parameters for care developed by professional groups; American Dental Association, American Dental Hygiene Association, and Specialty Groups. University Quality Assurance Audits objectives are: a treatment plan is present for those who request routine care, the plan includes all aspects of care for which the patient is eligible, and oral hygiene/preventive care is a component of the plan. Priority 1 is urgent care such as pain, swelling, infection, bleeding and anything leading to a life threatening situation and they are suppose to received definitive care within fourteen days of the exam and Priority 2 is interceptive care such as tooth decay, so that we may intercept it before they loose a tooth. And all offenders are eligible for Priority 1 and 2 care. We also have Priority 3 care which is for dentures, and we provide them when they are a medical necessity. Then Priority 4 is routine dental care such as cleaning, fillings, things of that nature and the offender is eligible for this when he has been incarcerated for more than one year. And then Priority 5 is when all care has been completed. Priority 1 and 2 needs are addressed at the sick call visit, a definitive periodontal type is established, and all patients scheduled for a dental follow up have care initiated within established time frames. Dental Resources Utilization we have monthly reports, statistical data on productivity on facility, district, and university. We do staffing reports, non compliance reports and access to care reports. Dental Services Manual Review we update dental procedures. We have same schedule as CMC Policy & Procedures Committee. We do process improvement		

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XI Joint Work Group Committee Overview: Dental Work Group (cont.)	with CMC policy change, dental subcommittee, staff suggestions, EMR, equipment or other technological change, and State Board of Dental Examiners/Occupations Code. Additional Topics we discuss are: TDCJ/University updates, Director Reports, District Director Reports, Specialty Coordinators, and Dental Hygiene Program Manager. Dr. Horton asks if anyone has any questions or comments.	Mr. Collier asked in your relation to dentures how many are done, how many are requested, and how many are actually delivered. Dr. Horton replied that at UTMB they did it a little different than Tech. UTMB has a review board and whenever a dentist had a patient that was eligible, he'll go ahead and have a physician sign off on the paperwork and he'll also follow the patients' weight and look into putting him on a blended diet. Anyway the process is the dentist sends all the information thru the committee, the committee reviews it and then decides whether or not we need to approve it or not. We do keep those statistics and we supply them to Dr. Hirsch. Mr. Collier stated that the question that he really had is the dentures that are actually ordered the delivery to the offenders are matching up, how long is the process. Dr. Horton answered it's usually 90 to 120 days. One of the biggest problems we've had	

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XI Joint Work Group Committee Overview: Dental Work Group (cont.)		is from the time mail leaving the mailroom to get to the lab. The lab will have a 2-3 day turn around and it still takes 15 days to get back into the dental clinic, so there are still some issues. Dr. Linthicum added that was part of their monitoring and I have asked Dr. Hirsch for information on what's being ordered and what's being denied. So, is that already available to us. Dr. Horton answered yes it is available; I've had to go back for several years. Dr. Linthicum said that she would like that information to go to Mr. Collier. Dr. Griffin added that he would also like a copy for the committee staff. Dr. Linthicum added that what is really a concern to her in terms of their monitoring function is the time frame that it takes to get the dentures. One of the things that I have done is talk to Mr. Hazelwood with industry about the possibility of us trying to do a dental lab and he is very receptive of the idea and wants to meet with all of us. More discussions were had on dental issues such as labs used and time issues, etc. Mrs. Lord asked what was the logic on no dental care for the first year unless it's an emergency. It seems to me you could save a lot of money if you start taking care of things at the beginning. Dr. Horton answered a lot of the offenders that come in have sentences that are less than a year. If you allow everybody within their first to have dental care, you might flood the	

