MINUTES
CORRECTIONAL MANAGED HEALTH CARE COMMITTEE

March 19, 2012

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

CMHCC Members Present: Ben G. Raimer, Cynthia Jumper, M.D.

CMHCC Members Absent: Lannette Linthicum, M.D., Billy Millwee

Partner Agency Staff Present: Janice Lord, Texas Board of Criminal Justice; Denise DeShields, M.D., Texas Tech University Health Sciences Center; Ron Steffa, Rick Thaler, Jerry McGinty, Robert Williams, M.D., Bryan Collier, Texas Department of Criminal Justice; Anthony Williams, John Pulvino, M.D., Lauren Sheer, Stephen Smock, Kelley Coates, Ben Ramirez, Dr Owen Murray, Dr. Penn UTMB; Allen Hightower, Stephanie Harris, Lynn Webb, CMHCC Staff.

Others Present: Kelly Kennedy, Jennifer Jones, Sunset Advisory Commission; Steve Timmons, Centurion, LLC

Location: East Texas Medical Center 801 Clinic Dr., Room #2, Tyler, Texas

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I. Call to Order **- Margarita de la Garza-Grahm**	Dr. de la Garza-Grahm called the CMHCC meeting to order at 9:00 a.m. then noted that a quorum was present and the meeting would be conducted in accordance with Chapter 551 of the Texas Government Code, the Open Meetings Act.		
II. Recognitions and Introductions **- Margarita de la Garza-Grahm**	Dr. de la Garza-Grahm thanked everyone for being in attendance and asked everyone to introduce themselves for the record. I wanted to point out a couple of individuals in attendance, Kelly Kennedy and Jennifer Jones with the Sunset Advisory Commission.		
III. Approval of Excused Absence **- Margarita de la Garza-Grahm**	Gerard Evenwel (absent Oct. 4th and 20th) and Margarita de la Garza-Grahm, M.D. (absent Oct. 20th) Dr. de la Garza-Grahm stated next on the agenda is the approval of the Minutes from the meeting held on October 4, 2011: revised Offender Health Services Plan, Exhibit A, (reviewed and updated September 2011) to the TDCJ Contract and the Minutes from the October 20, 2011 CMHCC meeting: Health Services Monitoring Report; both UTMB and TTUHSC medical		

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IV. Approval of Consent Items **- Margarita de la Garza-Grahm**	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. de la Garza-Grahm stated that she 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. Cynthia Jumper seconded the motion. The motion passed by unanimous vote.
V. Executive Director's Report **- Allen Hightower**	Dr. de la Garza-Grahm then called on Mr. Hightower to provide the Executive Director's report. Thank you Madam Chairman, just to bring committee membership and staff up to date the committee has continued to provide the audit with the university providers and to provide the requested items and data to the universities and to TDCJ and our office has worked quite a bit lately with TDCJ in regards to the audit process. We have continued to report to the legislature, sunset staff, the LBB and the Governors Office and make the relevant meetings to what we call the subcommittees of the committee that make the recommendations back to the full committee on the inmate health care plan. There is still one vacancy left on this committee. My information from the governor's office is that we can expect an appointee to be named or to be made any day now. We have continued to have interaction with the Sunset Staff to comply with request and information's needed for the reports. We have an exit an interview with the sunset commission on the 24th of April. This will give us the first that Mr. Millwee who is representing the Department of Health and Human Services as an ad hoc member. This will be the first meeting that we have had since he was put in that position. The committee staff continues to do all the obligations as required to do out of the government code and continues to pledge to work with the partners in the committee as requested.		

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V. Executive Director's Report (Cont'd)	Madam Chairman I don't have anymore information so I will end my presentation unless there are any questions from membership. Dr. de la Garza-Grahm asked if there were any questions or comments.	Dr. Raimer asked if there was any direction on what the role of the board will be, any specific instructions from either legislative office, lt governor speaker, anyone or the governor's office about what the role will be as we move forward. Mr. Hightower answered that he has not visited with the Lt Governor office. The only interaction I have had with the Governor's Office has been about filling the appointees to the board, but as far as direction I assume that the committee staff will be brought up to date on the recommendations that Sunset Staff will have at the exit meeting. Dr. Raimer asked if it was your assumption that we will continue to do the things that we were doing, the same as what we're doing. Mr. Hightower responded with I don't know what recommendation in the end will be the end product and when it gets to the legislature, I don't know how the legislature will accept Sunsets recommendation as to whether or not they want to amend it in different ways. There has been quite a bit of talk with our interaction with Sunset and the partnering agencies as we now exists that there needs to be some oversight from a clinical perspective of the inmate health care plan. So that will be the stance that our staff has taken and given to Sunset and I guess we will be brought up to date on the April 24th. I don't know if that answered your question or not, but it's the best I can do. Dr. Raimer responded with thank you.	

