

Agenda Topic / Presenter	Presentation	Discussion	Action
<p>III. Approval of Consent Items - Dr. Burrow</p> <ul style="list-style-type: none"> - Approval of Excused Absences - Approval of CMHCC Meeting Minutes – December 5, 2018 - Approval of TDCJ Health Services Monitoring Report - University Medical Directors Reports <ul style="list-style-type: none"> - TTUHSC - UTMB - Summaries of CMHC Joint Committee / Work Group Activities <p>IV. Update on Financial Reports - Ron Steffa</p>	<p>Dr. Burrow then moved on to agenda item III approval of consent items.</p> <p>Dr. Burrow stated that the following five consent items would be voted on as a single action:</p> <p>The first consent item was the approval of excused absences from the December 5, 2018 meeting –There were no absences.</p> <p>The second consent item was the approval of the CMHCC meeting minutes from the December 5, 2018 meeting. Dr. Burrow asked if there were any corrections, deletions or comments. Hearing none, Dr. Burrow moved on to the third consent item.</p> <p>The third consent item was the approval of TDCJ Health Services Monitoring Report and there were no comments or discussion of these reports.</p> <p>The fourth consent item was the approval of the University Medical Directors Report. There were no comments or discussion of these reports.</p> <p>The fifth consent item was the approval of the summaries of CMHC Joint Committee/Work Group Activities. There were no comments or discussion of these reports.</p> <p>Dr. Burrow then called for a motion to approve the consent items.</p> <p>Dr. Burrow next called on Mr. Ron Steffa to present the financial report.</p>		<p>Dr. Raimer made a motion to approve all consent items and Dr. Jumper seconded the motion which prevailed by unanimous vote.</p>

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<p>IV. Update on Financial Reports (Cont.) - Mr. Steffa</p>	<p>Mr. Steffa reported on statistics for the First Quarter of Fiscal Year (FY) 2019, as submitted to the Legislative Budget Board (LBB). The report was submitted in accordance with the General Appropriations Act, Article V, Rider 46.</p> <p>Mr. Steffa reported that the overall offender service population has decreased 0.6% from FY 2018. The offender population age 55 and over had a 4.2% increase with an average daily census of 19,294 through the First Quarter of FY 2019 compared to 18,512 through the First Quarter of FY 2018. This population represents about 13% of the total population, but accounts for 50.5% of the hospitalization costs.</p> <p>Mr. Steffa reported that unit and psychiatric care expenses represent the majority of health care cost at \$98.3 million or 52.8 percent of total expenses. Hospital and clinical care accounted for \$70.8 million or 38 percent. Pharmacy services were at \$17.3 million or 9.3 percent of the total expenses. The cost per day per offender had a 5.8 percent increase from FY 2018 to FY 2019. The cost per offender per day through the First Quarter FY 2019 was \$13.83 compared to \$13.08 through the First Quarter FY 2018.</p> <p>Mr. Steffa reported on unit and psychiatric care revenues of \$93.3 million and expenditures of \$98.3 million, which for the First Quarter of FY 2019 resulted in a \$5 million shortfall in this strategy. Mr. Steffa reported on hospital and clinical care revenues of \$48 million and expenditures of \$70.7 million leaving a shortfall of \$22.8 million in this strategy. Mr. Steffa reported on managed health care pharmacy revenues of \$15.8 million and expenditures of \$17.3 million leaving a shortfall of \$1.5 million in this strategy.</p> <p>Mr. Steffa reported that the combined total for FY 2019 with projections leaves a total shortfall of \$198.6 million. This total reflects the spend forward of funds from FY 2019 to FY 2018 of \$79.5 million that was requested to cover the FY 2018 shortfall, revenues of \$632.2 million and expenditures of \$751.3 million.</p>		

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<p>V. Summaries of Critical Correctional Health Care Personnel Vacancies (Cont.)</p> <ul style="list-style-type: none"> - Dr. Owen Murray 	<p>Dr. Murray reported that UTMB has 8 Physician I-II, 11 Mid-Level Practitioners (PA and FNP), 7 Psychiatrist positions and a Regional Medical Director position vacancy. Dr. Murray shared that there has been an additional vacancy which is a key position. The vacancy is at the Jester IV Unit, the Clinical Director position, which was formerly held by Dr. Phillip Farley who left in January.</p>		
<p>VI. Medical Director's Updates</p> <ul style="list-style-type: none"> - TDCJ – Health Services Division FY 2019 First Quarter Report -Dr. Linthicum 	<p>Dr. Burrow thanked Dr. Murray and then called on Dr. Linthicum to present the TDCJ Medical Director's Report for the First Quarter FY 2019.</p>		
	<p>Dr. Linthicum began by explaining that the Managed Health Care statute 501.150 requires TDCJ to do four things statutorily; ensure access to care, conduct periodic operational reviews or compliance audits, monitor the quality of care and investigate health care complaints. The Medical Director's Report is a summary of those activities.</p>		
<ul style="list-style-type: none"> - Capital Assets Monitoring 	<p>Dr. Linthicum stated that the TDCJ Medical Director's Report focuses on the First Quarter of FY 2019 (September, October and November 2018). During this quarter, Operational Review Audits (ORAs) were conducted at the following 9 facilities: Baten Intermediate Sanction Facility (ISF), Briscoe, Cotulla, Dalhart, East Texas Treatment Facility, Halbert, Middleton, Robertson and Rudd ISF. ORAs look at compliance with policies and procedures promulgated by this committee, compliance with contractual terms, compliance with accreditation expected practices and performance based standards as they relate to healthcare and any local, state or federal laws that are applicable. The compliance threshold is 80%. Dr. Linthicum referenced the 12 items found to be most frequently below the 80 percent compliance, and noted that corrective actions have been requested on all of these items.</p> <p>Dr. Linthicum reported that the Fixed Assets Contract Monitoring Officer audited the same 9 facilities listed above for ORAs during the First Quarter of FY 2019 and all 9 facilities were within the required compliance range.</p>		

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<p>VI. Medical Director's Updates (Cont.)</p> <ul style="list-style-type: none"> - Dr. Linthicum - Office of Public Health 	<p>Dr. Linthicum reported that during the same time period, there were 9,516 pre-release tests performed with 1 found to be HIV positive. For this quarter, 19 new AIDS cases were identified.</p> <p>Dr. Linthicum stated that there were 827 cases of Hepatitis C identified for the First Quarter FY 2019. This number may not represent an actual new diagnosis, but rather the first time it was identified in TDCJ.</p> <p>Dr. Linthicum reported that 172 cases of suspected Syphilis were reported. 120 cases required treatment or retreatment. Syphilis testing is done at intake. Syphilis can take months to identify. These figures represent an overestimation of actual number of cases. Some of the suspected cases will later be reclassified as resolved prior infections.</p> <p>Dr. Linthicum stated that 348 Methicillin-Resistant Staphylococcus Aureus (MRSA) cases were reported and 125 Methicillin-Sensitive Staphylococcus Aureus (MSSA) were reported for the First Quarter FY 2019.</p> <p>Dr. Linthicum reported that there was an average of 28 Tuberculosis (TB) cases (pulmonary and extra-pulmonary) under management for the First Quarter FY 2019.</p> <p>Dr. Linthicum next reported that the Office of Public Health employs a Sexual Assault Nurse Examiner (SANE) Coordinator who collaborates with the Safe Prisons Program and is trained and certified by the Texas Attorney General's Office. This person provides in-service training to facility staff in the performance of medical examinations, evidence collection, documentation and use of the sexual assault kits. This position also audits the documentation and services provided by medical unit personnel for each sexual assault reported. During the First Quarter FY 2019, there were 195 chart reviews of alleged sexual assaults. Dr. Linthicum reported that there were 43 deficiencies found this quarter and corrective actions have been requested. 49 blood-borne exposure baseline labs were drawn on exposed offenders. To date, no offenders have tested positive for HIV in baseline labs routinely obtained after the report of sexual assault.</p>		

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<p>VI. Medical Director's Updates (Cont.)</p> <ul style="list-style-type: none"> - Dr. Linthicum - Office of Public Health - Mortality and Morbidity - Office of Mental Health Monitoring & Liaison 	<p>Dr. Linthicum shared that all TDCJ facilities are Prison Rape Elimination Act (PREA) certified.</p> <p>Dr. Linthicum reported that during the First Quarter FY 2019, 8 units received a 3 day training which included the Wall Talk Training in the Peer Education Program.</p> <p>Dr. Linthicum shared that as of the close of the First Quarter of FY 2019, 100 of the 104 facilities housing Correctional Institutions Division (CID) offenders and 2 Intermediate Sanction Facilities had active peer education programs. During this quarter, 119 offenders were trained to become peer educators and 18,182 offenders attended the classes presented by peer educators.</p> <p>Dr. Linthicum reported that the Morbidity and Mortality committee is a joint committee consisting of the three partners: UTMB, Texas Tech and TDCJ. Dr. Ojo and Dr. Millington are the co-chairs. 150 deaths were reviewed during the months of September, October and November 2018. Of those 150 deaths, one was referred to a peer review committee.</p> <p>Dr. Linthicum shared that the Office of Mental Health Monitoring & Liaison (OMHM&L) is staffed by the director, Dr. Castleberry, Psy.D, four masters level psychologists and one licensed professional counselor. Dr. Linthicum next provided a summary of the activities performed by the OMHM&L during the First Quarter of FY 2019.</p> <p>Dr. Linthicum reported that Restrictive Housing (formerly Administrative Segregation) audits were conducted on 15 facilities. 2,381 offenders were observed, 2,085 were interviewed, and 5 offenders were referred to the university providers for further evaluation. Access to Care (ATC) for mental health indicators four, five and six were met at 100 percent at all 15 facilities.</p>		

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<p>VI. Medical Director's Updates (Cont.)</p> <ul style="list-style-type: none"> - Dr. Linthicum - Office of the Health Services Liaison - Accreditation - Biomedical Research Projects - Texas Tech University Health Sciences Center - Dr. DeShields - University of Texas Medical Branch - Dr. Murray 	<p>Dr. Linthicum reported that in the First Quarter of FY 2019, the Office of Health Services Liaison conducted 218 hospital and 34 infirmiry discharge audits. Of the 218 hospital discharge audits conducted, 198 were from the UTMB sector and 20 were from the TTHUSC sector. There were 128 deficiencies identified for UTMB and 12 identified for TTUHSC. Of the 34 infirmiry discharge audits conducted, 24 were from the UTMB sector and 10 were from the TTUHSC sector. There were 7 deficiencies identified from UTMB and 2 from TTUHSC. Corrective action has been requested to address deficiencies.</p> <p>Dr. Linthicum reported that the American Correctional Association (ACA) 2019 Winter Conference was held in New Orleans, Louisiana on January 11-15, 2019. During this conference, the following facilities were represented: Havins, Boyd, Hamilton, Pack, Powledge, Tulia, Neal, Montford, Murray, Hughes, Stringfellow and Middleton.</p> <p>Dr. Linthicum reported on the summary of active and pending biomedical research projects as reported by the TDCJ Executive Services. The CID has 28 active and 5 pending biomedical research projects. The Health Services Division has 9 active and 2 pending biomedical research projects. Dr. Linthicum explained that these numbers are a bit low due to the deputy director vacancy. When this position is filled the numbers will increase.</p> <p>Dr. Burrow thanked Dr. Linthicum and then called on Dr. DeShields to present the report for TTUHSC.</p> <p>Dr. DeShields stated that she had nothing further to report.</p> <p>Dr. Burrow thanked Dr. DeShields and then called on Dr. Murray to present the report for UTMB.</p> <p>Dr. Murray shared that hopefully by next month the UTMB sector will begin manufacturing dentures internally. In the past, an outside vendor was used and criteria for denture approval was based primarily on medical necessity. The new prosthodontic clinic will be housed at the Goree Unit.</p>		

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<p>VI. Medical Director's Updates (Cont.)</p> <ul style="list-style-type: none"> - Dr. Murray 	<p>Dr. Murray reported that the equipment cost is about \$65 thousand and a new prosthodontist and an additional dental assistant have been hired. This new clinic was the result of an unfunded mandate. Dr. Murray next explained the technology, which he stated is really interesting. A mold is made and then it is scanned into a 3-D imager and then from those images the dentures are printed out. The process used to take 90-120 days and will now be about 5 days. In addition to that, in the past, if an offender were to lose or break their denture we would have to go back through the process all over again. With this technology the image is stored and we can just reprint them a copy of their dentures.</p> <p>Dr. Murray reported that the initial goal is to print between 200-400 pairs of dentures annually. Dr. Murray shared that the FDA is looking to approve a step forward in the process. Currently we have to make a mold. Going forward, after approval, we will be able to take the wand that the mold is scanned in with and scan the jaw bone directly. From that we will be able to generate the dentures which would eliminate the need to make the mold.</p> <p>Dr. Murray answered that the criteria has been modified. To begin they will be looking at high risk clinical groups. Specifically, they will be looking at diabetic patients to track hemoglobin A1c and monitor to see if there is an improvement. It will give a legitimate clinical reason for making a change to the policy.</p>	<p>Dr. Burrow asked if the criteria for qualifying for dentures will change.</p> <p>Dr. Linthicum stated that this clinic is the result of a state policy maker decision. We have previously, successfully defended two lawsuits and have looked at the Medicaid program, which does not cover dentures.</p> <p>Dr. Burrow stated that this is not something that would be covered in the free world.</p>	

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<p>VI. Medical Director's Updates (Cont.) - Dr. Murray</p>	<p>Dr. Murray replied yes, 200-400.</p> <p>Dr. Murray stated that they have modified the EHR to collect that information. All three dentists were very clear that there is certainly an aesthetic value to having dentures and when migrating from the prison system to the free world dentures certainly would add something of value.</p> <p>Dr. Murray shared that in the history of our denture program there is a term called 'pocket dentures'. People get used to chewing without teeth and find it more efficient not to use the dentures, so they don't. From a mental health perspective there is also the aesthetics argument. Dentures may also assist with interviewing and being out in public.</p>	<p>Dr. Linthicum stated that the state policy makers would not accept that explanation and it was clear in which direction we needed to move.</p> <p>Dr. Burrow asked if they were anticipating 200-400 per year.</p> <p>Dr. Burrow stated that hopefully there will be some funding for this.</p> <p>Dr. Linthicum stated that what we will need to do is document at intake how many people come in to the system without dentures and how long they have been without dentures.</p> <p>Dr. Linthicum stated that was one of the arguments heard from state leaders. Dentures will help them vocationally and as it relates to reintegration in general.</p> <p>Dr. Burrow included that the person receiving the dentures has to be motivated to take care of them and willing to participate in follow up care.</p> <p>Dr. Hudson asked what the projected cost will be.</p>	

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<p>VI. Medical Director's Updates (Cont.) - Dr. Murray</p> <p>VII. Mental Health Program Updates - Dr. Joseph Penn</p>	<p>Dr. Murray shared that the equipment cost so far has been about \$65 thousand and they hired a part time prosthodontist. Probably on an ongoing basis we would be looking at approximately \$200-300 thousand. Material cost will vary depending on the volume.</p> <p>Dr. Burrow thanked Dr. Murray and then called on Dr. Joseph Penn to present Mental Health Program Updates for UTMB CMC.</p> <p>Dr. Joseph Penn began by introducing himself. He shared that he attended medical school at UTMB and corrections was kind of ingrained in him. He stated he was always fascinated by the TDCJ offenders who entered Hospital Galveston. He shared that he has been with UTMB for twelve years.</p> <p>Dr. Penn began his presentation by sharing that UTMB, Correctional Managed Care division, provides high quality care, access to care, continuity of care and comprehensive mental health and psychiatric services. Dr. Penn stated that UTMB provides service to approximately 80 percent of the offender population in TDCJ facilities and TTUHSC provides care to approximately 20 percent.</p> <p>Dr. Penn stated that none of what they do is possible without the TDCJ leadership and staff, because if you cannot make staff feel safe working in a correctional setting staff recruitment would not be possible. Correctional staff are trained very well. They are the eyes and ears for mental health staff. They relay their observations to mental health staff. The mechanics of getting the offenders to their appointments is a challenge, especially high security offenders. Dr. Penn stated that the partnership between TDCJ Health Services, UTMB and Texas Tech works very well and, without that partnership, he does not believe they would be able to accomplish what they do on a day to day basis. Dr. Penn shared that our population is the largest state prison system in the country behind the Federal Bureau of Prisons. We also receive approximately 65,000 intake offenders each year.</p>	<p>Dr. Linthicum stated that at this point we are unsure of the need which will augment the cost.</p>	

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<p>VII. Mental Health Program Updates (Cont.) - Dr. Penn</p>	<p>Dr. Penn next shared that UTMB offers a full range of outpatient, crisis management, inpatient and special programs providing mental health care to approximately 115,600 offenders in the UTMB sector. The majority of the population are male, with approximately 12,200 females. Crisis management and on-call psychiatric services are available every day, 24 hours per day. All new intake offenders receive mental health screening. There are some units that are considered non mental health caseload facilities which means that those facilities do not have dedicated mental health staff; however, those facilities utilize tele-medicine to access care and offenders are transferred to a facility with a mental health case load if needed.</p> <p>Dr. Penn reported that the mental health caseload census is close to 1,000 on the inpatient caseload, close to 22,000 on the outpatient caseload and over 18,000 of these offenders are on psychotropic medication(s) and are followed by a psychiatric provider.</p> <p>Dr. Penn next covered the “routine” or outpatient services that are offered in the UTMB sector. Services offered include intake assessment and referral as needed, outpatient psychiatric evaluations and treatment, psychotropic medication management, psychological testing, individual and group psychotherapy, restrictive housing mental health rounding, psychoeducation and skills building, case management services, mental health observation, suicide and violence risk assessments, which is clinical not forensic, and PREA generated mental health referrals for instances prior to incarceration or while incarcerated and is available for both victims and perpetrators.</p> <p>Dr. Penn next reported on specialty services offered in the UTMB sector. Services offered include crisis management and treatment tracks at Jester IV, Skyview and Mountain View, the developmental disabilities program (DDP), the neurocognitive disorders program at Jester IV, and the treatment and relapse prevention program (TARPP).</p>		

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<p>VII. Mental Health Program Updates (Cont.) - Dr. Penn</p>	<p>Dr. Penn shared that there are some very successful initiatives under way. One being the weekend review of offenders on constant direct observation (CDO) “pilot” telehealth program. The “pilot” is in quotes because of the length of the pilot and its success. Health Services would like it to be fully implemented. He explained that when offenders become suicidal or act out after hours they are placed in what is called CDO which can become a burden on security staffing. In December 2016 on seven TDCJ units a telemedicine program began for these offenders. The offenders are given a suicide risk assessment via telemedicine to determine whether they can come off of or should remain on CDO. In 2018, 963 assessments were completed and 545 offenders or 56.6% were released from CDO with no bad outcomes.</p> <p>Dr. Penn explained another program that has been very successful is the suicide risk screening of pre-hearing detention (PHD) placements. This program began in December 2017 at three TDCJ units. Offenders placed in PHD are screened for suicide risk by a mental health clinician. In 2018, 2,448 screenings were performed which triggered 170 full risk assessments and 67 offenders referred to crisis management. Another program involves suicide risk screening after offender protection investigations (OPI), prior to the offender being returned to his or her regular housing. This program was initiated at three TDCJ units in December 2018.</p> <p>Dr. Penn stated that they have also initiated specialized group therapy programming on human trafficking for female offenders. This program was initiated in the spring of 2018 at several female TDCJ units and will be expanding.</p> <p>Dr. Penn answered that he could provide more information on that, but he believes that they are being provided general psychoeducation about what it means.</p>	<p>Dr. Burruss asked how those women are identified.</p>	

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<p>VII. Mental Health Program Updates (Cont.)</p> <ul style="list-style-type: none"> - Dr. Penn 	<p>Dr. Penn thanked Dr. Burruss for his question and told him he would happily obtain and provide him with additional information.</p> <p>Dr. Penn stated that as you can imagine, this population has a high prevalence for post-traumatic stress, trauma and disassociation.</p> <p>Dr. Penn next went over the TARPP. This is a case management program developed to ensure that offender patients with serious mental illness (SMI) receive a continuum of care throughout the system. The program goals are to reduce relapse, decompensation and risk of recidivism. Dr. Penn further explained that the TARPP is available to both male and female offenders. The program targets the population of offenders with a SMI, offenders who require case management, ongoing monitoring and continuity of care including discharge planning. Case management and tracking are available no matter where an offender is housed and regardless of their custody level.</p>	<p>Dr. Linthicum shared that the Rehabilitation Programs Division (RPD) has a program for offenders who are ex-prostitutes and they utilize a screening tool to identify trauma. We collaborate with them to identify individuals that may benefit from these services.</p> <p>Ms. Kelly Garcia shared that Harris County Psychiatric Center has a unit specifically for human trafficking victims that the Health and Human Services Commission (HHSC) is partnering with.</p> <p>Dr. Burruss asked if that was for inpatient care.</p> <p>Ms. Garcia answered yes it is. This is a gap population and there has not been a lot of assistance available for inpatient stays. She shared that they are doing some very interesting work there.</p> <p>Dr. Linthicum stated that what we are trying to do is supplement on the therapeutic side, what is already happening on the program side with RPD.</p>	

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<p>VII. Mental Health Program Updates (Cont.)</p> <ul style="list-style-type: none"> - Dr. Penn 	<p>Dr. Penn thanked Dr. Linthicum and stated that this program is also another linkage to identifying folks before they are due to release and assist with their continuity of care. It is the same model of case management that is used in an outpatient mental health center.</p> <p>Dr. Penn next reported on the increase in the mental health caseload over the years and noted that they have seen a rise in the numbers each year which is expected to continue.</p> <p>Dr. Penn reported that there are three behavioral health units in the UTMB sector. Skyview in Rusk which has 562 beds and is co-ed, Jester IV in Richmond which has 550 beds and is primarily a male facility with some females and Mountain View in Gatesville which is a 20 bed female facility. Dr. Penn shared that three differences between the UTMB sector and the Texas Tech sector is that UTMB houses all the female offenders, all of the youth offenders (YOP) and all of the death row offenders. Dr. Penn stated that more female bed space is needed. Dr. Penn next reported on the census of treatment tracks available at Skyview and Jester IV. He stated that some of the offenders who check into these units stay for years and some will have to be housed there permanently. This is one of our biggest challenges; these are permanently assigned offenders that cannot function in general population.</p>	<p>Dr. Linthicum shared that the ACA Mental Health Committee gave a correctional definition for SMI which is much more expansive in the correctional setting. She shared that the TARPP program was developed as the result of what might be termed the 'frequent flyers'. Offenders who were recycling over and over through the inpatient facilities. This is the population that was targeted for this intensive case management to try to keep them in general population.</p> <p>Dr. Linthicum stated that is a challenge that we are facing from both a medical and behavioral health perspective. Some offenders will spend their entire incarceration at these facilities.</p>	

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<p>VII. Mental Health Program Updates (Cont.) - Dr. Penn</p>	<p>Dr. Penn reported yes and he will touch on that with the mental health therapeutic diversion program (MHTDP) overview. Dr. Penn next reported on the number of civil commitments from Skyview and Jester IV. He shared that when offenders are due to release and they are housed at Skyview or Jester IV all of the paperwork and necessary testimony is provided so that these offenders receive civil commitment.</p> <p>Dr. Penn shared that one of the programs that he is most proud of is the developmental disabilities program (DDP). The mission of the DDP is to provide opportunities to offenders with developmental disabilities to acquire those skills necessary to enable them to function more successfully within the least restrictive environment. This program is for both male and female offenders with intellectual and other developmental disabilities requiring further evaluation, testing and treatment services. Dr. Penn stated that the DDP is housed at the Hodge Unit in Rusk for the males which currently has 645 beds and at the Crain Unit in Gatesville for the females which currently has 106 beds.</p> <p>Dr. Penn reported that at the Crain facility there is a pilot program for occupational therapy which they would like to expand to the male population. The program funding is provided by Mrs. Patricia Crocker in memory of her husband Mr. Radford Crocker through the Crocker Foundation.</p>	<p>Dr. DeShields noted that another area of challenge is the dual diagnosed population of offenders that is steadily growing.</p> <p>Dr. Raimer asked if they are doing more to retrain the behavior of the particularly violent offenders to teach them new pathways as they reenter society.</p> <p>Dr. Linthicum noted that the DDP came out of the Ruiz settlement and they are very proud of the program.</p>	

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<p>VII. Mental Health Program Updates (Cont.) - Dr. Penn</p>	<p>Dr. Penn reported that the MHTDP is a program that is available to all restrictive housing offenders with mental health needs regardless of custody level. The program began at the Hughes Unit and has been expanded to the Michael and Murray units. The mission of the program is to effectively and efficiently provide for the mental health needs of TDCJ restricted housing offenders identified as requiring such services with the goal of assisting them to achieve the optimal level of functioning in a therapeutic diversion setting so they can successfully transition into a less restrictive housing assignment.</p> <p>Dr. Penn reported that the program began at the Hughes Unit in September 2015 and the capacity is 420 male offenders, which includes 100 chronically mentally ill beds. Treatment programs include individual and group counseling, psychoeducational groups, case management, psychiatric diagnostic evaluation and psychotropic medication treatment. There have been 615 successful completions as of February 11, 2019.</p> <p>Dr. Penn reported that the program at the Michael Unit began in August 2016 and the capacity is 420 male offenders, which includes 100 chronically mentally ill beds. Treatment programs include individual and group counseling, psychoeducational groups, case management, psychiatric diagnostic evaluation and psychotropic medication treatment. There have been 299 successful completions as of February 11, 2019.</p> <p>Dr. Penn reported that the program at the Lane Murray Unit began February 2019 and the capacity is currently 44 female offenders with a future capacity of 100 offenders. Treatment programs include individual and group counseling, psychoeducational groups, case management, psychiatric diagnostic evaluation and psychotropic medication treatment.</p>		

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<p>VII. Mental Health Program Updates (Cont.) - Dr. Penn</p>	<p>Dr. Penn reported on telepsychiatry in the correctional environment. He stated that there is a national shortage of psychiatrist. There is also the challenge of recruiting staff to correctional units, especially in rural remote sites. Telepsychiatry allows for more timely psychiatric consultation. It increases psychiatry specialty consultation, which includes routine or newly discharged patients from inpatient facilities and crisis access. They have the ability to use telepsychiatry statewide, at any facility that has teleconferencing equipment. Dr. Penn shared that it allows for an improved use of psychiatric provider time, with less time on the road traveling between units, lowering the transportation cost to off-site services. Dr. Penn shared that they utilize a “hub” model which fosters collegial group practice interactions and clinical supervision of psychiatric nurse practitioners and physician assistants. Dr. Penn reported that they do about 20 thousand visits per month and somewhere around 200-250 thousand visits per year.</p> <p>Dr. Penn shared that when the offenders are being seen via telepsychiatry they are in the room with a presenter. If there are issues related to affect, grooming, hygiene, etc. there is more objective information available to the provider in that the presenter can provide additional information.</p>	<p>Dr. Raimer stated that he thinks that it is important as we look to the future. He shared that there is data from a study of adolescent populations in current schools that show female students are more likely to be the most aggressive and were more likely to carry a weapon to school than males.</p> <p>Dr. Burruss commented that noting the almost 50 percent vacancy rate of psychiatrist in the UTMB sector and the vacancy rate of psychiatrists in Texas; this is the way we are going to do business. 75 percent of the counties in Texas do not have a psychiatrist directly they use telepsychiatry.</p>	

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<p>VII. Mental Health Program Updates (Cont.) - Dr. Penn</p>	<p>Dr. Penn reported on some of the current challenges they are facing. He shared that they are seeing more offenders entering TDCJ with serious mental illness and expect those numbers to continue to grow. Recruitment and retention of qualified psychiatric and mental health staff continues to be an issue. The medical disease co-morbidity numbers are growing and are more complex. This growing population of offenders with more serious medical/psychiatric comorbidities suggest a need for additional med/psych capacity. Dr. Penn shared that due to the aging population they are seeing more neurocognitive disorders. Lastly, they are seeing a lot of self-mutilating and self-harming which poses unique challenges.</p>	<p>Dr. Linthicum stated that with the population over 55, the fastest growing population; we are seeing more offenders developing age related illnesses. They are developing traumatic brain syndrome, alzheimer's and dementia and they cannot function in general population. The question then is where we place them. Infirmary beds or inpatient psychiatric facilities? Dr. Linthicum shared that one model that was implemented in the Regional Medical Facility when she was a unit provider is that 20 beds were designated for mental health patients with medical comorbidities and the other 30 for medical patients. However, the alzheimer's and dementia patients were very disruptive to the unit. Dr. Linthicum stated that these are some of the issues they are facing. Some of these offenders are not going to be released they have life sentences.</p> <p>Dr. Hudson asked about the impressive growth shown on the slide in Dr. Penn's presentation. He asked what Dr. Penn sees as the need and are we using that to bolster our projections for growth.</p>	

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<p>VII. Mental Health Program Updates (Cont.) - Dr. Penn</p>	<p>Dr. Penn stated that the number will continue to grow. Based on factors including the fact that there are less state hospital beds available and insurance company restrictions. He stated that there is a revolving door of sorts between jails, prisons and homelessness. There are two different populations, one is the chronically mentally ill and the other is situational or adjustment issues. The chronically mentally ill are going to be seen regularly and regardless of whether they want to be seen or not. The second group may self-report that they are fine and want to come off the caseload and may have no issues for years. Dr. Penn stated that he is always in favor of having more staff available on the units. He stated that he would like to have more doctoral level staff. He shared that they have bachelors and masters level, but only a hand full of Ph.D. level psychologists.</p> <p>Dr. Penn stated that in the free world a primary care provider might manage anxiety or depression. In our system our providers try to stay "in their lanes". Mental health staff are not prescribing for medical issues and medical providers are not prescribing for mental health issues. With our population it is what works best for continuity of care.</p>	<p>Dr. Borrow stated that the programs are impressive. He asked if the patients that get labeled with depression or anxiety get placed with mental health or do the primary care providers handle that.</p>	
<p>VII. Mental Health Program Updates - Dr. Jesus Guillermo Garcia</p>	<p>Dr. Burrow thanked Dr. Penn and then called on Dr. Jesus Guillermo Garcia to present Mental Health Program Updates for TTUHSC CMC.</p> <p>Dr. Jesus Guillermo Garcia began by introducing himself. He shared that he is not originally from Texas; he is from El Salvador. He did his medical training in El Salvador and his residency at Mount Sinai in New York. He shared that he also has a fellowship in electroconvulsive therapy.</p>		

Agenda Topic / Presenter	Presentation	Discussion	Action
<p>VII. Mental Health Program Updates (Cont.) - Dr. Garcia</p>	<p>Dr. Garcia shared that this career chose him rather than him choosing this career. When he was in his residency he said there were two things he was never going to do. One was that he was never going to be an administrator and the second was that he was never going to work in corrections. He stated that this is a career that found him and he is certainly glad it did.</p> <p>Dr. Garcia reported on the services provided in the Texas Tech sector which include inpatient, outpatient, crisis management, sheltered housing and special programs. He shared that Texas Tech has 23 prisons, approximately 30,000 offenders and the population is male only. The behavioral caseload is 5,931 as of February 2019 and are mostly outpatient. The Montford inpatient unit has 550 beds including a Regional Medical Facility which is the dual diagnosis facility and it is unique to the state. The Clements Unit houses special programs and crisis management and has 390 beds.</p> <p>Dr. Garcia next reported on the Montford Unit. It has 550 correctional psychiatric inpatient beds and includes the Regional Medical Facility. There are 50 crisis management beds and 50 diagnostic and evaluation (D&E) beds. He stated that when patients are past crisis management and we assume that they are going to need to be admitted to the hospital they go through the D&E process which can be considered an interim acute hospitalization.</p> <p>Dr. Garcia reported that they conduct approximately 1,000 telepsych encounters per month.</p> <p>Dr. Garcia next went over the scope of inpatient services offered. He stated crisis management is the emergency room for psychiatry. The three major issues or reasons they would be placed into crisis management are danger to self, danger to others or great disability or inability to care for themselves.</p> <p>Dr. Garcia stated that they have several distinct tracks. There is the acute/partial remission program (PRP), transition, impulse control, mood, chronic and neurocognitive tracks.</p>		

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<p>VII. Mental Health Program Updates (Cont.) - Dr. Garcia</p>	<p>Dr. Garcia stated that some of these services are cross overs from Dr. Penn's presentation and he would move on unless there were any questions. Dr. Garcia reported that they offer psychotropic medication management, psychological assessments, social work assessments, individual and group therapy, recreational therapy which includes mobile library services, pet therapy, gardening and art. They offer civil commitment assessments, which Dr. Penn explained, and they offer PREA related assessments.</p> <p>Dr. Garcia confirmed that through the school system and the colleges they have been able to retain multiple volunteer services.</p> <p>Dr. Garcia reported on the special programs offered. The special programs are at the Clements Unit. Dr. Garcia explained the program for the aggressively mentally ill offender (PAMIO). It is a multidisciplinary cognitive-behavioral program for the aggressively mentally ill offenders in restrictive housing. The focus is on effective management of aggressive behavior for successful general population reintegration. There are 246 beds and it is a level based system. There is individual and group therapy, art therapy, psychotropic medication management and in cell homework. The success rate is about 68%. They offer a GED with the Wyndham School and have created an intern grad program for the offenders who have completed the program to work as mentors.</p> <p>Dr. Garcia shared that PAMIO is an eighteen month program. They have worked with classifications and have made some modifications to extend this time if needed.</p>	<p>Dr. DeShields noted that the recreational therapy is almost entirely voluntarily.</p> <p>Dr. DeShields asked what the average length of time for program completion is.</p>	

Agenda Topic / Presenter	Presentation	Discussion	Action
<p>VII. Mental Health Program Updates (Cont.)</p> <ul style="list-style-type: none"> - Dr. Garcia 	<p>Dr. Garcia next explained the Chronically Mentally Ill Treatment Program (CMI-TP) at the Clements Unit. The CMI-TP is a multidisciplinary cognitive-behavioral program designed to treat and manage the identified chronic mentally ill offenders who require structured monitoring and supervision. The goal is to further stabilize their mental illness and assist them in achieving their highest level of functioning. This is a level based program and has 130 beds and patients fluctuate in levels based on psychiatric stability.</p> <p>Dr. Garcia reported on the Chronic Mentally Ill Sheltered Housing Program (CMI-SH) at the Clements Unit. This is TDCJ designated housing; all of the other programs are voluntary. This program provides a structured, secure environment and ambulatory behavioral services to high custody offenders who cannot or will not participate in a structured behavioral health program due to their chronic psychiatric instability. This is a rapidly growing demographic. There are currently 78 beds and 14 beds at Clements designated as crisis management.</p> <p>Dr. Garcia next reported on the outpatient services offered which include intake behavioral health assessments, psychotherapeutic interventions, psychotropic medication management, safety assessments, PREA related assessments and referrals to inpatient, crisis management and special programs. Dr. Garcia noted that they have challenges with recruitment of psychiatrists and advance practice providers. Statistically, 6% of the free world population have serious mental illness compared to 20% of the prison population.</p> <p>Dr. Garcia reported on Texas Tech behavioral health statistics noting that there has been a 7% increase in staffing from 2016 to 2018. The behavioral health case load has increased 26% from 2016 to 2018. Montford behavioral health encounters have increased 15% from September 2018 to December 2018.</p>	<p>Dr. DeShields noted, for the new members, that the Clements Unit is located in Amarillo.</p>	

Agenda Topic / Presenter	Presentation	Discussion	Action
<p>VII. Mental Health Program Updates (Cont.) - Dr. Garcia</p>	<p>Dr. Garcia reported constant direct observation (CDO) has seen a decrease of 84% from September 2018 to December 2018. Dr. Garcia explained that CDO is used for crisis management offenders, when there are no crisis management beds available. CDO offenders are monitored by security 24/7 until they come off CDO. Seclusions have decreased 67.5% from September 2018 to December 2018 and at Montford self-harm decreased 50% and restraints decreased 81% for the same time period.</p> <p>Dr. Garcia stated that change can happen and it must happen. We will continue to work in that direction.</p>	<p>Dr. Raimer stated that those statistics are good. People do doubt that change can happen.</p> <p>Dr. DeShields stated that it takes a lot of dedicated effort on the part of staff. Despite the staffing issues these numbers are truly impressive in a relatively short period of time.</p> <p>Dr. Linthicum stated that she would like to congratulate Dr. Garcia and the staff that work with the unique population at PAMIO. These are restrictive housing offenders and they have an outstanding program in place. Dr. Linthicum stated that the next big challenge is the remaining caseload that are still in restrictive housing. There are still about 1,500 offenders in restrictive housing. Most of this population is gang affiliated offenders, security threat groups and some very dangerous individuals. She shared that they have tried to place some in the mental health therapeutic diversion program and they proved very disruptive and uncooperative. The Joint Mental Health Work Group has been working on answering the question of how to get those 1,500 offenders out of the restrictive housing setting and into a more therapeutic setting and what would that look like. Dr. Linthicum stated we would welcome any ideas or any input that any of you would like to share.</p>	

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<p>VII. Mental Health Program Updates (Cont.) - Dr. Garcia</p>	<p>Dr. Garcia stated that it becomes a very complex situation given that we have more than 20 different gangs.</p> <p>Dr. Garcia noted that the caveat to the GRAD program is that prior to going into the program they need to be observed and monitored by the security threat group captions or security to make sure that they are not exchanging letters or communication or still pledging allegiance to their gang.</p>	<p>Dr. Linthicum reported that under the ACA's 5th Edition Standards, no person with a serious mental illness can remain in extended restrictive housing. Dr. Linthicum explained that extended restrictive housing is defined as beyond 30 days unless there is extreme mitigation such as they are a definite danger to themselves or to others.</p> <p>Dr. Linthicum shared that TDCJ does have programs such as the Gang Renouncement and Disassociation (GRAD) and the Serious and Violent Offender Reentry Initiative (SAVORI) programs. There are programs on the programming side, but our unique 1,500 also have a serious mental illness.</p> <p>Dr. Burruss asked if there are other states that have set standards related to this issue.</p> <p>Dr. Linthicum stated that other states will be looking to us. Texas and California probably have the biggest security threat group problem out of all the state systems. Dr. Linthicum shared that we asked for, in our legislative appropriations request as an exceptional item, funding for 1,600 new mental health beds to care for this population. The model would be a cell block program at various maximum security units. She stated one item that we have spoken about with our prison director, Ms. Davis, is the possibility of having 200 beds at 8 units and if that would be manageable. Having 200 gang members on a unit might not be manageable and we would have to space them out further.</p>	

Agenda Topic / Presenter	Presentation	Discussion	Action
<p>VII. Mental Health Program Updates (Cont.) - Dr. Garcia</p> <p>VIII. Public Comments - Dr. Burrow</p>	<p>Dr. Burrow thanked Dr. Garcia and then noted that in accordance with the CMHCC policy, during each meeting the public is given the opportunity to express comments. He stated that no one had signed up to speak.</p>	<p>Dr. Linthicum stated we are working multidisciplinary among the three partner agencies on the therapeutic side and on the prison management and operations side we are working collaboratively with CID. These are some of the things with which we are struggling. Dr. Linthicum stated that the bottom line is that we have to get these seriously mentally ill offenders out of restrictive housing.</p> <p>Dr. Raimer stated that he would like to draw everyone's attention to the deficit in the financial report on page 109. He shared that currently the legislature has underfunded the health care services and there have been no adjustments to the base for the last two sessions. That has created a need for a supplemental appropriations request, which has been made. The House approved \$160 million, but it is not \$160 million it is \$198 million. If we continue at the burn rate that we are on with the expenses of health care at this point right now it will be closer to \$208 million or more by the end of our calendar year. The Board of Regents is concerned to the point of stating that they cannot continue to participate in a contract that is underfunded to this amount because that money comes out of the overall operating funds and we are not able to adequately fund our main mission which is the education of students. Dr. Raimer shared that he and UTMB President Callendar met with the Governor two weeks ago and discussed this and it was also discussed today with various offices. He shared that he does not know what will happen. He appealed to the board to use their influence to get this message out.</p>	

Agenda Topic / Presenter	Presentation	Discussion	Action
<p>VIII. Public Comments (Cont.)</p> <ul style="list-style-type: none"> - Dr. Burrow 		<p>Dr. Raimer shared that the partnership with UTMB brings a \$200 million savings to the state each biennium through 340B pricing.</p> <p>Dr. Jumper stated that it confuses the issues when the universities have to go and ask for these supplemental appropriations requests for correctional care and the universities are there asking for educational programs.</p> <p>Dr. Raimer stated that he and Dr. Jumper had recently gone over the price per prisoner.</p> <p>Dr. Jumper reported that she had shared that with a few of the board members. The PEW Foundation rated nationally, 50 states on the cost per prisoner/per day. Out of 50 we were ranked 36th or 37th. This shows that we are very cost efficient. Dr. Jumper stated that she has the report or you can just Google the PEW prison report which was published in October 2017.</p> <p>Dr. Raimer stated that this is not an issue between the TDCJ and the university partners. We have one of the best working relationships we have ever had in my almost twenty-five years of being involved. We have excellent leadership in all areas of TDCJ and they round with us and advocate for us and we are all on the same page. There is no dispute over these numbers.</p> <p>Dr. Jumper noted that another comparison that can be made is Medicaid, and we are cheaper than Medicaid.</p> <p>Dr. Burrow clarified that they were speaking about approximately \$13 per day and asked what the cost per day is for a Blue Cross patient.</p> <p>Mr. Johnson stated that it is higher than that.</p>	

Agenda Topic / Presenter	Presentation	Discussion	Action
<p>VIII. Public Comments (Cont.) - Dr. Burrow</p>		<p>Dr. Jumper shared that the cost for an ill Medicaid patient is about \$44 per day. If you average all three Medicaid populations it is about \$20 per day.</p> <p>Dr. Linthicum stated that the private sector could not match our cost per day.</p> <p>Dr. Burrow agreed.</p> <p>Dr. Linthicum shared that the 340B pricing alone saves the state \$200 million per biennium.</p> <p>Dr. Hudson asked if on the financial report they could show what areas actually drive the deficits and how it compares to what was projected or proposed.</p> <p>Dr. Raimer stated that the costs go up in the areas of the growing population of offenders over 55 and the high cost chronic diseases.</p> <p>Dr. DeShields stated that if they treated every offender in the system with Hep C, it would cost \$98 million. There are 4,500 that are priority one which would cost \$98 million.</p> <p>Dr. Raimer stated that he believes that there is a misconception that TTUHSC and UTMB do this because they are making money.</p> <p>Dr. Jumper stated that there is a law in place that requires any allocated unspent funds be returned to the state. In the past there have been funds returned. The universities are not allowed to keep it or reallocate it.</p> <p>Dr. Raimer stated that he wanted to share this issue with the group so that they are aware and not surprised about the financials.</p>	

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<p>VIII. Public Comments (Cont.) - Dr. Burrow</p>		<p>Mr. Steffa stated that what he can do in addition to showing the per diem and growth rate of about 4% annually is that after this session he can show what was requested and projected as the need against what is actually funded.</p> <p>Dr. Murray stated that if you take all the funding issues off the table and just look year after year the growth rate is about 4% to 5% consistently. Given the nature of the patients that we care for, the care we are asked to provide and the comparison between ERS and TRS and Medicaid we are significantly less expensive than any other state funded health care program that the state has going right now. If our funding were matched with that growth rate we would be fine and we could manage with that and maybe have a small supplemental request or possibly even have a small amount to return to the state depending on the population fluctuation. But that is not the way we get funded and politics get involved with these supplemental requests. Dr. Murray stated that everyone around the table does a very good job of taking care of these patients and the people that are funding the program should take a great deal of pride for what they have created, because every other state wants to be us.</p> <p>Dr. Linthicum stated that the past is prolog and we have to learn from it. The Ruiz lawsuit went from 1972 through 2002. It was the longest class action correctional lawsuit in the history of corrections. We didn't vacate the final judgment until 2002. We were under a federal judge from 1972 to 2002. It has created the system that we are today; a premier correctional health care system and we need to maintain that.</p>	

Agenda Topic / Presenter	Presentation	Discussion	Action
IX. Adjourn	<p>Dr. Burrow next called for a motion to adjourn the meeting.</p> <p>Dr. Burrow thanked everyone for their attendance and adjourned the meeting. Dr. Burrow announced that the next CMHCC meeting is scheduled for June 25, 2019 in Conroe, Texas.</p> <p>The meeting was adjourned at 3:15 p.m.</p>		<p>Dr. Jumper made a motion to adjourn and Dr. Raimer seconded the motion which prevailed by unanimous vote.</p>


 Rodney D. Burrow, M.D., Chairperson
 Correctional Managed Health Care Committee

Date 6/25/19