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XI Joint Work Group Committee Overview: Dental Work Group (cont.)		system and we don't have the staff. Mrs. Lord said that she didn't think we had that many that would be in for less than year. Dr. Linthicum added that would only be in a state jail. Dental care is a litigious area historically with correctional health care. We struggle the medical directors constantly on what is the right thing to do. One of the things Mrs. Lord is prior to doing a lot of dental work a person has to be motivated to take care of the work that has been done. So, this delay thing waiting for a year is seeing if the offender is going to brush their teeth, floss, and doing what is necessary because once you start doing restorative type work. Because what happens is once you do restorative work and they don't brush, they don't floss, they end up coming right back at ground zero. More discussions were had on dental oral hygiene and procedures on incoming inmates, staff and staffing issues. Dr. Linthicum added that she did have one concern that she discussed with Dr. Hirsch one of the Dental Directors that she thinks it's time for us to look at this whole criteria for dentures as a medical necessity and the criteria we're using and have asked him to do a literature search. The problem is there's not much out there in terms of a literature search that we can hang our hat on in terms of established national criteria. But right now they are looking at BMI for criteria if someone gets dentures. Dr. Horton states that he wanted to defend the system a little bit. Teeth are basically the first process in the digestive process. And they are meant to masticate and to grind and chew up your food. We have an opportunity if they don't have dentures and they are not able to eat soft food off the main food line to give	

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XII. Financial Report **Lynn Webb**	Dr. Griffin next is Financial Reporting Update presented by Mr. Webb. Mr. Webb stated that the financial summary will cover all data for the 1st Quarter FY 2010 ending November 30, 2009. Quarterly Information for 1st Quarter FY 2010 (Tab G) Population Indicators on pages 132 and 133 As represented on (Table 2 and page132), the average daily offender population has increased slightly to 151,551 for the 1st Quarter Fiscal Year 2010. Through this same quarter a year ago (FY 2009), the daily population was 150,760, an increase of 791 or (0.52%). Consistent with trends over the last several years, the number of offenders in the service population aged 55 or older has continued to rise at a faster rate than the overall offender population to 11,574 as of 1st Quarter FY 2010. This is an increased of 850 or about 7.9% from 10,724 as compared to this same first quarter a year ago. The overall HIV+ population has remained relatively stable throughout the last two years at 2,430 through 1st Quarter FY 2010 (or about 1.60% of the population served). The two mental health caseload measures have remained relatively stable: 1). The average number of psychiatric inpatients within the system was 1,927 through the 1st Quarter of FY 2010. This inpatient caseload is limited by the number of available inpatient beds in the system. 2). Through the 1st Quarter of FY 2010, the average	them a blended diet. Dr. Hirsch himself did try one of the blended diets which is all of your fruits, vegetables, or whatever blended individually and it really wasn't that bad and when you do give a blended diet they may not like it but that is the first part of the digestive process. More discussions were had on dentures and the bones ridges in you mouth how whether you have dentures or not the bone absorption will still happen. It's like a hill with a tree and its roots. It keeps the hill there. You take the tree away the hill will eventually flatten out. The same thing with the bone, you have teeth there in the bone, as soon as you take the teeth out the bone starts to absorb, so putting dentures in is not going to help prevent the bone from absorbing.	

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XII. Financial Report (cont.)	number of mental health outpatient visits was 19,744 representing 13.0% of the service population. Health Care Costs (Table 3 and page 134 and 135) Overall health costs through the 1st Quarter of FY 2010 totaled $139.9M. On a combined basis, this amount is above overall revenues earned by the university providers by approximately $8.975M or 6.9%. UTMB's total revenue through the first quarter was $104.3M; expenditures totaled $112.4M, resulting in a net shortfall of $8.1M. Texas Tech's total revenue through the fourth quarter was $26.6M; expenditures totaled $27.5M, resulting in a net shortfall of $899K. Examining the healthcare costs in further detail on (Table 4, 4a of page 136 and 137) indicates that of the $139.9M in expenses reported through the 1st Quarter of FY 2010: Onsite services comprised $65.1M, or about 46.5% of expenses: Pharmacy services totaled $14.1M, about 10.1% of total expenses: Offsite services accounted for $45.7M or 32.7% of total expenses: Mental health services totaled $12.2M or 8.7% of the total costs: and Indirect support expenses accounted for $2.7M, about 2.0% of the total costs. As requested at our last quarterly meeting Table 4a was constructed to give everyone the breakout of expenses by the UTMB and Texas Tech Sectors. Table 5 and page 138 shows that the total cost per offender per day for all health care services statewide through the 1st Quarter FY 2010, was $10.14, compared to $8.54 through the 1st Quarter of the FY 2009. The average cost per offender per day for the last four fiscal		