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VI. Performance and Financial Status Report - **Lynn Webb**	Hearing no further comments, Dr. de la Garza-Grahm thanked Mr. Hightower for the report. We have moved Mr. Webb's financial report which is sometimes rushed from the last item to a more prominent place. Mr. Webb began with that we do continue to meet the financial requirements that the committee has. We do continue to report monthly financial information according to what the Government Code indicates. Those monthly quarterly reports are done for the Governor's Office, Lt. Governor's Office, and the LBB all according to the guidelines that we are given. My report will essentially come from Tab C, so if you will follow along with me I will try to walk you thru. We have had some new changes in our reporting so I will try to highlight those as I go along to give you an idea of some of the changes that are now in effect as we go thru this fiscal year. This financial summary report will cover all data for the 1st Quarter FY 2012 ending November 30, 2011. This report is found in your packet at Tab C. **Population Indicators** As represented on (Table 2 and page 90), the average daily offender population has increased slightly to 153,350 for the First Quarter Fiscal Year 2012. Through this same quarter a year ago (FY 2011), the daily population was 152,386, an increase of 964 or (0.63%). 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 13,441 as of 1st Quarter FY 2012. This is an increase of 1,031 or about 8.3% from 12,410 as compared to this same first quarter a year ago. Hospital Inpatient Census is a new statistical indicator established to reflect the health care dollars spent in the		

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VI. Performance and Financial Status Report (Cont'd)	C.1.8 Strategy "Hospital and Clinic Costs". The hospital inpatient average daily census (ADC) served through the first quarter of FY 2012 was 202 for both the Texas Tech and UTMB Sectors. Outpatient Clinic and ER Visits is another new statistical indicator established to reflect the health care dollars spent in the C.1.8 Strategy "Hospital and Clinic Costs". The medical outpatient clinic and ER visits served through the first quarter of FY 2012 was 3,230 for both the Texas Tech and UTMB Sectors. The overall HIV+ population has remained relatively stable throughout the last few years at 2,331 through 1st Quarter FY 2012 (or about 1.52% 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 1,864 through the First Quarter of FY 2012. This inpatient caseload is limited by the number of available inpatient beds in the system. 2). Through the First Quarter of FY 2012, the average number of mental health outpatient visits was 18,204 representing 11.9% of the service population. **Health Care Costs** Overall health costs through the First Quarter of FY 2012 totaled $121.1M. On a combined basis, this expense amount is more than overall revenues earned by the university providers by approximately $2.5M. UTMB's total revenue through the first quarter was $94.3M; expenditures totaled $97.3M, resulting in a net shortfall of $3.0M. Texas Tech's total revenue through the first quarter was $24.3M; expenditures totaled $23.8M, resulting in a net gain of $513K.		

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VI. Performance and Financial Status Report (Cont'd)	Examining the healthcare costs in further detail on (Table 4 of page 95) indicates that of the $121.1M in expenses reported through the First Quarter of FY 2012: Onsite services comprised $55.7M, or about 46.0% of expenses: Pharmacy services totaled $13.7M, about 9.6% of total expenses: Offsite services accounted for $37.9M or 31.3% of total expenses: Mental health services totaled $10.4M or 8.6% of the total costs: and Indirect support expenses accounted for $3.4M, about 2.8% of the total costs. Table 5 and page 97 shows that the total cost per offender per day for all health care services statewide through the First Quarter FY 2012, was $8.68, compared to $9.60 through the First Quarter of the FY 2011. This is a reduction of 9.6% in costs year over year from the previous fiscal year. The average cost per offender per day for the last four fiscal years was $9.44. As a point of reference healthcare costs was $7.64 per day in FY03. This would equate to a 13.6% increase since FY03 or approximately 1.6% 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 98 shows that encounter data through the 1st Quarter indicates that older offenders had a documented encounter with medical staff 2.8 times as often as younger offenders. Table 7 and page 99 indicates that hospital and		

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VI. Performance and Financial Status Report (Cont'd)	outpatient clinic costs received to date this Fiscal Year for older offenders averaged approximately $899 per offender vs. $120 for younger offenders. Regarding hospitalization and specialty clinic costs shown in Chart 12, the older offenders were utilizing health care resources at a rate of 7.5 times higher than the younger offenders. While comprising only about 8.7% of the overall service population, older offenders account for 41.8% of the hospitalization and outpatient clinic costs received to date. Also, per Table 8 and page 100, older offenders are represented 4.6 times more often in the dialysis population than younger offenders. Dialysis costs continue to be significant, averaging about $20.1K per patient per year. Providing dialysis treatment for an average of 219 patients through the First Quarter of FY 2012 cost $1,103,024. **Drug Costs** Please note that Table 9 and page 101 shows that total drug costs through the 1st Quarter FY 2012 totaled $10.8M. Of this, $4.9M (or under $1.6M per month) was for HIV medication costs, which was about 44.9% of the total drug cost. Psychiatric drugs costs were approximately $638K, or about 5.9% of overall drug costs. Hepatitis C drug costs were $872K and represented about 8.1% 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 6.2 Million Dollars such		

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VI. Performance and Financial Status Report (Cont'd)	reserves which is left over from FY 2011 SAR and report a total operating loss of $2,996,409 through the end of the 1st Quarter of Fiscal Year 2012. Texas Tech reports that they hold no such reserves and report a total operating gain of $512,579 through the 1st Quarter FY 2012. A summary analysis of the ending balances of revenue and payments through November 30th FY 2012, on (Table 10 and page 102) for all CMHCC accounts are included in this report. The summary indicates that the net unencumbered balance on all CMHCC accounts on November 30, 2011 is $36,855.75. In accordance with Rider 61, TDCJ Appropriations, Senate Bill 1, 81st Legislature, the CMHCC end of year balance from FY 2011 of $34,536.01 has been returned to TDCJ for return to the Sate 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 and procedures. The testing of detail transactions performed on TTUHSC's financial information for September 2011 through November 2011 found all tested transactions to be verified with appropriate backup documentation. The testing of detail transactions performed on UTMB's financial information for September 2011 through November 2011 found all tested transactions to be verified with appropriate back-up documentation except for one in September 2011. Dr. de la Garza-Grahm asked if there were any questions.	Dr. Raimer asked you always mention here the different grades for cost per day varies between the two universities. The sentence we always see is based on mission population and acuity level. Do we actually breakdown the acuity level?	

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VI. Performance and Financial Status Report (cont'd)		Mr. Webb responded that we don't and I think that's probably something as we have expanded now into breaking out of the three strategies. Primarily you see acuity levels in inpatient health care reporting, so I think now we actually pioneering new ground in reporting on a monthly and quarterly basis. Inpatient average daily census in both the UTMB and Texas Tech sector I think that that would be appropriate that we could reference this acuity level because I think those are some indicators that would give us an idea of the intensity of our inmate population or exposed to it as they go thru the inpatient . Dr. Raimer added that he would be curious about that because we have a lot of utilization contribute to the population over 55. You might ask Dr. Jumper or Dr. DeShields if they are also seeing that. It is our impression that the acuity level compared to five years ago just overall the population is much greater. I mean the kinds of illnesses we are seeing now I, Denise I went thru an oncology clinic with a tour group and there were forty patients waiting in oncology and five years ago there would have been four or five. So there are really in a hospital ICU beds that are really packed with people who are ALS they are on respirators and stuff and we used to not see this much. I just wonder are we capturing the severity of those illnesses and considering that. Just a thought, regardless of who provides the care, that's expensive care, and we need to be sure the state has that kind of data as to what the average population is having now that contributes to the cost. Mr. Webb responded that he didn't see a problem with recording that Dr. de la Garza-Grahm if you want to go forward in capturing the inpatient average daily census and the inpatient setting from both sectors that would	

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VI. Performance and Financial Status Report (Cont'd)		probably is an easy indicator that we could measure and try to report and have that available. Dr. de la Garza-Grahm added that I think that would make a significant difference in the cost because ICU care is so much more expensive than regular hospital care or outpatient. Additional discussion was had in reference to critical care patients between Dr. de la Garza-Grahm, Dr Raimer. Dr. Murray added that when you really look at our population it's compounding of the chronic disease patients that we got and the overlap of a lot of that, some of those patients certainly end up in critical care beds but I think we used to use that card system to kind of rate our population, but with the EMR now we can go in and really kind of pull out how many patients have a single chronic disease and how many really have two, three, four chronic diseases and begin to kind of report some those metrics. Maybe a suggestion might be is to kind of let the three parties get together and really kind of really try to come up with suggestions on how to understand our acuity. Not necessarily but certainly from a hospital prospective but I think we have a lot of outpatient the ones you are talking about that really drives a great deal of cost at the facility level and the employee level. And I think that goes un-reflected in some of these discussions and maybe it would be good to put together a group to kind of look at that and make recommendations to the committee. Dr. de la Garza-Grahm responded that would be a very good idea. I'm trying to think of the schematics of your suggestion and how to get three groups together and try and go thru how	

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VI. Performance and Financial Status Report (Cont'd)		to identify cohabitates and include them in your acuity setting. It's just a matter of a phone call. Mr. Hightower added that the three medical directors together and they can come up with a plan on what we are talking about together. Isn't that what you had in mind? Dr. Murray responded correct that the three medical directors would put together some suggestions and certainly bring some data to the next meeting and this is what we would suggest on an ongoing basis to kind of better state acuity from a committee prospective. Dr. de la Garza-Grahm agreed. Dr. Raimer stated the reason I was bringing this up Dr. de la Garza-Grahm, was the focus in health and human services right now which if Mr. Millwee was with us has really been on attacking three chronic diseases. In particularly there are three emphases one to do with improving health for all kinds of pregnant women, and one for infants in ICU, and the third one is this whole emphasis on chronic disease management and improving their performance. I certainly see that it's something that we in the corrections setting are really focused on too is the more that we can improve the health status in a chronically ill it would seem the less acuity down the line that we're going to experience that's going to require urgent or emergent hospitalization. Dr. de la Garza-Grahm as for Dr. Raimer to repeat the last sentence. Dr. Raimer responded that he wasn't sure what all was said. The more we can improve the health status of people with chronic disease, like manage their hypertension, we can prevent a stroke, manage their cardiovascular disease, and we may be able to decrease some of the	

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VI. Performance and Financial Status Report (Cont'd)		utilization that could be associated with this acute disease. Mr. Hightower added that they would not only get together but they will call our various subcommittees groups together to bring forth the information and the medical directors will make sometime of decision and bring back to the full committee and make recommendations.	
	Dr. de la Garza-Grahm thanked Mr. Webb		
VII. Medical Director's Updates - Critical Vacancies	Dr. de la Garza-Grahm now called on Dr. Williams who is to provide the Critical Vacancies for Dr. Linthicum for TDCJ. Dr. de la Garza-Grahm also mentioned that Dr. Griffin was going to be at the meeting but his father passed away and for everyone to keep him in their thoughts.		
- **Lannette Linthicum, M.D. (TDCJ)**	Dr. Williams proceeded with the Chief Public Health Officer which changed from full time to part time and posting is on hold. The Manager III a new position for Office of Professional Standards was posted and boarded. The Nurse IV & II have been filled. The Investigator III has been filled, waiting on clearance and the Associate Psychologist III is on hold while we are organizing some staff issues. Dr. de la Garza-Grahm thanked Dr. Williams and called on Dr. Murray for UTMB.		
- **Owen Murray, D.O. (UTMB)**	Dr. Murray stated that they were running at a 12% vacancy rate in our physician group. Our key vacancy right now is Dr. Phar who is been our virologist and overseeing our HIV care. Back in the fall he went to Syracuse University and we have had three candidates and the last one had accepted the job. We were ready to start actually at the end of this month and unfortunately she found that to continue her research that she was not going to be able to be part-time, she was going to do about 75% time for us which are what we needed. We are back at square one, we have people covering that		

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VII. Medical Director's Updates **- Critical Vacancies** - **Denise DeShields, M.D. (TTUHSC)**	position right now but obviously that is going to be a key hire for us for the next three months. We have the job posted and we've had good luck and good success in getting applicants in and getting people interested in the job, it's just actually getting someone to take and fill that job. Dr. DeShields stated with Texas Tech their primary vacancy is the PAMIO Medical Director at the Clements Unit. That vacancy has been there for over three years I'm sure. We have been covering it with locum and telemedicine. Again it's been included in a number of advertisements and again as I have always mentioned just trying to make sure that we have had a couple of applicants but getting people interested enough to actually take the job is where we have met our greatest challenge Dr. de la Garza-Grahm thanked Dr. DeShields and took the privilege of calling a 5 minute break. Dr. de la Garza-Grahm called the meeting back to order at 9:44a.m. Asked Bryan Collier, to give an update of the transition of TDCJ to CMHCC and the University Providers. Mr. Collier noted that he was going to give a brief update and welcome anyone that wants to jump in. We have a	Dr. de la Garza-Grahm asked if she thought that it's the financial incentive that is not there. Dr. DeShields answered that they have increased the salary of that position by nearly fifty thousand dollars from last year to this year. Again, I think its location, dealing with aggressively mentally ill population and it's just not a very desirable job. And as far as psychiatrists go we've had a real struggle trying to fill that position. We're also having difficulty filling just ordinary staff psychiatrist physicians as well. And again, we have taken the approach of increasing the salary to make it more marketable and again it's just a very difficult sell.	

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	FY12-13 in place with Texas Tech that has been negotiated. We have been negotiating and have a 2012 agreement with UTMB for unit health care and hospital health care and have been negotiating a 2013 agreement since November. We stopped, we'll didn't stop but we essentially got to a point when we could not reach a resolution by the end of January and at that point we had an outside offices that began to look at this as well. Governor's Office, Lt. Governor's Office, Speaker's Office, others that began to look at contract negotiation and that's essentially where it is now. We still do not have a 2013 contract in place but we feel confident that we will have a 2013 contract in place with UTMB. We don't know how the provisions of that will look like and we don't know when potentially the ending date of that contract could be because it could be that the contract ends earlier than the August 2013 time schedule, it could be potentially May of 2013 which is one of the provisions. Things as we look forward I guess things that are issued potentially when the contract on unit care who's going to administer the unit care, would that be continued to be done by UTMB or would there be another party or TDCJ involved in that piece. UTMB would continue to be the primary hospital for us although we do have a new partner that we have contracted with in Huntsville for nine beds at the Huntsville Memorial Hospital. Some of the offsite could be done at the Huntsville location. At one time we were proceeding to look at other areas including UT Tyler, Palestine as well but looking at other sites where we could do some more off site at this point we have just completed the Huntsville contract with nine beds and at this point we are waiting to see what the 2013 contract language will look like before we proceed any further. Dr. de la Garza thanked Mr. Collier and asked if there were any questions.	Dr. Raimer responded that the contract negotiations are for us at least waiting on the Board of Reagents that are being involved in that.	

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VIII. Medical Director's Updates (Cont'd.) - **Lannette Linthicum, M.D. (TDCJ)**	Dr. Williams sitting for Dr. Linthicum began with report on page 106 of the agenda packet. During the 2nd quarter of FY 2012, Dr. Williams reported that ten operational review audits were conducted. The summary of the 10 items found below 80 percent compliance during those ten operational review audits and the corrective action to ensure future compliance are found on pages 106 & 107.		
- **Operational Review Audit**	Dr. Williams further reported the following: **Item 6.360** requires the provider to document the reason if treatment for Hepatitis C Virus is determined to not be indicated for offenders with chronic Hepatitis C Virus infection. All 10 facilities were not in compliance. **Item 5.250** requires documentation that three Hemoccult cards were collected from offenders 40 years or age or greater, or that they refused the screening test, within 60 days of their annual date of incarceration. Nine of the 10 facilities were not in compliance. **Item 5.210** requires an annual physical exam for offenders 50 years of age or greater to be documented in the medical record within 30 days of their annual date of incarceration. Nine of the 10 facilities were not in compliance. **Item 6.030** requires offenders receiving anti-tuberculosis medication at the facility be assessed monthly by a provider or nurse. Eight of the 10 facilities were not in compliance. **Item 6.010** requires screening for tuberculosis to be performed on offenders annually at the facility. Eight of the 10 facilities were not in compliance. **Item 6.080** requires Texas Department of State Health Services Tuberculosis Elimination Division (TB-400) form to be completed for the following offenders receiving Tuberculosis (TB) chemoprophylaxis, all TB suspect cases, active cases, and upon termination or completion of TB therapy. Seven of the 10 facilities were not in compliance. **Item 6.380** requires the pneumococcal vaccine be offered to offenders with certain chronic diseases and conditions, and offenders 65 years of age or older. Seven of 10 facilities were not in compliance.		

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VIII. Medical Director's Updates (Cont'd.)	**Item 6.020** requires offenders with a positive tuberculin skin test be evaluated for active disease or the need for chemoprophylaxis by a physician or mid-level practitioner before initiation of medication. Seven of the 10 facilities were not in compliance. **Item 6.330** requires the initial evaluations of offenders diagnosed with Hepatitis C be completed by a physician or mid-level provider. Seven of the 10 facilities were not in compliance. **Item 5.140** requires newly assigned intra-system transfers arriving at the facility by a physician or mid-level provider, have their medical records reviewed and signed (HSN-1) within 48 hours. Seven of the ten facilities were not in compliance. Dr. Williams added that the one thing that is most alarming is that the trend that we have recently been noticing and not brought it to the universities attention. We've noticed that a majority of these items has to do with infectious disease. This is a serious issue that needs close management in an institutionalized setting.	Dr. de la Garza-Grahm responded she's not sure how to say or ask, but for someone that would be listening for the first time hearing you say "so many were out of compliance, so many were out of compliance. It makes it sound that we are not doing our job but many times Dr. Linthicum does give us a little more details of why as an M.D. she can do that in her other presentations. I know that you are not able to give us details as of why some of these are out of compliance. Dr. Williams responded as Dr. Linthicum's deputy I'm a physician also. Dr. de la Garza-Grahm responded with I did introduce you as doctor, my apologies. Dr. Williams continued in saying that as far as infectious diseases the university medical directors may want to comment as well but we think the biggest factor in this performance is the reduction in force and increased workload	

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VIII. Medical Director's Updates (Cont'd.)		on the unit nurses who are responsible for management of infectious disease on each unit. Dr. Murray added that sixteen years ago we had 4,500 positions that were out and spread across the facilities. Right now on the UTMB side we have less than 3,000. So, we have taken cuts across the board, we have cut hours of operation, we have cut everywhere we can possibly can cut. Unfortunately what happens is that you focus on the main issue at hand. People presenting the sick call, emergencies, chronic care, and unfortunately a lot of this other detail work does not get addressed or does not get documented the way that it would support audit findings that would be a bit different than is. Dr. de la Garza-Grahm added that she didn't think that is going to change. The problem is not going to get any better in fact it may get worse before it gets better. Simply because we don't have the numbers. Nurses and doctors, personnel. Dr. Murray stated that Dr. Williams and Dr. Linthicum, we talked about this and what we ended up doing is the CID position which is the Coordinator Infectious Disease that is a position that does not provide direct patient care in terms of emergent care, etc. so, when you start making concessions what do you do, you start looking at that. Historically we have taken those positions out in the beginning on reduction in force and people ask how do you remain AC accredited. We're still ACA accredited in all facilities. It's the detail work and our own audits that support that we really have seen the significant reduction in the level of quality and the level of consistency of care that we used to have a decade ago and that is without a doubt directly attributable to the reduction of employees that we have had in the	

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VIII. Medical Director's Updates (Cont'd.)		last fifteen years. Dr. De Shields added that 90 % of those perimeters that you just discussed are CID driven. And often times with the rif that has occurred these positions may not have necessarily been eliminated. But those people are pulling the floor to take care of acute issues. Dr. de la Garza-Grahm said you are preaching to the choir, and I just don't see any change in this anytime in the near future.	
- Capital Assets Monitoring	Dr. Williams continued that the Fixed Assets Contract Monitoring officer audited the same ten units and that these audits are conducted to monitor compliance with the Health Services Policy and State Property Accounting Policy regarding inventory procedures. All 10 units were within the required compliance range.		
- Grievances and Patient Liaison	He then reported that the Patient Liaison Program and the Step II Grievance Program received a total of 4,156 correspondences. Of the total number of correspondences received, 402 requests were generated. The UTMB & TTUHSC combined percentage of sustained offender grievances closed in the First Quarter of FY2012, for the Step II medical grievances was 10 percent. Performance measure expectation is six percent or less. UTMB had eight percent and TTUHSC had two percent.		
- Quality Improvement (QI) Access to Care Audits	Dr. Williams next reported that the frequency of the Sick Call Request Verification Audits was changed, in the Fourth Quarter of FY2011. Units with an average composite score of 80 percent or above in each discipline will be audited one time per fiscal year. Those with average composite scores less than 80 percent in a discipline(s) or less than a two year history of scores will have that discipline(s) audited quarterly. He added during the 1st Qtr of FY2012 the Patient		

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VIII. Medical Director's Updates (Cont'd.)	Liaison Program nurses and investigators performed 40 SCRVAs at 38 facilities. A random sample of Sick Call Requests was also audited by the Office of Professional		
- Office of Public Health	Standards staff. A total of 315 indicators were reviewed at 38 facilities and 28 of the indicators fell below the 80 percent compliance threshold representing nine percent. The Public Health Program monitors cases of communicable diseases in newly incarcerated offenders as well as new cases that occur in offenders within TDCJ. The data is reported by the facilities for 11 infectious conditions. There were 194 cases of suspected Syphilis were reported in the first quarter FY2012 compared to 224 in the same quarter of 2011. 142 offenders required treatment or retreatment; 206 Methicillin-Resistant Staphylococcus Aureus were reported in this quarter, compared to 409 during the same quarter FY2011. 124 Methicillin-Sensitive Staphylococcus Aureus were reported in the 1st Qtr FY2012 compared to 195 reported for FY2011. With regard to skin infections, our methodologies has changed we don't require cultures on all obvious infections. There was an average of 58 Tuberculosis (TB) cases under management for the first quarter FY2012, compared to an average of 42 per month during the same quarter in FY2011. This is part of our concern the ability to manage infectious diseases. Tuberculosis is a big concern in the institutionalized setting.	Dr. de la Garza-Grahm stated that you're probably not treating for six to eight weeks as some infectious diseases. Once the skin is closed you don't have to keep treating. Dr. Williams agreed. Dr. de la Garza-Grahm responded what did you say TB. That is why item #8 bothered me a little bit. Because it requires a positive skin test to identify an infectious disease. That seems to be one of the big items that are troubling us; we might need to pay a little more attention to that particularly. Dr. Williams added that some of the units that filled out in their annual monitoring did so not just barely. If their not even doing the screening, then you are not going to know if you are missing them.	

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VIII. Medical Director's Updates (Cont'd.)	In FY2006, Office of Public Health began reporting the activities of the Sexual Assault Nurse Examiner (SANE) Coordinator. During the 1st Qtr FY2012, three educational in-service program sessions were held and 24 medical staff received training. There have been 143 chart reviews of alleged sexual assaults performed for the 1st Qtr FY2012. No deficiencies found during this quarter. 21 blood borne exposure baseline labs were drawn on exposed victims and there were no seroconversions as a result of sexual assault. During the first quarter FY 2012, 98 of the 111 facilities of the peer education programs were audited. There were 103 offenders trained to become peer educators and during the same quarter of FY 2011 there were 154 trained. 20,050 offenders attended classes presented by peer educators; this is a slight decrease from the same quarter in FY2011 of 20,119 participants.		
- **Mortality and Morbidity**	The Mortality and Morbidity Committee reviewed 107 deaths. Of those 107, 13 were referred to peer review committees. You can see the chart on page 110.		
- **Mental Health Services Monitoring and Liaison**	The Mental Health Services Monitoring and Liaison during the 1st Quarter of FY2012; database was reviewed for 2,676 offenders, who were received into Intermediate Sanction Facilities. 574 offenders were identified as having a documented history of mental illness. Further offenders monitored in Administrative Segregation within TDCJ-ID/State Jails every six months: 1st qtr FY2012, 20 Ad Seg facilities were audited; 3,671 offenders were observed, 2100 of them were interviewed and seven offenders were referred to the university providers for further evaluation. Access to Care met or exceeded 90 percent compliance for the 20 facilities that received SCR from offenders in Ad Seg; four SAFPF were audited for continuity of mental health care and four were appropriate; four inpatient mental health facilities were audited to ensure that all incidents of compelled psychoactive medication documented on		

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VIII. Medical Director's Updates (Cont'd.)	the security Use of Force Log were also documented; All 24 intake facilities were audited to ensure offenders entering TDCJ with potential mental health needs received an evaluation within 14 days of identification. In the first quarter of FY2012, 24 offenders were reviewed and 17 of them were allowed to participate in BAMBI.		
- **Clinical Administration**	Dr. Williams next reported that during the first quarter of FY 2012, 10 percent of the combined UTMB and TTUHSC hospital and infirmary discharges were audited. A total of 132 hospital discharges and 42 infirmary discharge audits were conducted. The significant findings here is the grand total 53% were discharged without documentation of vital signs. Looks like all were appropriate to the facility that was received only 7% did not have chain in, 3% required unscheduled care within 7 days upon discharge and 45% were lacking some documentation in one form or another. With regard to infirmary discharges only 7% were discharged without vital signs. All but 2% were received at the appropriate facility. 17% did not have chain in done, 2% had unscheduled care within 7 days of discharge and only 4% lacked documentation.		
- **Accreditation**	The American Correctional Association Correctional Accreditation Manager's Association Conference was held in Phoenix, Arizona January 20th through the 25th of 2012.		
- **Biomedical Research Projects**	Dr. Williams concluded by stating that the summary and pending research projects as provided by the TDCJ Executive Services are included in the consent items of the agenda packet.		
		Dr. Raimer directed this to Dr. Murray that he still didn't understand why these individuals are coming out of the UTMB are not having	

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VIII. Medical Director's Updates (Cont'd.)		their vitals taken. Dr. Murray responded with he was just making himself a note that they have discussed and He needs to get with Hospital Galveston team and look at how the audit can get conducted to ensure that again all of the relevant data is being reviewed. Dr. Raimer responded with its electronic medical records and the nurses are doing routine vital signs and I don't understand our own system but this looks bad and if their getting their vital signs why doesn't show up? Dr. de la Garza-Grahm added because they don't go to the computer and insert them possibly. It's not they don't get done; they do get done just not documented. Dr. Raimer also noted that this looks like real shotty record keeping and I hope it's not shotty clinical care. I would like for Dr. de la Garza-Grahm put this on the agenda to explain why this keeps occurring, it's been occurring for a year and it needs to stop. Dr. de la Garza-Grahm added that it was her guess they are taking the vital signs and they were not inputting the information in a timely fashion. That would be my guess, because that happens in big hospitals also. Mrs. Lord directed to Dr. Williams that she has been following these reports for a number of years now and the numbers on the monitoring just about always looks bad. I think I'm seeing a change from maybe problem being documentation to more problems being serious quality of care. Dr. Williams responded we have some real concerns especially with the infectious disease. The infectious disease management, when I	

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VIII. Medical Director's Updates (Cont'd.)		first came on board 4 years ago there was dedicated nurses on each facility that was all they did. The performance has drastically changed. Dr. de la Garza-Grahm added that they had just discussed that and it's not going to change. You don't have the personnel. Mrs. Lord added you are right! Yes we have discussed that problem at in denial. Now my other question is the corrective action plans and I assume the units give them to you, what happens to then, is there monitoring to see if the corrective plan is actually carried out and how does that work? Dr. Williams responded with based on the performance level the units will be required to perform their own self monitoring and not just at the unit but the person who is responsible for it but someone above them comes back to monitor and to verify the compliance continues. Mr. Hightower added that to get ready for the next board meeting for the agenda to say, Dr. Murray did you make a recommendation to place that and who to report? Dr. Raimer also added that your point is well taken. I would like to see some delineation the amount of corrective action plans was addressed and what happen to them. If I was just monitoring this I would be very alarmed that there was a lot of problems and we would never see that they were solved. You know what I'm saying. Mrs. Lord added that is what she wants to see. Dr. Raimer agreed with Mrs. Lord and I think it is important that we have a report that we found out of 40 there were 20 deficiencies. We	

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VIII. Medical Director's Updates (Cont'd.)		asked them to do corrective action plans. And then of round one of those 20 how many of the got fixed. Or else the general public keeps reading this assumes we keep getting bad reports and nothing happens. So I would like to see what is happening. Dr. Williams added that in the report it's written on each item that corrective actions were requested, the time frame is just that we are conducting these operational review audits in a three month time period that's being reported here. Over the next three to six months the units are working on making those corrections. That time lag makes the reporting it doesn't all go good together. But what we had done in the past, before you were on the committee, Dr. Linthicum had brought some samples of deficiencies that were found, the corrective actions that were required and example of corrective action report that was presented. We could do that again. Dr. de la Garza-Grahm added that her opinion that is something that needs to be ongoing. So that there is not any question that we are not attempting at least, we cannot correct everything but we can at least attempt to correct everything and have some sort of response from you guys to let us know that we really doing this. Perhaps those units that are not in compliance maybe have two or three reports from different facilities at every meeting, ok these are items we asked for and this is the response we got and this is how we're are compiling. If we had that at every meeting two or three examples that we know that we are trying to stay on top of this rather than retroactively fix it. I understand what you are saying that the report it looks bad because we're lagging behind. If we did all the time quarterly rather than once a year perhaps that reflection would not look so bad. Does that make sense?	

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VIII. Medical Director's Updates (Cont'd.)		More discussion was had between Mrs. Lord, Dr. de la Garza-Grahm, Dr. Williams, Mr. Hightower and Dr. Murray. Mr. Hightower asked Dr. Murray is there any, because I look at the number of patients and percentage of the budget that they spend. Are there any other diseases we feel like that is going to fall into this same situation of federal prisons? And HIV especially. Dr. Murray responded well again from a HIV perspective we have not really changed substantially are numbers either being positive or being treated. Certainly new therapies are coming out and I think our issue with HIV care is we always get excellent outcome while our patients are in prison. Unfortunately they leave prison they get off their medication and then they come back to us in a certainly in a more developtated state than when they left which ends up putting us in a position to treat that disease your now moving into a more complicated regiment. So I think it's more as newer therapies coming out salvage therapies we will have to be I think amendable to looking at some of those. Certainly Dr. Powell was a great asset to the system I think he was very judicious about how he looked at those, how we added those treatments and how we provided those treatments to the patients. So, I think certainly in our discussions whoever will fill that position you know that's one of those things trying to take a more conservative route. I think that on the horizon there's nothing other than really Hep C that is going to create any kind of financial disability or clinical disability that will be of any substance other than this. Mr. Hightower added but if admissions grow and Bryan you can slow me down. If admissions grow, obviously since the counties	

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VIII. Medical Director's Updates (Cont'd.)	Dr. Murray continued with again moving into the new legislative session that is on top of salary adjustments among other things that are going to have to be a priority issue of discussion, certainly education as to what is a standard of care is.	have the legal authority to fast forward the inmates so that you would accept. They would normally fast forward the unhealthiest of their patients to deflect the cost on the counties. What I'm saying as the population grows your medical system will grow at a faster rate than they normally have with these types of diseases. Because of the expense that goes with it. Dr. Murray noted we have seen a lot of dialysis that is the number one patient certainly patients who are in mid state chemotherapy that are rolling out from some of these state jails. Literally they just got their last treatment and their rolling out to get admitted, so I think the jails do preferentially send us those patients. The big thing we all have to tackle is to we don't have sound admissions, because they are already HIV. We have a speculative kind of serial prevalence rate that we throw out there. But if you look at the total number of identified patients, its marketable smaller than what we would project. And I think that's along with therapy is going to come that question do you want to begin to identify patients on their way in and potentially on their way out as we do with HIV. Again, another difficult clinical question that the state and potentially the committee is going to have to answer is that what do we do regarding testing? Dr. de la Garza-Grahm added I guess we are going to have to make that recommendation sooner or later.	

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VIII. Medical Director's Updates (Cont'd.) - **Denise DeShields, M.D.** - **TTUHSC**	And also the pressure that we already face just in terms of litigation. One therapy becomes so prevalent and so obvious if we're too far behind the line your going to have offenders just giving our prevalence of Hep C, we're going to see more lawsuits, etc. And it's going to be a difficult place and you'd rather not have that be the catalyst for having to do therapy. Dr. de la Garza-Graham called on Dr. DeShields for her medical director's report. Dr. DeShields responded that she didn't have much to add to what Owen has already said. Much of what he is experiencing in East Texas, we are experiencing in West Texas. In the first quarter of course it's been very difficult to try and get the dust settled with regard to our contract negotiations and so forth. And getting thru issues with regard to the RIF, we have established and revised health care plan and making adjustments to that before we take control there. Meeting the criteria from medical necessary in the mandatory care. We have also seen this globally I'm sure that you get public as well. A significant reduction in volume of patients that are coming thru I think that is as a result of Health Services fee. I not quite sure how much of a reduction is seen. You have probably seen about a 50% reduction. We're keeping our finger on this in regard to that since the $3.00 co-pay fee came about a similar reduction. I think a markedly increase reduction with $100.00 co-pay fee. We are starting to see that our researchers continue to match the volume in time. One of the things of course we have been working with our providers as well as just reducing our pharmacy indicated judicious prescribing habits I think some of those things have actually lead to much of what Mr. Webb was reporting except for maybe $1,000 in the black in Texas Tech First Quarter. We do however have quite a number of high dollar cancer patients, cardio	Additional discussions were had between Dr. DeShields, Dr. Raimer, Dr. de la Garza-Grahm.	

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VIII. Medical Director's Updates (Cont'd.)	vascular patients which may offset that for the Second Quarter as well. Those are biggest up to date. Dr. de la Garza-Grahm thanked Dr. DeShields for her report.		
IX. - CMHCC FY2012 First Quarter Performance Status Report (pgs 115-126)			
X. - Appointment of System Leadership Council Joint Work Group Committee	Dr. de la Garza-Grahm is making an appointment to change the Leadership Council Joint Work Group Committee from Dr. Own Murray to Dr. DeShields.		
IX. Public Comments	Dr. de la Garza-Grahm then stated that the next agenda item is where the Committee at each regular meeting provides an opportunity to receive public comments. Dr. de la Garza-Grahm noted that there was no such request at this time.		
X. Date / Location of Next Meeting **- Margarita de la Garza-Grahm, M.D.**	Dr. de la Garza-Grahm next noted that the next CMHC meeting will announced at a later date.		
XI. Adjourn	Dr. de la Garza-Grahm asked if there were any other questions. Hearing none adjourned the meeting.		

6/7/12

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

Date: