SANTA FE COUNTY

BOARD OF COUNTY COMMISSIONERS

SPECIAL MEETINNG

July 9, 2013

Kathy Holian, Chair – District 4
Robert Anaya – District 3
Liz Stefanics – District 5

Miguel Chavez – District 2 [Excused]
Danny Mayfield, Vice Chair – District 1 [Excused]

COUNTY OF SANTA FE)
STATE OF NEW MEXICO) ss

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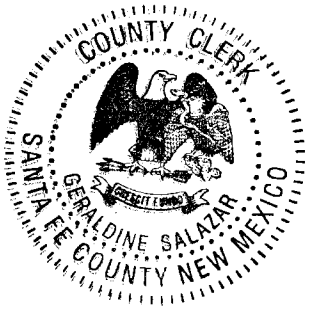

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July 9, 2013

This roundtable work session on medical services for the Corrections Department held by the Santa Fe Board of County Commissioners was called to order at approximately 10:16 a.m. by Chair Kathy Holian in the Santa Fe County Commission Chambers, Santa Fe, New Mexico.

The following Commissioners were present:

Members Present:
Commissioner Kathy Holian, Chair
Commissioner Liz Stefanics, Chair
Commissioner Robert Anaya

Members Excused:
Commissioner Danny Mayfield
[Commissioner Mayfield – jury duty]
Commissioner Miguel Chavez

Introductions

BILL TAYLOR (Procurement Director): Good Morning, everybody. I want to thank you all very much for your time and interest in the request for information regarding medical services for Santa Fe County correction Department. I know that it took time and expense for you to come here and help us on this fact-finding effort by the County. So I'd like to begin if I could with just some simple introductions if you don't mind. I'd like to start with the Santa Fe County Commission.

CHAIR HOLIAN: Good morning and thank you for being here. I'm Kathy Holian, the chair of the Board of County Commissioners.

COMMISSIONER STEFANICS: Good morning. I'm Liz Stefanics, a Santa Fe County Commissioner. The prison, or the jail actually resides – the adult facility is in my district and borders Commissioner Anaya's district.

COMMISSIONER ANAYA: Robert Anaya, Santa Fe County Commissioner, District 3, essentially the southern half on the west side of Santa Fe, the southern half of Santa Fe County.

MS. MILLER: I'm Katherine Miller, Santa Fe County Manager. Just real quickly, I want to say I appreciate you coming in today. The Commission has questions and a request for information on what time of medical healthcare services are out there and we want our facility to improve services if possible. So we appreciate your response to that. I know that it was a while ago we did that. I appreciate your coming into town to visit with the Commission and the staff. So thanks for being here.

PABLO SEDILLO (Public Safety Director): I'm Pablo Sedillo. I'm the Public Safety Director for the County of Santa Fe. My responsibility is overseeing Santa Fe County

Fire Department, Santa Fe County Corrections Department, and the RECC which is our Regional Emergency Communications Center as well.

JEFF ARCHAMBEAU: I'm Jeff Archambeau. I'm CEO of Correctional Health Partners. [inaudible]

JACK DONAHUE: I'm Jack Donahue. I represent NaphCare this morning. I've been with NaphCare for about a month after retiring from the Las Vegas Metropolitan Police Department after 27 years. So you'll have to bear with me today.

TODD MURPHY: Good morning. Todd Murphy, Director of Business Development for Correctional Healthcare Companies out of Denver. Glad to be here.

VICKIE FREEMAN: Good morning. My name is Vickie Freeman. I'm regional vice president for Armor Correctional Health Services.

CHAIR HOLIAN: Excuse me. Could you please use the mike when you speak because it's difficult for the audience to hear, I believe because your backs are to them and also our transcriber needs this on tape.

COMMISSIONER ANAYA: Madam Chair.

CHAIR HOLIAN: Yes, Commissioner Anaya.

COMMISSIONER ANAYA: Madam Chair, if I could make just a few additional brief comments. I was one of the Commissioners that ask questions relative to – to not just correctional health per se but questions around how as a County can we better understand what opportunities or what other ways of doing business exist if we just continually are doing the same things. That's not to take away from the business that we're currently doing but I think the interest was what else are other organizations doing and what might be some of the reasons some of those organizations are doing it. So the way we had to do it is we had to do a formal request for information as we've done, an inquiry, if you will, to get a better breadth of what's out there. So as our Manager said, I appreciate what you're doing here and look forward to listening and learning about potential options that are out there for us to look at.

Like I said, it doesn't take away from anything that we're doing in the Correctional facility as it stands now but as one Commissioner who wants to make sure we're evaluating all potential opportunities we may have we have to look at a breadth of things. So I'm happy that we're doing this and I don't see this as being a one-time or one-issue type situation. I can see us as a County looking at other things we might do across County government to better understand what other entities might be doing. So thank you for being here as well.

CHAIR HOLIAN: Thank you. And now I believe that Pablo Sedillo, our Public Safety Director, will give some opening remarks regarding our Correctional facilities and health program.

Opening Remarks

MR. SEDILLO: Thank you, Commissioner, Madam Chair. We currently have two facilities. We have an adult facility and we have a juvenile facility. Our adult facility has approximately 640 beds and that's excluding our medical unit and our booking area. We average about 10,000 bookings a year with about 9,575 releases a year. We have about 86 percent of the individuals that come into our facility who have substance abuse issues. About

67 percent have a dual diagnosis of mental illness and substance abuse, and about 45 percent of them that come in have a severe mental illness. So we have that.

In our juvenile facility we average about anywhere from 17 to 27 juveniles at one time. Our capacity there is 63. We're certified 63 by New Mexico Children, Youth and Families Department so we currently have that as well. The majority of our intakes are at the adult facility, however.

CHAIR HOLIAN: Thank you, Mr. Sedillo. Now I believe that Bill Taylor will kick off the discussion with some questions.

Discussion

MR. TAYLOR: Thank you, Madam Chair. I appreciate it. We had a total of six respondents to this RFI and Diamond Pharmacy was one that chose, elected not to come and the other was Corizon. So just for FYI at the RFI.

You were all presented with basic questions that we wanted – that came out of this RFI from management, from the Commission and just to sort of kick this off you have those questions and so we'll just dive into those questions if that's the pleasure of the Commission.

My first question, we were asking to provide a brief description of your basic medical services management plan with bullets under that question that sort of – that primarily explains your staffing levels and how they would be implemented, provide a list of services. Let me just reiterate, this is very informal. The RFI process is a very informal process. This is a roundtable discussion. We can start out left going right with comments on that. I think we can – as long as we don't get too professional in our presentation I think we can handle it. I'm sure that we're not going to do anything like that; I'm being facetious. If we want to start out here going left to right, or anyone that wants to start out. Let's start with you.

MR. ARCHAMBEAU: Do you want me just to address staffing levels or both bullets, or how do you want to – they're sort of different questions.

MR. SEDILLO: Sure. Why don't we go to staffing levels at first, break it down into two parts.

MR. ARCHAMBEAU: Okay. Our approach at our company is we prefer to prioritize our instaffing over LPN staffing. It's a little more expensive. Now, those are all limited by budget and so we have in the end, we tend to do a mix, often. But our preferences is to stick with RN staffing because we believe that that skill set allows you to take care of more medical issues on site at the jail end of the clinic, to spot more medical conditions that are going on before they need to be shipped out to the ER. So it's really a preference as much as budget allows is to prioritize our instaffing over LPN.

We also prefer to use nurse practitioners as the primary care provider at the jail. They're much less expensive than an MD. They in almost all states have independent prescribing authority and for the same dollars you can have a provider onsite more often than you can when there's a physician as your primary care provider. Other issues have to do with whether the County does 24-hour staffing at the jail. A number of jails we see in your size sometimes do, sometimes don't. That's also very much budget-driven and there's a trade-off between how much are people going out at night to the ER and is there a trade-off? Would

you save money if you had had an RN on duty over night? So those are the things we look at when we come into a new jail, take a look at.

MR. DONAHUE: What NaphCare's preference is as far as staffing, it's basically on NCCHC accreditation guidelines as well as American Correction guidelines. Most of our staffing is always predicated by those standards. The important part is too the 24-hour clinical supervision to assure the highest level of risk management. We want to make sure we have that supervision onsite to ensure the best quality healthcare.

And then I think the last part of this where I can be very brief on this is to actually discuss staffing from our perspective is to ensure, we have to see the facility. Where I came from as the deputy chief, we had a totally different setup prior to NaphCare coming into our agency and with NaphCare coming in we were able to change and then lower our staffing levels based on the procedure we do now. Making sure it's loaded up front. Make sure we can do the things we do upfront. So that definitely affects. So we have to see the operation to ensure how we would correctly staff that. I know that was very brief but I think the NCCHC accreditation and ACA guidelines are there for a reason. They protect the agencies and you're living up to that standard.

MR. MURPHY: With CHC, what we're operable to do is to come in and not offer an off-the-shelf staffing pattern. We like to come in and begin a partnership with the County and that starts with communication, beginning with what are your needs, what are your desire, what kind of staffing patterns, are you 24/7, what are your goals, both today and in the future? We also begin with an RN basis and with that RN would be an HSA – health service administrator. And the program really revolves around he or she.

We always try to – we always hire locally, so 100 percent of our personnel would be from Santa Fe County. We always try to hire everyone who's onsite now, assuming that the County wishes to retain most of those people. Typically we see a 99 retention rate, but again, that's based around RN/HSA with the support of lots of medical personnel around them – LPNs, LVNs, CMAs, EMTs. Again, we're looking at trying to stay budget conscious and work towards your goals, your short- and long-term goals. But the idea is to again provide maximized services onsite as opposed to going offsite, and the way that we do that is through an RN-based system.

COMMISSIONER ANAYA: Madam Chair.

CHAIR HOLIAN: Yes, Commissioner Anaya.

COMMISSIONER ANAYA: I'm familiar with some of the acronyms but I think in the interest of the people that are listening in, if you could not use the acronyms or let us know what they are. So you were talking about some of the other staffing individuals. Isolate them and go through the acronyms. You said RN, ASA, CMA – why don't you go through each one of those.

MR. MURPHY: I'm sorry about that. The base of our program would be based around RN – registered nurse and a health service administrator, HSA, and he or she would be the administrator of the medical program and administer of the lesser medical personnel. You'd also – licensed professional nurse, LPN, licensed vocational nurse, LVN, EMTs, the paramedics. And of course that's all overseen by a physician or nurse practitioner.

COMMISSIONER ANAYA: Thank you.

MS. FREEMAN: Good morning. I think I want to introduce Armor by speaking about Dr. Armas who's the owner of the company and that sort of makes us different. We are a physician-owned company. Briefly, Dr. Armas started Armor in 2004 when the sheriff in Brower County came to him and said you have 600 medical clinics on the east coast of Florida, what can you do for the inmates' medical care in my facility? And so Dr. Armas started Armor and what drives the whole philosophy of the company is patient care and his line in the mission statement is: of service to others. So that's where it comes, from the top down.

When it comes to staffing our number one goal is to meet his mission of providing service and providing good patient care. We too, in a facility of this size, would probably have a physician, probably 20 hours, maybe less, with a full-time advanced nurse practitioner. We'd have an HSA, a DON, we'd have a number of LPNs and RNs. A lot depends on the facility. I don't know if you have an infirmary in this facility. You say you want to meet NCCHC standards. There are certain staffing requirements for an infirmary that would need to be in place that you don't have when you don't have an infirmary.

We would have round the clock nursing care. One of the successful things that Armor's very proud of is when it goes into the facilities that it goes into, because it provides most of the care onsite, we have reduced offsite care for others of facilities by hundreds of thousands of dollars, in some cases millions. And in our document we substantiated those examples to you. So we do staff up in order to produce a low utilization factor offsite. So we need good staffing in place, a medical director that is a leader, a health services administrator that is a leader that provides administrative leadership. So you have your clinical and administrative leadership.

I haven't heard a whole lot about mental health but I did hear that you have significant substance abuse and mental health issues at your facility. We have a very strong behavioral health component piece in Armor from the corporate level on down. Our folks do provide CIP training. We provide in-house programming. We provide board-certified psychiatry, and we do also use locally – local staffing. So I hope I've addressed the questions from a staffing standpoint.

COMMISSIONER ANAYA: Madam Chair.

CHAIR HOLIAN: Yes, Commissioner Anaya.

COMMISSIONER ANAYA: I have a follow-up, Bill, if I could? Is that okay?

MR. TAYLOR: Absolutely. This is informal.

COMMISSIONER ANAYA: So – and I'd like the feedback from those who didn't – there was one comment relative to accreditation and accreditation I something we are constantly hearing about. I would like those that didn't or I think it was you that talked about the accreditation aspect – to talk about how accreditation works into your system and what are the positive aspects of it and what might be some of the negative aspects associated with accreditation. Because sometimes accreditation turns into a laundry list of items you're supposed to complete to get a stamp that doesn't necessarily equate into a good thing. And I'm not saying what you said is bad, but we're in the process of dealing with accreditation. We're trying to get accredited for our state and national system. Right, Mr. Sedillo?

MR. SEDILLO: Madam Chair, Commissioner Anaya, that's correct.

COMMISSIONER ANAYA: So I guess I'd like your feedback, each of you, on that piece alone and how that presents a case for good healthcare in a system, in a correctional facility or maybe not. Start wherever.

MR. ARCHAMBEAU: I'd be glad to comment on that. When we look at different jails across the country who address this issue almost universally you're going to see them say that we want to meet NCCHC or ACA accreditation guidelines. My sense is less than half actually go for the actual accreditation for exactly the reasons you're talking about, Mr. Commissioner. And I think the standards are good but the process can be expensive and it can include some things that maybe you decide you don't need in your facility. I think there's certainly some bragging rights to being full accredited. To be honest with you I personally don't see that as necessarily the most important thing to do in a particular jail, to be honest with you. Within the guidelines is fine but actually getting the accreditation, I'm not sure what it gets you. I think there's other ways to get you what that might.

MR. DONAHUE: I probably will take a different perspective on that and I apologize for going to my background but our agency traditionally has been always been an agency that pursued accreditation. NaphCare is the same way. I think it's a level of standards that's expected. It's accountability to hold your employees to. And it's a level of service that you expect delivered. So I'm very much a proponent as is NaphCare for accreditation standards.

MR. MURPHY: I also agree that national accreditation is important. We're talking about both NCCHC – National Commission on Correctional Health Care and American Correctional Association. Those are the national accreditations we're talking about. I also agree that those are important in addition to being in some sense bragging rights, but also to hold your personnel at a higher standards, which is critical in this phase. Inmate healthcare is the County's largest liability and because of that we have to take it seriously and accreditation is a way of doing that.

Now, with respect to taxpayer dollars, because that's who's funding this, the taxpayers, a County run facility does not have to be accredited to meet those standards. As a matter of fact our policies and procedure protocols are written at and mirrored at NCCHC, ACA and state standards. So, no, you do not have to be accredited for us to manage your program to those standards, because we're doing that anyway. And because New Mexico has recently started the state jail standards we also have written our policies and procedure protocols to those standards as well. So I hope that answers your questions. It is important to aspire to be there and to go that way, but I don't believe you have to be accredited to function through accreditation. Because we're already working through that and industry best standards. What that does is that helps us with liability, helps reduce liability on the County and on us. It helps reduce cost to the taxpayers. I hope that answered your question.

MS. FREEMAN: I am an NCCHC surveyor. That's the National Commission on Correctional Health Care and you're right. The last percentage of jails that were accredited that I heard was less than eight percent of the jails in the country are actually NCCHC accredited. Which makes it a prestigious group. It does reduce liability, and it's a report card. It tells you that you have independent people coming in, telling you that we are meeting the community standard of care. Do we have to do it? No. Armor too has all it's policies and procedures set up for ACA and NCCHC and state standards. And we have internal auditing

teams that come to our sites unannounced to make sure that we are compliant with those standards. So we work to do that. Not all our jails are accredited but all of them seek to have compliance. So we found that on the negative side of all that is somebody comes in every three years and about six months before they show up everybody starts fixing up the place and polishing the floors and all that. Well, there should be a little bit of that. Really, having unannounced audits, that means we're ready all the time. So we take a lot of pride in doing that and that's one of the programs that we have that sets us apart from others.

COMMISSIONER ANAYA: Thank you.

CHAIR HOLIAN: Thank you. Bill, do you have your second question ready?

MR. TAYLOR: In an effort to make a roundtable discussion I'm going to just throw the questions out there and I want us to discuss it as a group with input and we can share the mike, so to speak, on this question. This is regarding Obamacare. Is Obamacare going to affect these services, correctional, medical services? Will there be any reductions created through Obamacare? And with that, that is the discussion on the table.

MS. FREEMAN: Well, I noticed that New Mexico is moving in that direction. New Mexico is moving in that direction by following or requesting or getting the Medicaid expansion. That will be in effect in January 2014, and then also most recently has established a state health insurance exchange. So some states are already compiling information on the patients/inmates in their facilities so that when they come back in the next time they already have this information, or – and understand what the primary focus of this is, why we want to do this. We want to establish either Medicaid eligibility or insurability so that when folks – and you have 86 percent of your people have substance abuse issues, 67 percent dual diagnosis and 45 severely mentally ill. That is a targeted population for this group so that recidivism is reduced. When they walk out of the facility they go to the local community mental health center, and there isn't somebody saying to them, I'm sorry, but you don't have your Medicaid. You have to reapply. By the time all that happens, realistically, they're unstable and they're back in jail again. They become your responsibility.

So the purpose of putting all these things in place is to help you reduce your costs. Now, Medicaid eligibility is going to increase. That's why you have the Medicaid expansion come next year, because pretty much your entire population is going to be eligible. New Mexico has the second highest uninsured population in the United States. That means you have a lot of people who are going to be eligible for this group. And what that's going to mean for you is when you send people to inpatient hospitalization that is going to be federally funded to a certain percent. It's not going to be 100 percent but there's a range of 50 to 84 percent will be funded for inpatient hospitalization.

I don't know what your utilization is but inpatient hospitalization is one of the big dollars that we all have to survive through. And then, currently there are things in place that most communities are not taking advantage of. There's – for persons that are under the age of 27 whose parents – and how you do this hasn't been established yet – but whose parents are insured, maybe in another country or state – probably just another state, you have access. That inmate should have access to those insurance funds under the current Obamacare plan that's already in place.

There's complications. You have to get the inmate to cooperate. You have to find out who the parents are. There's a lot of those things in place. But there are dollars that you will

save, especially in the state of New Mexico because of the nature of your population and what does need to be discussed is who's going to handle that billing? Do you want to handle that billing? Do you want a contract provider to handle that billing? There seems to be some ability to receive some form of reimbursement for someone that is hired for that. Some computer equipment perhaps. It's questionable; it's not solid. But there are those things in place. But those are questions we need to have answered. But there's money.

MR. TAYLOR: Anybody else?

MR. ARCHAMBEAU: Yes. We're working very closely with both the state of Oregon and the state of Colorado at the DOC level to begin to access Medicaid funding in two particular areas. The Centers for Medicaid and Medicare Services have said that an inmate is out of the jail and in an inpatient setting for more than 23 hours they're eligible for Medicaid reimbursement. So we're working with both of those states and increasingly with our county clients as well to figure out how to access that. The idea is relatively straightforward; the mechanics of it are extremely complicated. They have to do with how does somebody qualify for Medicaid? Is their Medicaid suspended when they're in jail or in a prison?

So we're working through a couple things. One is how to expedite that process for eligibility. How to do that retrospectively – if somebody comes into the jail and it turns out they do not have Medicaid but they would qualify. And then figure out how to – because the reality is that if somebody comes in and goes into the hospital, they either have or they don't have Medicaid at that time. We typically pay the claims with our clients. If all of a sudden we start saying to the hospital, oh, now you're going to have to wait for Medicaid payment it's not only going to be a delay but it's less, you start impacting your network's willingness to work with inmates.

So we're working with both states and the counties that we work with to figure out a way that we could go ahead and pay the claim and then recoup those monies from Medicaid so that it's invisible, basically, to the provider, and to say to the County, it can recoup at least the Medicaid portion of that payment. In the Medicaid expansion, mainly adults without dependent children, the feds are going to be paying 100 percent of that category. So most people looking at this are trying to drive everybody possible into that category, which, as you've said, most people coming out of jails and prisons who don't otherwise qualify or have private insurance, a DUI person may have private insurance, for instance, that we'll be able to access that Medicaid.

The other way that we're talking about with our clients besides just recouping a lot of inpatient dollars is in re-entry services with people coming out and how can you start to – and you can do this much more easily at the state level but you guys have a lot of services for your inmates to help them readjust in the community. What we're talking about with our clients is how to wrap that Medicaid eligibility and that access to Medicaid services around some of the other re-entry services of housing and education and employment. So that as they get re-established in the community after they come out that they have those connections and are less likely to reoffend and end up back in jail.

So there's a lot going on and I think that both by recouping the inpatient dollars and by long-term impacting your recidivism rates I think there will be a lot of help coming with this change.

MR. MURPHY: As January 1st approaches there's no question there's still a lot of gray area in regards to the Affordable Care Act. There's a lot that none of us here on the panel knows yet – a lot of gray. Everything that's been said is true. There's some good to the Affordable Care Act. It's going to save the taxpayer money for outside care for those that are enrolled in Medicaid. There's also some costs to the bureaucracy and more resources of the County in terms of enrolling inmates and billing claims and utilization management. But as all this evolves there's no question that all of us on the panel are watching this closely because it affects our business. But there's a lot of gray area, a lot of unknown. But it will drive resources, drive bureaucracy resources to the County and all of us.

MR. DONAHUE: I would just have to leave that at what was said here at the table a minute ago. Three things you heard was establishing that eligibility, the billing itself, and then having that re-entry capability for later. It's established while they're in custody. When they leave they have that continuity of care throughout the community so you have a start. So rather than reiterate everything that's already been said I think some good points have been made on that.

CHAIR HOLIAN: Commissioner Stefanics.

COMMISSIONER STEFANICS: Thank you, Madam Chair. The National Association of Counties has been working at the federal level to allow inmates to have Medicaid coverage while in, and there's been a great deal of resistance because of sequestration, etc. But the way Obamacare does read, or the ACA is that for the first 30 days they could be eligible. And so my question is have any of your companies jumped into the federal fray about this since you represent different states?

MR. ARCHAMBEAU: What I've seen, and it varies state by state – Oregon, for instance, just passed a law that set pre-sentencing, including for a misdemeanor, that insurance, including Medicaid – well, they've said private insurance but they're going to take the battle to Medicaid, still has to cover before somebody has been sentenced for a crime. That's I think the big move that we're seeing around the country, is I think once somebody is convicted and resides inside the correctional facility that's going to be a tough fight. But the notion that somebody prior to being convicted of a crime should not have their insurance, including Medicaid apply, I think is one that's very much worth fighting.

MS. FREEMAN: I can respond a little bit. The state of Oklahoma is different. As he indicated, different states, different things. In the state of Oklahoma Medicaid is available to those who qualify, but only in certain categories. They need to be pregnant or the need to be disabled, blind. There's certain groups. But the also have other statutes that tend to reverse that because they have a statute on pre-existing conditions. So hopefully, someone who is pregnant was pregnant prior to coming to the facility. So they have corresponding things. It has been difficult to actually obtain some of those funds.

Now the insurance, they also have a statute that allows for insurance reimbursement for those persons with certain categories prior to adjudication of guilt and the changes that are going to take place in 2014 also includes some of those pieces.

COMMISSIONER ANAYA: Madam Chair.

CHAIR HOLIAN: Yes, Commissioner Anaya.

COMMISSIONER ANAYA: Just based on the responses and even the question Commissioner Stefanics asked, I break it out in my head into two categories, the

administrative function and the operational function of dealing with healthcare. And so as it gets more complex, as we all know it will and it does get complex, talk specifically about your systems associated with case management, associated with data collection and maintenance. You made a comment about linkage. I think a lot of times the first reaction is what do we do to cut costs or save money but the reality is that the whole piece of work that creates efficiency, not any one function. I know as it gets more complex on the administrative/billing/tracking side that there's going to have to be solid systems, whether we stay with what we're doing as a County now or not. So speak to that. Speak to what you have and how you feed off of one another or areas understanding there's differences between state, all under the same auspices of we're talking about Obamacare right now.

MR. DONAHUE: I can start out. I think from NaphCare, and what I've seen in my past experience is the electronic healthcare records system. You have to have it. NaphCare has a system called TechCare which has that ability to track medications. It has the ability to track how many mentally ill inmates you have in your custody, and the list goes on and on. The prime example I can give is going from a very large file room, top to bottom of files, hundreds of thousands of files that I had to deal with as a jail administrator, go down to using a single computer when NaphCare came in. I think that's going to be the future with the connection to Medicaid. I think you have to have that linkage, as you said, Commissioner, to have that ability to pass on, and not only for your own agency at a County level but be able to pass that on at a state level as they go on to the prisons.

So I think the electronic healthcare system is the wave of the future and I totally agree with you, Commissioner, that that has to be in place to be in successful in something that we're going to be faced with with the Obamacare.

COMMISSIONER ANAYA: Do you have that in place?

MR. DONAHUE: Yes, we do.

COMMISSIONER ANAYA: In all your facilities?

MR. DONAHUE: Yes, actually NaphCare uses it across the board.

COMMISSIONER ANAYA: That's a state system across all systems.

MR. MURPHY: With CHC, we're in 29 states including eight counties in New Mexico and with that you have a corporate partner backing, Santa Fe County would have, and with that comes – you achieve a professional [inaudible], building, collecting records and operations and systems. Onsite of course, as you discussed earlier, you have a leader/manager in your health services administrator, who oversees the health records. Electronic medical records is a key aspect to the Affordable Care Act. We also have an electronic medical record system ourselves called Vision. But with us the County does not have to purchase Vision. You can purchase it off the shelf if you like as well. We're willing to work with that. But it's about compiling an efficient system onsite and keeping those records onsite. A team of professionals, starting with your health services administrator, through the contract manager at operations, it's efficiency that's important.

MR. ARCHAMBEAU: Commissioner Anaya, can I ask for clarification? Was your question about how will we coordinate specific to Medicaid?

COMMISSIONER ANAYA: Medicaid or overall records management and collection of data and implementation, maintenance of data, which is especially – I hear you speak about recidivism. We know recidivism is a reality and we get a revolving door. It's

when you begin to intervene and keep people in a CHP, a community healthcare provider and begin to integrate other services outside the facility that you start to see the change.

MR. ARCHAMBEAU: Yes, we've been struggling with that and I don't think all the answers are in place yet. But one of the things that we've been most concerned about in terms of additional coordination, specific to Medicaid and the Obamacare expansion, has to do with the potential loss of data. What happens right now is with all of our clients we pay the claims and we use that claims data to generate lots of reports for [inaudible] for clients, to look at how the system is performing, to look at where costs are out of control, that are within expected limits, etc.

There's two solutions that we've been looking at, because if Medicaid starts to pay the inpatient bills, for instance, that data then falls out of our system and then we start to have these very big holes where you're spending a lot of money. So two of the solution – and they're two different solutions, depending on where we're looking at them. One is to go ahead, as I mentioned earlier, to pay claims first so we'll still have that claims data and can still continue so we've got seamless data. And then recoup the money from Medicaid as sort of a backend reconciliation.

The other way that we're talking about doing this – this would happen to be in the state of Oregon, is to have Medicaid go ahead and pay those bills, but then they send us a claims file so that we can sort of fill that hole in our data to be able to generate those reports without having major holes in it. Because once you have big chunks of missing data then you start to invalidate all your reports and it gets very difficult to know how you are doing. We're very data-driven. That's sort of our origins. We were also started by primary care docs who built our infrastructure to support them in their private practices. We sort of adapted that in correctional medicine, looking at the jail as a primary care provider. But it really is about managing that whole network. So we're very concerned. We'd love to be able to offset some of the expenses of clients but then we don't have a cost being that now we're flying blind because we have major holes in our data. So that's sort of where we're looking. We're also having to figure out how do you interface with the systems at the various Medicaid programs that different states are building, to also make services better coordinated and more seamless, regardless of correctional medicine and how do we then interface with that? How do we get inmates coming out of a jail or prison sort of ready to take advantage of the resources that are being built in the community for people that sort of have a criminal background, quite frankly.

So there are a lot of interfaces that are having to be built. I still think it's going to be a net plus, but you're right. Some of these changes are creating some new challenges that require coordination between state and local agencies that we haven't had to deal with before.

COMMISSIONER ANAYA: Mr. Sedillo, what are we doing?

MR. SEDILLO: Well Madam Chair, Commissioner Anaya, currently we are putting in our budget for electronic healthcare records, so we are going to be keeping that. Right now we have a CQI team that gathers all the medical data through our medical department and that's what we do right currently.

COMMISSIONER ANAYA: CQI?

MR. SEDILLO: I'm sorry. CQI is continuous quality improvement plan.

CHAIR HOLIAN: Commissioner Stefanics.

COMMISSIONER STEFANICS: So this is follow-up, but the question is, I'm sure you've gone into facilities where you've wanted to do electronic health records and there were thousands of past records. And some of those past records are for current prisoners and inmates. So what have you done – have you tackled any of these past records in any of your work? Because we've talked about this, of going to electronic health records but the whole idea is to get the past, to scan in, to have some continuity with the client and to keep working.

MS. FREEMAN: We have experience with that at one of our facilities, a 2,500-bed facility. We started to – we do not have an electronic healthcare record at Armor. We have relationships with two very popular companies out there. This way you keep your records. If for some reason you choose to send us away we don't walk away with the electronic medical records. It's yours to keep, so I think that's a plus. But we had a 2,500-bed facility in February of 2011 that we needed to convert to electronic medical records. NCCHC requires that you have three years of medical records onsite. Okay? So this is what we chose to do. First of all, we made sure we had three years of medical records onsite. We put the medical records of all of those inmates that were currently in the facility and scanned them into the existing electronic records and then we proceeded to – all the new inmates coming in created new records. We still had access to existing paper records, but that made the most sense to us and it worked for us in that one facility.

MR. MURPHY: We also have experience in scanning records and going from paper files to EMR systems, electronic medical systems. This is where our partnership and our implementation strategies have got to be in sync with each other. We're in communication with the County,[inaudible] We've got to establish what it is you want. We have a 100-bed jail in Texas today where we're scanning back five years of history in to EMR and it's something that the jail administration wanted us to do so we're doing it. It's part of our partnership. So again, as part of our implementation plan for today and going forward and looking backwards as well, we have to negotiate and decide together.

But we have no problem; we're doing it today. We have no problem going back three to five years and scanning each of those files because it's what we do.

MR. ARCHAMBEAU: I've seen different strategies, and this is certainly one of them, to scan old records, but there's a cost to that. There's an FTE cost to that, depending on how many records you've got, how much you're trying to scan in. Are you scanning in everything? Are you scanning in labs? Are you scanning in just critical summaries? Those are all sort of tactical decisions that you've got to make. But the more you scan in the more you've got an FTE cost for everything from one to maybe three years even as you scan that stuff in. It all depends on how you go at it.

What I've seen other people do to is that they will basically start clean with a new electronic record as people come in and a lot of time it's driven by space. If you have space for the other paper records that may have an effect – relatively little cost. You've still got to file and pull old charts but it's another strategy. I think you just have to look at the cost of going either way. I think what a lot of clinicians that I talk to would say too is that how far back are you really going to look? Are you really going to look back at a medical record from five years ago? Probably not. Probably not. You're really going to be – it's going to be six months to a year and beyond that you're probably going to want to repeat tests or re-examine the patient.

COMMISSIONER STEFANICS: Well, I want to give you an example. Well, a couple comments. One is that our hospital – we only have one hospital in the community. So our hospital has tried to work with other clinics around town to have the same electronic medical records so that they could speak to each other, number one. Number two, the length of time is questionable here, and I want to give you an example. One of my constituents has a severely mentally ill son and he has been in our jail at least five times, and the jail didn't even know he'd been there five times because his name was misspelled on the third or fourth time and so he didn't come up and being there five times. But all of those records over the past ten, fifteen years would have been relevant in terms of the medications he was taking, etc., etc.

Do when you get to substance abuse, when you get to mental illness, when you get to chronic illness, the length of time, the shortness, and those are the people we're seeing come back in terms of the cycle. So I just wanted to bring out those two points about integration and speaking with our hospital records. UNM is a whole – UNM Hospital treats some of our clients but that's on a different basis. And they have their own medical records system which is different from Christus St. Vincent's.

MR. ARCHAMBEAU: Do you know what system they use, by any chance?

COMMISSIONER STEFANICS: No.

MR. DONAHUE: Commissioner, I go back to the comment you made on to how long? You never know when that litigation is going to come, and that helps. It's such a great deal when you can go in and query, and then [inaudible] file and have that electronically right before you. NaphCare currently, besides Clark County Detention Center in Las Vegas is implementing TechCare in Orange County, California as well as Maricopa County in Arizona. It's not up and running yet. It's in the process of being rolled out but they too agree that having that at a touch of a button, whether it's how much psychotropic medication you're administering a day from the operations aspect for a jail administrator or the doctor on scene, you have that right before you. So I can't stress enough the importance of having that electronic health care system.

CHAIR HOLIAN: Other questions? Yes, Commissioner Anaya.

COMMISSIONER ANAYA: Madam Chair, I don't know if we're going to – if I get in trouble with you, Bill, just crack the whip. But one of the things that comes up when we have these discussions that we hear in the hallways is associated with staffing. People start saying, oh, my gosh. I'm going to lose my PERA benefits or my County benefits, and so I'm going to ask you a question about at what level of latitude does your company provide proposals to and is there a baseline? Is it as far as what you would consider to do in a facility? Is it all or none associated with medical management? Is it partial? Talk about that a little and keep in mind what I said about concerns that we hear as Commissioners as staffing that are saying, well, you know, we'll lose our benefits and what's the balance? And here's my – it's not a leading question, it's a pointed question. My concern associated with the amount of paperwork it takes to track medical claims outside of a correctional facility, much less the additional requirements inside a correctional facility. The data management, the collections and the use and the access of that data is paramount, regardless of who does it. So speak to what your companies do in other places and how a hybrid approach has worked or poses challenges. Talk a little bit about that. Because I think for me, that gets to the crux of

part of the discussion that we're having today and issues related to are we prepared to be able to access medical data? Are we prepared to be able to access federal, state and other local funding? Are we making the appropriate linkages that we need to? Do we have all the right tools to even do it? So any of you or all of you, I'd like to hear your response on that.

MR. MURPHY: If I could, as I said earlier, we're in 29 states including eight facilities – nine agencies, eight county facilities in New Mexico, including New Mexico Military Institute. So I'd like to focus on New Mexico for a second. In New Mexico, in the past we have pieced out our services. In Otero County today we provide physician services only. Eddy County, New Mexico we provide –

COMMISSIONER ANAYA: What was the services?

MR. MURPHY: Otero is physician services only.

COMMISSIONER ANAYA: Just the doctor.

MR. MURPHY: Just the doctor. In Eddy County, New Mexico, we provide mental health/psychiatric services only. Sandoval, New Mexico, a year and a half ago we started out with mental health services only and now we're comprehensive.

Sandoval County always wanted – to use them as an example – always their end goal was always to go full comprehensive, because they didn't want to piecemeal, they didn't want to leave anything out and they also understood the continuity of care and having a one-stop shop, having everything in-house, mental health, comprehensive healthcare offsite, onsite and indemnification and liability.

So with that said, it's certainly our hope that we go comprehensive, one because our programs are correctional base standards. We can indemnify the County 100 percent if it's our employees, our programs, our policies and procedures written under you. But yes, we can piece that out. But we hope to do a comprehensive eventually.

CHAIR HOLIAN: Anybody else?

MS. FREEMAN: Yes. I thought I heard two questions, one about benefits for employees and one about managing claims and information regarding claims.

COMMISSIONER ANAYA: Yes, let me just clarify. We have a system that has a pretty good retirements benefits package at Santa Fe County. We've been pretty good to our employees, so many of them, probably all of them probably wouldn't want to lose access to that. So what I'm asking is do you do hybrid approaches where you have County employees that stay County employees or state employees and then other functions like what the gentleman said related to physicians or partial services?

MS. FREEMAN: We do have hybrids currently in the state of Wisconsin. We have a contract where the employees there remain county employees, so we work arrangements with those employees. We do have a 401-k plan. I don't know how it works with your retirement plan. We do have certain policies in place. I'm not really strong on the HRPs but when we come in, if you have an employee who's been with you for five years we adopt that person as having been with us for five years, so they're not starting over. So there are some considerations for the change from one employer to the other and the concerns they have about losing some benefits.

When it comes to managing claims, we, at the corporate level and at many of our site levels, depending on the hospitals we have relationships with. For example, in Hillsboro County, Florida, we have electronic medical arrangements with the medical director – goes

onto the electronic medical record of the person that's in the hospital today and reviews what the physician there is doing for three hospitals. And it's also done by our utilization management folks at the corporate level. Our goal is to get those people the best care but to get them back to the facility as soon as possible.

I would like to go back to the concept of recidivism and connections and linkages to the community. A lot of our sites, we encourage the implementation of a discharge planner. Hillsboro County, Florida won the program of the year from NCCHC for its discharge planning program. We find that that helps with reduction of recidivism, they work with community agencies, they work with the sheriff's office who also has someone who's working within the community, and they meet frequently to talk about specific patients. We all have those that are the most difficult to handle and to relocated.

CHAIR HOLIAN: I'd like to follow up on that just a little bit. Do you have any actual data on that as to how effective that program is?

MS. FREEMAN: Yes, I can provide that to you.

CHAIR HOLIAN: Okay. Great.

MR. ARCHAMBEAU: Commissioner Anaya, to get back to your question, we do it a number of different ways with our clients. In some cases we manage only the onsite care and not the offsite care. Others, we manage only the offsite care and not the onsite care. And then we have comprehensive contracts. I think the question to me is what do you need a vendor like us to do? I think, or we think our claim to fame is in helping our clients know what's going on with their system, having good data to know what their utilization is, where it's out of control, where it's working fine, and to make sure that you've got a legally defensible community standard of care that you've been providing. That's what the courts say you have to do.

Just a brief reference back to the accreditation question, I don't think accreditation helps you in court if you made a bad decision on a particular case, and that's the inmate who goes on to sue you. I think you're going to look at how did you make your decisions in that particular case.

So I think that there's different ways to skin that cat. I think that what we feel we bring to the table is in helping know better how your system is doing and in putting the information in front of you about how, by bouncing individual clinical decisions up against national standards, like Milliman Care Guidelines is one that many people use; we also use. So you can go to court and say we did the care that was necessary; we didn't do the care that wasn't necessary. That's what we think we can do. Now, can you do that while the nursing staff in the clinic remain County employees? You can. You absolutely can and you do. The thing to keep in mind is what the primary drivers are and that is different by every single county.

If a major concern for this County is, you suggest, maybe taking good care of County employees that have put a lot of years in and think they have a promise with the County about what their pension is going to be, for instance, then that's fine. What you may give up is in the ability to make changes a little more quickly. I think that's the advantage. When you sit in a chair like ours, that's where a comprehensive contract looks more attractive because you control both sides of the equation. But you can work with it either way. I think it's just a

matter of what the individual desires are for that particular county, that particular correctional facility.

MR. DONAHUE: And I would just add to that too, what's already been said, NaphCare does offer a hybrid approach to those kinds of services and some of them not mentioned were dialysis, for instance. We do have several clients that have just services for dialysis. Offsite management, bill management, bill payment, x-ray and the list goes on. So there is that hybrid approach with our company also.

MS. FREEMAN: I would like to say one thing. Armor likes to keep its clients very informed, and it provides its clients with a monthly reporting process that we're very proud of. We do monthly projections on both pharmacy and offsite care and we will show you what we have been billed and what we pay so that you understand what work we are doing on your behalf, what we have negotiated, either through contract or through – if you have an exceptionally expensive case we'll go in, we'll negotiate something outside the contractual arrangement that we already have in place with that offsite facility. We're working all the time and you'll get that report the 15th of the month. It has graphs. It has projections and it gives you information by inmate name so that you can explore and learn what is happening at your family.

We had a facility recently increase its ADP – average daily population – by a significant amount and they couldn't understand why their pharmacy cap was going up and why their offsite was going up and we were able to show them specifically by inmate and by quantity of inmates, when they went up 500 ADP, they picked up – they doubled their HIV population, what it cost them and also there were some dialysis patients in that mix. So their finance director learned a lot from our folks who met with them every month and explained some of those reports.

So we're very transparent with all of that. We have a claims department. It's an independent department that processes all our claims for us and we have some really great negotiators. As I said earlier, we have gone in after other providers and have reduced utilization management by hundreds of thousands of dollars and in some cases, millions. So right behind somebody else is in the same business. So we do manage claims. We do work electronically with hospitals and we do report to you regularly.

CHAIR HOLIAN: Any other questions? Yes, Commissioner Stefanics.

COMMISSIONER STEFANICS: Thank you, Madam Chair. Many of you alluded to employing local people in the positions. What happens when there's medical/health staff shortages in the area? What do you do next? And I'm predicting that's correct for us.

MR. MURPHY: If I could start with that. It's important to have a culture. Our company, CHC has a culture, a culture where the employees work altogether, they enjoy where they work and we compensate them fairly. We have great benefits. We're a place that lots of medical professionals want to work. We haven't really had a hard time recruiting over our 20-year period.

COMMISSIONER STEFANICS: But let me just point out that New Mexico has a staffing shortage in healthcare professions. So it's not just about Corrections. We have a staffing shortage around the entire state. So this could be a reality that you would face, regardless of how much you paid. We have been struggling here to get a nurse practitioner for

our mobile health van. So it's not just Corrections. It's everywhere in New Mexico. What would you do next?

MR. MURPHY: With that, if I could continue, we have to be innovative. We have to be creative. For example, Eddy County, New Mexico, we had a hard time recruiting a psychiatrist there, so we used telepsychiatry. That's where we can have a psychiatrist/psychologist in Albuquerque, say, and treat [inaudible] if need be. And we just have to – again, we just have to work hard at that. That's what we do. In my opinion, that's why you'd want us because we are the recruiters; it's our business. We're able to tap into the communities to see how many licensed RN, psychiatrists, providers, LVNs are in the community. And we test them.

We've also gone to nursing schools and trade marts and recruited there. It's part of what we do.

CHAIR HOLIAN: Ms. Freeman, did you have a comment?

MS. FREEMAN: Yes. Of course it's ideal if you can hire locally. But we've had similar experiences in Oklahoma. There are only 136 board-certified psychiatrists in the entire state of Oklahoma. They ranked – or did rank 48th in the nation when it comes to mental health treatment. The particular facility was under the watchful eye of the Department of Justice for years prior to us coming there. They would not permit telepsychiatry in that facility as the primary source, and we had to become extremely creative. We're very proud to tell you that we had for several months a full-time psychiatrist. For a year, a psychiatric mid-level in that facility because we created an environment with the health services administrator, medical director and the director of nursing that is one that they want to go to every day.

We had similar problems with a medical director there. I can tell you I personally interviewed 48 physicians to hire before I could hire a medical director. And we had an emergency room doctor who had been done with emergency room medicine after 32 years, and he came to us. And after about a month he said, you know, I had a knot in my stomach for the last two years and now I just love it here. So he has provided great leadership and the team has really pulled together. It takes a lot of work.

We have several recruiters on staff that we use that work really tirelessly for us in our most difficult sites. So I know what it's like to go to a recruiting firm and they'll tell you, oh, yeah, everything's – we'll call you. And you'll hear from them a year later, did you hire that doc yet? We have in-house recruiters that are dedicated to Armor and to the services we provide and they do a great job.

MR. DONAHUE: I would have to agree with those comments. It is a challenge, but it's a challenge that has to be brought to the table. You have to make sure that you have a robust recruiting plan. Not only the local area, you've got to get on your website, your company website and have those recruiters in place, being able to monitor those inquiries to your company and be able to retain them afterwards. You want that retention. So I do think it's a huge challenge, especially for a state like New Mexico, but if you would attack that innovatively you'll meet the challenge.

MR. ARCHAMBEAU: Commissioner Stefanics, the creativity I hear is a lot about the providers, the physicians, the psychiatrists, maybe the mid-levels although they can be rare as hens' teeth as well. Nursing is where the crux of the matter is I think in correctional

medicine. There's very little way around having that nurse onsite. You can't do telemedicine with nursing. They've got to be there. And it's a challenge for all of us. We all face that. I think it's something that you have to approach with your eyes open. Like everybody said. We all face this challenge. We actually use a staffing partner who's national who does a lot of that recruiting for us because we're frankly not big enough to have somebody in every state.

So it's something that you attend to, but realistically, I think when these changeovers happen – I haven't seen it happen yet, where some of the incumbent staff decide that it's time that they had to leave. For any number of reasons. It's age, it's they don't want to lose their pension so they bump somebody in another department in the County or any number of things. But I think you have to step into this with open eyes and make sure that your vendor – that you know that some of that's going to happen at changeover and contract and that you've got a solid plan for how you're going to go after it. We've certainly put some of our own staff on plans to actually work shifts in a jail as you get through that initial implementation process. It's a hardship for their families but it's something that they do and it's an opportunity for us to train the new people coming in. But it's – I would certainly not want to gloss it over; it's a big challenge when you do these things.

CHAIR HOLIAN: Any other questions?

COMMISSIONER ANAYA: Madam Chair.

CHAIR HOLIAN: Yes, Commissioner Anaya.

COMMISSIONER ANAYA: Madam Chair, I want to make a comment on the record and I want to invite any and all of you to continue to provide us whatever follow-up information, go back to some of the minutes and provide us whatever follow-up information that you might want to that might help us better understand what you do and better understand how you potentially could support or help us. And I want to ask the County staff to provide whatever information that is public to these individuals to better understand what we do fundamentally.

We have people from our Health Planning Commission sitting behind you. We have people from our Jail Advisory Committee. I want to welcome all them and thank them for coming. We have our staff here. And I want to say on the record, you made comments, all of you about accreditation and standard of care and I think all of us want to have a high standard of care. You would in your businesses, wherever you serve and us within Santa Fe County. Ms. Miller and Mr. Sedillo, I think – I really want to put on the record that it's up to us as a County Commission and the staff to define what that standard is that we're aspiring to get to, and utilizing the tools that we have from our Jail Advisory Committee and our Health Planning Commission and our community, frankly, to set that standard, whatever it is, and then determine, based on the tools available to us if it's us that needs to accommodate all those aspects to get to or what other partners we might think about engaging to get there.

Frankly, I don't think it's a one size fits all in anything we do in government. I always think there may be ways to partner and figure out what's the hybrid that doesn't scare employees out of benefits that they've worked hard to attain, or what's the hybrid that doesn't put us in a legal predicament where we're not able to have a model that's defensible and that meets the letter of the many requirements that we all have. So that's kind of my follow-up. I have a few other questions that I thought about that are important to me as I think about others and their experience. The connection to the medical field and connection to New

Mexico is important to me and how you might take on that linkage and how you might engage in that discussion or work in New Mexico if you haven't been here. If there's some of you that aren't in New Mexico. More specifics on how to hybrid public-private relationships work in some of the other facilities and maybe just specifics on exactly what's the breakout. Is it just a physician? Is it a hybrid of physicians and nurses? What is the level and specificity of each of those examples?

What other systems, tools, protocols, does your agency use to manage care for the patients and maintain the administrative efficiencies under the auspices of trying to keep our costs efficient and manageable. Our correctional facility eats our lunch and it eats every single county institution's lunch in the state of New Mexico. I know for a fact because Commissioner Stefanics and I sit on the board at the Association of Counties and have discussions as does our staff, our director and others with counties all over and we're continually trying to figure out how do we provide that high standard of care but how do we also not break the bank and take away from any other functions that we're legally bound to do.

So those are some additional thoughts that I would have that I wanted to put on the record. But overall, I thank the chair and the Commissioners and staff and you for coming because I think it's this type of dialogue that might help us improve our outlook as we progress.

CHAIR HOLIAN: Thank you, Commissioner. Any further questions?

COMMISSIONER STEFANICS: Yes. Thank you, Madam Chair. I'd like to know if any of you have been in our County jail, either adult or juvenile facilities. And secondly, you were asked, and some of you alluded to it about when you've gone into facilities, what kind of cost savings you've been involved in. But think about our size. I'm not interested in a very large size; I'm interested in our size and what you might have done comparable. So how many of you have been in our facilities and what kind of savings have you had in other comparables?

MR. MURPHY: It's been roughly three, 3 ½ years since I've been in your facility. The example I could give is for Starr County, Texas. It's a 600-bed facility, 680 average daily population. They came out with CHC on New Year's Eve about three years ago. It was a nine-day implementation startup and they estimated previous us to us [inaudible] losses. They had some high costs and high transports. In year one of our partnership we reduced transports by 52 percent and we have letters from the sheriff in Starr County that testifies to that. We saved them $200,000 on day one going from a pharmacy provider to us, going to a one-stop shop. We managed the protocols, we managed the policies and procedure protocols and pharmacology practices.

So I think that's a good example. We've done that for the last 20 years. We're in 29 states and being in New Mexico today, in [inaudible], it's about limiting your liability, reducing your costs and reducing your headaches, being a one-stop shop, if possible. But yes, we have done that. That's one example and the way we've done that is through our policies, procedures, protocols are written to maximize our services onsite to keep the transports down. Every time you transport an inmate out you have two officers on that and it costs the County money. You have your hard costs and your soft costs. It's taxpayer expenditure. If we can reduce that that's the goal.

We reduce costs through our partnerships with dental, lab, x-ray, waste and pharmaceutical companies, because again, as large as we are and we've been doing this for 20 years, corrections is all we do. Our correctional based partnerships with those companies and our bulk volume discounts are going to save us money, because again, this is a partnership. And again, just having leaders onsite, having an HSA who's a leader who can manage those offsite transports and keep those who don't need to go offsite in-house. Having a provider who shares the same philosophy. That's what's going to save us and our partnership money. Yes, we have done it before.

CHAIR HOLIAN: Does anybody else want to chime in?

MS. FREEMAN: Sure. I have not been to your facility. I'd love to see it. It would probably generate a lot more discussion for me. But I do have a facility that's about the same size as yours. We have several large facilities that we quoted in the document that we sent to you. But Santa Rosa County, Florida – I'm thinking it's like a 600-bed facility, we went in there in February of 2010 and we reduced offsite and pharmacy utilization by 57 percent, and that translated to a savings of $1.7 million. And that's verifiable.

There are other ways to save money and liability. We haven't talked a whole lot about indemnification but Armor would indemnify you from any legal liability. We haven't talked a whole lot about pharmacy. We have a great pharmacy director who goes to each site. She doesn't sit out at the corporate office and sent out a bunch of paper. She goes to each site, she analyzes the nature of the population. Certain populations you would want to have a stock pharmacy. Certain populations you would want to have a patient-specific pharmacy. She's implemented things like spacers for inhalers and has negotiated with some pharmaceutical companies to get scholarship funding for those $3,500 a month kind of medications. So she's really very – she's served on some of our state board pharmacy – board of directors of pharmacy. She speaks at most of our national conferences. She'll be speaking in July, just exactly that, July 20th at NCCHC on how to reduce pharmacy costs and utilization.

So pharmacy – I always say this. There are three areas on a financial sheet that we have to worry about. One is the pharmacy. The other is salaries, okay? And then there's offsite utilization. And so we work very hard to manage all three of those on your behalf.

MR. DONAHUE: I'll just be brief on that. I'm actually pretty much in agreement on the pharmacy costs. The transport is huge. And I think what you have to do is you have to look at a company that's going to match the model to the operation. You want to make sure, whether you're a mega-jail or a 500- or 600-bed jail. You want to come in and take a look at the operation and adapt that model to it.

My brief experience with NaphCare alone right now, I can't allow for a lot as far as the other clients that we have, but I go back to the Clark County Detention Center. One of the huge problems we had in Las Vegas was dialysis. The number of inmates that were on dialysis, and not enough clinics to be able to handle that. NaphCare came in and put two dialysis chairs in the Clark County Detention Center at their cost. They saw the need. They saw the savings that there would be for us and them and did that. So that's why I say you have to adapt the model to the operation.

MR. ARCHAMBEAU: I'd say similar things. I think we all bring similar tools to the table. I think the risk areas for both cost and liability are pretty straightforward everywhere. I don't know where we could save you money. I think without looking at your

data, looking at your utilization. I think one of our jails – we looked at how often they were referring to ERs and it was way through the roof. They weren't aware of it. We helped them look at how they could train their nurses to handle some things in-house and be not quite so ready to send people out.

Another jail was paying claims for emergency room visits if they matched up the bill from the ER to their jail management system and saw, yes, that was one of our prisoners, they would pay the claim. What we figured out was how to capture the time of booking, so that if the time of booking came after the time of the ER visit we didn't pay. We denied the claim. If it came after the time of booking we paid the claim and it saved them a ton of money.

I've also been in jails where they've managed it so well I've said, you guys are doing a great job. You would not save money hiring us or anybody. It really depends. It's about knowing the data. Without knowing what your utilization is it's kind of hard to know what those areas are.

CHAIR HOLIAN: Okay. Ms. Miller, our County Manager has a question.

MS. MILLER: Actually, Jeff, you just hit on it a little bit. I think that Santa Fe County has a well run facility under the director and the warden, and what we've done over the last few years in particular at training and staffing up. But there are areas that we do contract out, and I wondered if – well, for instance right now we currently contract out our pharmacy, but these aren't for one group. We have separate contracts. Our doctors group, medical director. We have contracted out the dentist before. I think we currently have an in-house dentist. I also think, our mental health we have contracted out before but currently we're doing it in-house.

But I wondered if any of you come in and do – as you know, we have to do RFPs for any of those services. Do you come in and do an assessment of what could be contracted out as a group. I know you're in the job of trying to get business for your company, but looking at what we do well and saying that would work to stay just as you have it, but we could complement those services in these areas as a whole contract. For instance in all those three or four areas that we do contract out in addition to electronic medical records. I think that's an area, we went to move in that direction. Can you come in and do assessments like that? Because I think for us to do a proper RFP for things that we might need assistance with or that we currently contract out, having an external entity come in and look at – well, those things you should keep doing yourselves. We don't think that that's something that we can improve upon, but these are things that we see weaknesses and we think you can improve upon. Because what I'd hate to see the County do is take something that we currently do in-house, contract out for it and it not be better. And I'm not talking just cost; I mean better service.

And then, can you integrate in-house and external contracts better? Or do you have too many issues with separation of liability and just a constant desire to do it all as a one-stop shop?

MS. FREEMAN: We do it all the time. What we do is we – that's exactly what you want to do is open a dialogue with the client, in your case with the client and find out what it is that's working for you, what it is that isn't working for you. We do have a number of our sites, we'll use onsite dialysis. They'll come in, they bring all their equipment, they provide all the services, a nephrologist – everything. But we coordinate services with

them. We have onsite ultrasound, onsite x-ray. Some of our contracts it works so many hours per week, some of our contracts we have somebody sitting there every day of the week. So there is no offsite, there is no problem with getting stat x-ray. We do contract our pharmacy, but we have excellent contractual relationships with our pharmacy contracts. We don't stay with just one pharmacy because competition is good. So we work with several, and we're always shopping to have new business with others.

So we do a combination of employees and contracted workers at our facilities. They seem to go very well and we're not worried; we never run into any problems with liability that I'm aware of.

MR. MURPHY: As you recall I've been working with Santa Fe County for several years. I've been working in New Mexico for 11 years, seven years with CHC and we've had several – a couple of meetings where we tried to come in and do an assessment and understand the costs in the programs that you're currently doing. Where it's maybe falling short, where you may need some help, and ways we can help you. I would very much like to come back in and do a walk-through of the facility with an operations person and understand – look at your costs. Your pharmacy costs, your offsite costs, your staffing costs. What are you paying an RN? What are you paying an LVN? There are several questions that I would need an answer to in order to understand what your program looks like. To look at your costs we can compare those with other costs of like-sized facilities to see where you're at. But an assessment would be a great idea. And in doing that we would come in, and again, as part of our partnership. Again, I'll give several examples as to how we don't have to come in and be a one-stop shop. We can piece it out. We're doing it today and we can do it tomorrow.

I'm sure – I know there are some things you're doing fantastic. I'm sure there are things that you may want help with, such as liability, cost containment, utilization management, things that we can – I'd love to talk with you about it.

MR. DONAHUE: I'd have to agree with Mr. Murphy's comments. I think identifying those needs is what drives your RFP. What do you need, rather than buy something you don't need. So I would agree with his comments also.

MR. ARCHAMBEAU: We'd love to come down and talk with you about that. We're actually quite deliberately not a one-stop shop because – two reasons. One is you're trying to sell the whole package all the time, and secondly, I just don't see too many companies who are good at everything. And so we've made a pretty conscious decision to stick with what we do well and to have key partners for the parts that they do better than us, quite frankly. So it really isn't any big deal for us to not always do it comprehensively. That works fine.

I do think that some places do things very well, and everybody does some things well and not others. So I think that's a good conversation. I would absolutely agree that that's the best decision that you could make, is to make sure your RFP is driving what you think you need and what's the unique solution that works for you. And if our advice can be helpful in determining that we're happy to be part of that.

COMMISSIONER ANAYA: Madam Chair.

CHAIR HOLIAN: Yes, Commissioner Anaya.

COMMISSIONER ANAYA: Madam Chair, I appreciate the comments from the Manager and the feedback and just thinking out loud, I think the scoping of a proposal could have various phases that deal with what's necessary for each person that's going to propose to retain. So thoughts on general categories or specific category, probably better said, might help Mr. Taylor and Ms. Miller as we would scope something that would provide for an opportunity for a more detailed review of all the respondents, and then the clarity of what each respondent might propose in an actual proposal.

Going to Commissioner Stefanics' comment about having been there, I think that you responded to an RFI and you should be afforded the opportunity to walk through the facility now. The level of detail, I think, you wouldn't want to take yourself out of any potential RFP, so I think they should all be afforded the opportunity to go through the facility and then get some general feedback that we could pass through the Manager and staff to actually decide what might our potential proposal look like. But that would need to include a phase of recovery of assessment of information before they can respond. And I've heard this from others. So this is helping all of us. I just want you to know, because what we always struggle with is how do you engage in a dialogue without pre-empting the procurement process, and so this is kind of a hybrid way for us to do some exploratory work and maybe build a better RFP.

CHAIR HOLIAN: Okay. Thank you. Any final comments? Would you all maybe like to make a closing statement? It's getting close to noon.

MS. FREEMAN: I'll make it brief. I do have one question. Someone mentioned minutes. Would we be able to get copies of those minutes?

CHAIR HOLIAN: Yes. I believe so.

MS. FREEMAN: Great. I want to thank you all very much. This is a big step for you. I think you know a lot about your business and I'm sure that Armor would be able to help you in some way if you were to give us an opportunity, have a tour, come in provide some information. We'd love to do it. Thank you.

MR. MURPHY: Again, thank you so very much for having us here. I know this is a big step for the County. I commend the County for taking the step. I know it's scary. It is. It's different, scary, it's pushing outside the box, and again, New Mexico is – in New Mexico today, we've been here for seven years. [inaudible]. It's important to me; it's important to us and I very much look forward to the process. Thank you.

MR. DONAHUE: And again, I'll thank you myself. I know you're all very, very busy and to take the time out to address a serious situation like medical healthcare in a detention setting. I think NaphCare can help you with the whole ball of wax or just the piece of the onion, whatever you want to say, whatever you identify as the needs. So we'd be happy to help you.

MR. ARCHAMBEAU: And likewise, thank you all. This is – I go to a lot of jails and this is – I've never seen this process before, particularly having County Commissioners involved this early in the process and asking such great questions and being that involved. I've just never seen it. So it's pretty interesting and I thank you. I think it's going to be best for you in the long run. We'd love to be part of the process. I love being in Santa Fe. I'd love to come back down. It's a great reason and I've enjoyed the talk with you. Look forward to more conversation. Thank you.

CHAIR HOLIAN: Thank you all for being here and participating in this important conversation this morning and it's almost noon now and I hope you'll go have lunch at a very nice restaurant in Santa Fe.

Adjournment

Having completed the agenda and with no further business to come before this body, Chair Holian declared this meeting adjourned at 11:56 a.m.

Approved by:

Kathy Holian

Board of County Commissioners
Kathy Holian, Chair

ATTEST TO:
Geraldine Salazar by VT

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