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XII. Financial Report (cont.)	years was $8.38. As a point of reference healthcare costs was $7.64 per day in FY03. This would equate to a 32.7% increase since FY03 or approximately 5.2% increase per year average, well below the national average. Aging Offenders Older offenders access the health care delivery system at a much higher acuity and frequency than younger offenders: Table 6 and page 139 shows that encounter data through the 1st Quarter indicates that older offenders had a documented encounter with medical staff a little under three times as often as younger offenders. Table 7 and page 140 indicates that hospital costs received to date this fiscal year for older offenders averaged approximately $671 per offender vs. $125 for younger offenders. Regarding hospitalization costs shown in Chart 15, the older offenders were utilizing health care resources at a rate more than five times higher than the younger offenders. While comprising only about 7.6% of the overall service population, older offenders account for 30.8% of the hospitalization costs received to date. Also, per Table 8 and page 141, older offenders are represented five times more often in the dialysis population than younger offenders. Dialysis costs continue to be significant, averaging about $21.9K per patient per year. Providing dialysis treatment for an average of 193 patients through the 1st Quarter of FY 2010 cost $1,056,842. Drug Costs Please note that Table 9 and page142 shows that total drug costs through the 1st Quarter FY 2010 totaled $10.8M. Of this, $4.6M (or over $1.5M per month) was for HIV medication costs, which was about 42.7% of the total drug cost. Psychiatric drugs costs were approximately $.5M, about 4.6% of overall drug costs. Hepatitis C drug costs were $1.2M and represented		

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XII. Financial Report (cont.)	about 11.4% of the total drug cost. Reporting of Reserves It is a legislative requirement that both UTMB and Texas Tech are required to report if they hold any monies in reserve for correctional managed health care. UTMB reports that they hold no such reserves and report a total operating shortfall of $8.1M through the end of the 1st Quarter of Fiscal Year 2010. Texas Tech reports that they hold no such reserves and report a total operating shortfall of $898,978 through the 1st Quarter FY 2010. A summary analysis of the ending balances revenue and payments through November 30th FY 2010, on (Table 10 and page143) for all CMHCC accounts are included in this report. The summary indicates that the net unencumbered balance on all CMHCC accounts on November 30, 2009 was $<5,355.91> due to CMHCC Operating Account personnel changes as compared to budget allocations. The FY2009 unencumbered ending fund balance of $30,072.62 has lapsed back to the State Treasury according to Rider 67 of House Bill One of the 80th Legislature and paid back in November 2009. Financial Monitoring Detailed transaction level data from both providers is being tested on a monthly basis to verify reasonableness, accuracy, and compliance with policies and procedures. The testing of detail transactions performed on TTUHSC's financial information for September 2009 through November 2009 resulted in one non-allowable expense discrepancy, and found all tested transactions to be verified. The testing of detail transactions performed on UTMB's financial information for September 2009 through October 2009 resulted in two classification error discrepancies and found all tested transactions to be		

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	verified. November 2009 transactions will be reported in the December 2009 Financial Report.		
XIII. Public Comments - **James Griffin, M.D.**	Dr. Griffin ask if any other comments. Since we have no one that has registered to make public comments.		
XIV. Date / Location of Next Meeting - **James Griffin, M.D.**	Our next meeting is scheduled for Tuesday, June 8, 2010 at 9:00 a.m. to be held at the Frontiers of Flight Museum.		
XV. Adjourn	Dr. Griffin thanked everyone for attending; then adjourned the meeting.		

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

6/8/10
Date: