CITIZENS HEALTH CARE WORKING GROUP

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Wednesday, June 8, 2005

9:30 a.m.

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Jackson Medical Mall
Suite 615 Committee Room
350 West Woodrow Wilson Drive
Jackson, Mississippi 39213

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APPEARANCES:

RANDALL L. JOHNSON, Chair
CATHERINE G. MCLAUGHLIN, Ph.D., Vice Chair
FRANK J. BAUMEISTER, Jr., M.D.
DOROTHY A. BAZOS, R.N.
MONTYE S. CONLAN
THERESE A. HUGHES, M.A.
AARON SHIRLEY, M.D.
DEBORAH R. STEHR

I-N-D-E-X

P R O C E E D I N G S

(9:30 a.m.)

HEARING: HEALTH CARE ACCESS

CHAIR JOHNSON: We would like to welcome you to this hearing here in Jackson. The Citizens' Health Care Working Group is an organization that came out of the Medicare Modernization Act and was formed to have a group of citizens from across the country come together to learn more about citizens in many states throughout -- in fact, as many states as possible throughout the United States.

We are in the process of conducting hearings, hearings in different regional areas. And we're just delighted to be here this morning to hear from you here in Jackson. It's our first regional hearing although we've conducted a hearing in Washington, D.C. We expect to go to two or three other locations.

But we're just delighted to be here and delighted for the hospitality that Dr. Aaron Shirley has shared with us and provided us as we've been here yesterday and today.

For those of you who are not familiar with our members, we'll just ask each of them to introduce themselves very briefly and talk about where they're coming from, their state, and just briefly what they do. And then we'll introduce each of our friends who will be testifying this morning.

But first, again, just a word of thanks to you, Aaron Shirley, for your hospitality here. We've had a great time. We are honored to be with you. Dr. Shirley is known not only in Mississippi, as most of you probably are aware, but throughout the United States and is a thought leader among many of us for his work and his influence in medical systems. So thank you again.

And for those who might not know who you are why don't you indicate. And then we'll go around the table.

DR. SHIRLEY: I'm Aaron Shirley, Director of Community Medical Services at the University of Mississippi Medical Center and Chairman of the Jackson Medical Mall Foundation.

MS. CONLAN: My name is Montye Conlan.

I'm here to represent the consumers. I am a Medicare and Medicaid beneficiary. And I come from the great state of Florida.

MS. STEHR: I'm Deb Stehr from Iowa. I'm kind of representing rural areas. I don't have health insurance. My husband and I are both self-employed and literally can't afford it. And we have a son who's 22 years old who has cerebral palsy and is in a wheelchair, so he depends on us as his full-time caregivers. And I'm a self-employed Medicaid provider. John hired me as his consumer representative. So nothing else.

CHAIR JOHNSON: Thank you.

Frank.

DR. BAUMEISTER: I'm Frank Baumeister, and I'm a physician. I'm a gastroenterologist in private practice in Portland, Oregon. I'm a clinical professor at Oregon Health Sciences University and the past president of the Oregon Medical Association. Nice to see you.

MS. BAZOS: I'm Dotty Bazos. I'm from New Hampshire. I'm the Director of Community

Development for the Community Health Institute in New Hampshire and a professor at Dartmouth.

MS. HUGHES: Therese Hughes. I represent clinics. I work for the Venice Family Clinic, which is the largest free clinic in the nation. And I come from Southern California.

I'm also a end stage renal disease patient, now transplanted. And while I was on dialysis, I -- my insurance company dropped me. So I come as well to represent uninsured.

The majority of the population at our clinic, over 77 percent, are working poor people who are uninsured with dual or tri-income families.

MR. GROB: I'm George Grob. I'm the Executive Director for the Citizens' Group.

VICE CHAIR MCLAUGHLIN: I'm Catherine McLaughlin. I'm a professor at the University of Michigan School of Public Health. I'm an economist, and for the last several years I've also been a Director of the Economic Research Initiative on the Uninsured.

CHAIR JOHNSON: And I'm Randy Johnson.

I come from Illinois. I work with Motorola but very interested in helping to improve the health care system, as are all of our Working Group members. So we're delighted, again to be here.

This morning we have Dan Jones, who is the Vice Chancellor for Health Affairs and the Dean of the School of Medicine at the University of Mississippi Medical Center.

We also have Roy Mitchell, who is the Director of Advocacy for the Sisters of Mercy Health System, and a Director of Mississippi Health Advocacy Program.

And finally, we have Dr. Herman Taylor, who is from the Mississippi Medical Center.

And we welcome all of you. We're looking forward to hearing from you each. And we encourage you to take approximately 10 to 12 minutes to have some introductory comments if you would. And then we'd like to ask -- be available -- be able to ask you some questions regarding your programs and so forth.

So why don't we introduce -- or why

don't we go ahead and ask you to speak in the order that you appear on our agenda.

And that would mean that Dr. Jones would be first.

DR. JONES: Good morning. Thank you for this opportunity. Thank you for coming to Mississippi. You've already acknowledged Dr. Shirley is an important member of this group. And we certainly are pleased to see him included and believe that he'll add a lot of value to your deliberations.

A lot of what I will say this morning will be laced with some passion. And I don't apologize for that. These are difficult issues that we are discussing. In my role as the Chief Executive of Mississippi's only academic health science center, a lot of the national problem of access to care comes to bear in the decisions and deliberations that I deal with every day.

This happens to be budget season for us. And so budget is on my mind. And so if I talk more about money than you think is healthy, forgive me

for that. But this is a money issue for our country and for our health system. It translates into reality in individual lives.

Much of this issue of access to care is in the heart and center of what I consider our country's biggest health problem, Mississippi's biggest health problem, and this community's biggest health problem. And that is the problem of health disparities.

We spend, as you well know, more than any other country per capita on health care. And yet we have more people in this country who have difficulty accessing that health care than any other industrialized country. And the poorer the state and the more rural the state, the worse the problem is and the closer we are to the center of the crisis that this country is facing in health care.

Health disparities focus in Mississippi. Our health disparities in this country are typically described around economics. We have a lot of poor people here. Described around geography, the Southeast is indeed the worst area in terms of

health and, sadly, race and ethnicity. And that certainly comes to bear in Mississippi with the highest percentage of African Americans of any state in the country.

We are interested in this in our own institution. I want you to know that we are focused on trying to bring solutions as we deal with the realities of the current problem as they exist.

One of those efforts is manifested in our recent designation of a Chair for the Study of Health Disparities named for Dr. Shirley. The funds for that chair come from a gift from the Jackson Medical Mall Foundation to our institution with encouragement from that group to help us to focus on health disparities.

Sitting to my left, Dr. Herman Taylor is the first holder of the Shirley Chair for the Study of Health Disparities.

And so we want you to know that we're interested in this. We're not just sitting back and complaining, but we're moving forward to try to help find solutions.

Our medical center serves as the safety net health system for this state. We're the only academic health center in this state. This state has only one medical school, one dental school, etcetera. And all of that is focused on our campus.

Our health system has served as the safety net system for the state for the 50 years that it has been in existence. It serves as the safety net system in two ways. As all academic health centers, it provides very high end technology that no one else can provide to the state. So if you need a bone marrow transplant in this state, our center is the only place where you can receive it, etcetera, etcetera.

We also have served as the safety net hospital for tertiary care and sometimes for primary care for those who can't receive care other places. And that has been an increasing burden financially on our system that I'll describe more.

Access to care is indeed a major part of the problem of health disparities. There are social issues unrelated to access to care. There are

probably some biological issues. Those are probably minor in our challenge of health disparities. But access is a major part of the problem of unequal access to care.

In this state, as in some other states and our nation as a whole, we literally have no plan for how to care for uninsured patients. I'll focus what I will say now on how we deal with uninsured.

If I could use the analogy of how we provide food for people in this country. If you are recognized as being poor enough, then you have food stamps and you can go through a grocery store and get food.

If you are marginally poor, then you do the best you can. You feed your family the best way that you can. This society does not expect the grocery store industry to provide free food for those that are just above the poverty level. It might be good if we did; I don't know.

But we have sadly expected our health system -- health care providers and clinics and health systems, large health systems -- to simply

open their doors without any plan for reimbursement to provide care for the uninsured.

We do have a plan for access for primary and preventive services through our federally qualified Community Health Centers. That works well in some areas. And is some areas it works less well. So there is some plan for that.

But once someone receives a diagnosis of coronary heart disease or congestive heart failure, cancer, and specialized care is needed, there's simply no plan in this state for how to provide the care for that.

So if we take an individual patient who has the misfortune of being self-employed without health insurance who has chest pain, he delays for awhile because he has no health insurance. Doesn't want to add to his families financial burdens by going to a clinic and having bills. And so he delays and delays.

And then finally the day comes that he goes to an emergency room because the chest pain is severe. He receives a cardiac catherization.

Receives a diagnosis of coronary artery disease. And he needs a stent. He needs a drug diluting stent. But the cath costs a lot of money. The drug diluting steint costs a lot of money. And someone pays for that.

And in our system in Mississippi -- in some states there is some plan for how to care for that uninsured patient who needs that very expensive procedure, but in this state there is simply no plan. And so it's left to some health -- typically in this state, it's some county hospital or non-profit institution.

And more and more it's referral to our institution for that care. Last year that care to uninsured cost the University of Mississippi Medical Center $73 million dollars. Let me put that in perspective: that's against a total budget in our health system of around $450 million dollars.

Now all of your are keenly aware that the plan that we have for providing that care is for that care to be provided off of the margin of health care. And the margins in places like ours used to

be two or three percent for non-state. For non-state affiliated, non-profit hospitals, it used to be of eight to 10 percent. And off of those margins by overcharging the insured, there was the ability to provide care for the uninsured.

In the last five years, that bill for the care of uninsured in our health system has moved from the 20 millions to the 30 millions to the low 40 millions two years ago. And last year 73 million. We skipped the 50s and the 60s and went right to the 70s.

In that same year, we lost -- because of federal change in policy -- we lost $23,000,000 in the upper payment limit program. And in that same year intragovernmental transfer in the Medicaid program, we lost $18,000,000 in the difference in what our state appropriated to us for an intragovernmental transfer and what we actually received back for Medicaid for the care of those patients.

During that same period of time, we lost roughly $15,000,000 in recurring state support in

our operational budget. Put all that together, we've lost the ability to take care of uninsured patients off of our margins. We simply can't continue to do it.

We'll end our fiscal year this fiscal year -- at the end of this month. I anticipate a loss somewhere in the range of 30 to 35 million dollars in our health system this year. This is a health system that two years ago had a small margin in the range of a half percent to one percent. And we were able to provide a large amount of uninsured care.

We have begun the process to put into place policy, some of which will be healthy, and some of which will be unhealthy, to try to bring financial stability to our safety net hospital so that we will be able to continue to provide care for those who can't receive it anywhere else.

One of those policies is an agreement with the Primary Health Care Association, which represents the federally qualified Community Health Centers, an agreement that will allow us to do a

better job of triaging patients and having patients who need primary care and preventive services to receive it there rather than in our health system.

And the state Department of Health is cooperating in that agreement as well. We believe that this is a positive and a healthy step for us. But most of the care that we provide is not primary care and preventive care. This will only be a very small portion of that $73,000,000 of care that we provide.

We are beginning to put into place policies that will call for co-pays for non-emergency services. We've not had that in the past. We have simply provided care for the uninsured regardless of their ability to pay, regardless of whether their service that was needed was emergent or non-emergent. Now we will only be able to provide emergent care.

We will resist referrals from other hospitals who have referred to us in the past when that hospital system has the ability to care for the patient.

All of this is being done, not in a mean-spirited way to make access to care more difficult for uninsured patients, but is being done simply in a spirit of trying to balance the books on what's now a 30 to 35 million dollar loss in our health system so that we can be there next year to provide that essential service that no one else can provide for the uninsured.

So as I conclude, let me go back to the patient with the chest pain. This is real for that patient. This real debt that that person incurs, that that family incurs. Many of those patients don't get to us because they delay and don't get to a health system but die at home. Some come and receive our services and don't come back because the bill is too high, and they're embarrassed to come back because there's no plan for helping them to receive their health care. So the crisis is real for that individual.

But I need you to hear clearly that the crisis is real for health systems like ours around this country. The problem is not next year's

problem. The problem is this year's problem.

It is -- I will use the word crisis to describe this. We will be out of business if we don't deny access to more patients than we're doing right now. We simply can't afford to continue to provide the care.

I don't believe there are enough resources in the state of Mississippi in our current system to provide the care to uninsured that we need to do in an ethical and moral way.

And in my view, it is time for a national solution to our health care shame and our health care crisis that we're dealing with in this country.

I don't apologize for the dramatics. I don't apologize for the passion that's there. This problem is real, and it's real today in our state.

Thank you for being here. Thank you for caring. Thank you for being interested in this. Thank you for the privilege of this few minutes to share with you this very difficult story.

CHAIR JOHNSON: Thank you. Appreciate

your comments. And we'll look forward to hearing some more in just a little bit.

Mr. Mitchell.

MR. MITCHELL: Thank you, Dr. Shirley, for this opportunity. And thank you, Health Care Working Group for this opportunity to speak today.

I am the Director of the Mississippi Advocacy Program, which is a non-profit, public interest advocacy program sponsored by the Sisters of Mercy. Sisters of Mercy came to Mississippi almost 150 years ago. And while they no longer run schools or hospitals in our state, the Sisters of Mercy partner with the UMC School of Nursing; Coastal Family Health Clinic, a Community Health Center on the coast; and non-profit organizations all over the state in the delivery of health care and advocacy and support of improved health and welfare policies.

Over the course of one and a half centuries, we've made slow progress, but there remain serious inequities in this state. There are over 487,000 Mississippians, including 94,360

children, who have no health insurance. All or part of 66 of Mississippi's 82 counties have been designated as health professional shortage areas for primary care. We have 750,000 residents receiving Medicaid in this state.

And I think these statistics underscore what Dr. Jones just said. The problem of the uninsured is not simply looking at numbers of the uninsured. It's a problem of access. It's a problem of reimbursement as well.

I think we err when we just look at the uninsured in a vacuum. And we've see a lot of this. You have to look at it in the whole as a problem of access and reimbursement combined with the uninsured.

Our safety net system here in Mississippi is fragmented. It's financially unstable. But it does play a critical role in providing primary and preventive health care to thousands of Mississippians.

There's many layers to this safety net; it includes governmental agencies, health care

organizations, individual providers -- each providing some primary care services in geographic areas to some segments of the population in need. Providers include public and teaching hospitals, federally funded Community Health Centers, and county health departments.

Safety net providers also include non-profit hospitals that provide uncompensated care as a part of their community benefit obligations, private clinics, and other organizations that provide care at no cost or discount.

With about a quarter of the state's population under the federal poverty level, Community Health Centers play a vital role in the provision of care. And because so many areas in Mississippi have been designated as health professional shortage areas, Community Health Centers, as I said, operate in the health professional shortage areas.

On a whole, looking at nationwide, we have a disproportionately high number of federally funded CHCs. They provide significant amounts of

medical and dental care to Medicaid recipients and indigent persons. HRSA funds 22 community health care organizations in Mississippi, whose clinics and satellites comprise a total of 83 primary care delivery sites. These Community Health Centers provide 821,000 medical visits per year to 271,000 Mississippians in 2003.

Health Departments. Since the late `70s, the Lakewood Health Department has been organized into nine districts, each under the auspices of a District Health Officer. Each of these county health departments within the district provides traditional public health service such as STD management, tuberculosis, contagious disease management, environmental health services, immunizations, and water and sewer maintenance. And they provide primary care such as prenatal care, family planning, EPSDT, and perinatal high-risk management.

Hospitals. The Mississippi hospitals report spending roughly 706,000,000 in uncompensated care for 2003. And as Dr. Jones said, public

hospitals such as UMC offer primary care, outpatient clinics, and neighborhood satellites.

Medicaid. We can't talk about the safety net in Mississippi without talking about Medicaid. Medicaid is the primary source of health care financing for low income persons who would otherwise be under served. Medicaid DSH funds, of course, compensate care for the uninsured patients. And Mississippi relies heavily on these Medicaid dollars.

And we have a significantly high match rate. The F map in Mississippi is 77.23 percent. For the CHIP program the F map is 83.63 percent.

Because of this reliance on Medicaid policy, any changes in Medicaid reimbursement have significant impact on the safety net in Mississippi. We in Mississippi, I think it's safe to say -- the providers in the safety net can no longer survive with the decreased payment rates. And the potential cuts at the federal level are particularly ominous at this point.

As I mentioned, the safety net's

fragmented. There are several holes in the safety net I'd like to just touch on.

Rural areas. Many rural counties have inadequate numbers of primary care physicians. Large proportions of the population have no health insurance. And they're struggling hospitals with no safety net clinics.

In urban areas there is a plethora of health care safety net agencies that overlap each other's coverage areas but still have inadequate capacity to serve the low-income and uninsured patients in need.

Suburban areas. There's rapid growth in suburb areas in the extreme north and south part of the state. The growth in jobs in small businesses and industries that do not offer health benefits have put an increased burden on the safety net.

Immigrant populations. Mississippi's rapidly growing immigrant populations have also put a burden on the safety net, evidenced by the fact that the Hispanic population has quadrupled in the past decade. And the Hispanic population

incidentally also has the highest rates of being uninsured among all ethnic groups in Mississippi.

Mississippi chronic illness or disabilities or mental health needs are overwhelming. Individuals high on the list of disabilities -- well, mental health problems often have primary care needs that go beyond the scope of services provided by our health departments or primary care safety net clinics. Their needs include sub-specialist care and sophisticated ancillary services.

And I guess what I'm saying here is that we have a patchwork system; it's full of holes. We need to work together to ensure that appropriate providers are able to deliver needed care to our under-served populations.

A few of the recommendations that our program has is that Mississippi take full advantage of all federal dollars, that we coordinate state and local efforts to maximize resources, avoid duplication, and enhance service delivery.

We could do this by establishing an

organizational structure that allows for shared information systems. Expand CHIP eligibility to include mothers and fathers in low income working families. Develop a pharmacy assistance program for the uninsured and under insured. Expand community health services in centers in under-served areas of the state. Develop a program to subsidize access to specialty care, diagnostic services, prescriptions for uninsured patients in Community Health Centers.

Enable private non-profit clinics to qualify for grant funding and designation as a Community Health Center. These grant funds would be used for primary, ambulatory, specialty care as well as on a targeted basis oral, mental health, and substance abuse services.

Even as we expand the number and distribution of health centers offering community based primary care, we must also invest in expanding capacity of existing centers to serve the growing patients of need.

We must assure access for Mississippians to the most cost effective level of care, prevention

of primary care that will prevent the suffering and economic consequences of unnecessary illness, hospitalization, disability, and death.

On behalf of the Mississippi Health Advocacy Program and the Sisters of Mercy, I thank you for this opportunity today.

CHAIR JOHNSON: Thank you very much.

Dr. Taylor, last but not least in our panel. Thank you very much for coming.

DR. TAYLOR: Thank you very much for the invitation, Dr. Shirley and the committee. It's a great pleasure to speak with you.

I think it's important and appropriate that the first two statements focused a lot of their time on the economics of the situation because I don't have to tell you that when the American economy sneezes, the disadvantaged in America catch pneumonia. This is particularly important when we talk about health disparities.

I will ask Dr. Jones to nudge me if I go over my 10 minutes.

I, like the other two gentlemen here, am

very passionate about these issues.

I'll start by reminding everyone that we sit here today in the midst of what many term a golden era for cardiovascular disease. I'll focus on cardiovascular disease because I am a cardiologist. And much of the work in disparities has indeed been done on cardiovascular disease. So that will be my focus.

But we sit at a time that is referred to by many as the golden age in cardiovascular disease and for a good reason. There have been many outstanding developments in the last 30 to 40 years that have really fundamentally altered our approach to cardiovascular disease and for the nation as a whole produced a dramatic decline in mortality from that cause or that group of causes.

But that decline, while it is enjoyed by the nation as a whole, when you take a microscope to the statistical trends, you'll see that there are widely divergent trends if analyzed according to race and ethnicity as well as other important dimensions.

But we're focusing on race and ethnic disparities. For African Americans perhaps the best summary I could use is a quote from a paper that Dr. Shirley thrust into my hands, I think, on the second day that I was here in Jackson.

It was the front page of the Wall Street Journal. And there was an article about health in Mississippi, and one quotable line was, "It has been discovered that the health of African Americans in Mississippi is deteriorating while the health standards for the nation are improving." That paper was dated 1969.

A quote from the journal Circulation, the leading organ of the American Heart Association, later said, "Cardiovascular disease -- cardiovascular deaths among African Americans in Mississippi seem to be rising while they have fallen for the rest of the country."

The first quote, 1969; the second quote, 2000. Thirty-two years, an entire generation apart, but the news is the same. So disparity, as well as getting a lot of focus here in recent years, is

really an old story. We were just unaware.

Unfortunately the story goes on, the beat of disparities goes on with at best a stable gap between blacks and whites in the United States and in certain areas a worsening gap.

This may be particularly important for women of color in that we have traditionally learned in medical school that cardiovascular disease -- or being male was a particular risk factor for cardiovascular disease. And indeed if you adjust by age, men are a greater risk in general.

However if you look at the trends for African American women in certain parts of this United States, Mississippi being the example we're focusing on today, but it's not confined to Mississippi, there are clear trends that suggest that the death rates from cardiovascular disease in women, African American women, will overtake that of white males in the United States. In some places it has already done so, Mississippi being one.

But there are certain select metropolitan areas with a high concentration of

African Americans in this county where that trend is also evident.

So my point here is that, despite this golden age of cardiovascular disease, the fruits of American research and American medical practice have been unevenly taken advantage of by different pockets of the American population.

Instead of having a system in which everyone enjoys the fruits of research and technology, we have a mosaic of mortality varying in some instances as much as 14 to 1 in the risk ratio for death in certain parts of the Northwest or certain parts of the Mississippi Delta. So we've got a significant problem.

I feel as though I am probably preaching to the choir, but I will just remind you of a couple of important facts. First, African Americans receive less cancer screening, less treatment for depression, less secondary prevention for myocardial infarction in terms of the use of simple things, things as simple as aspirin or as proven as beta blockers. There's less in the way of diabetic

screening both for retinopathy as well as for vascular insufficiency compared to whites.

Latinos receive fewer vaccines and cancer screening, are less aware of high blood pressure than other groups in the United States, are less often treated for depression, and have poorer pain management by our system.

Native Americans receive later prenatal care. And Asians receive fewer vaccinations and fewer pap smears, and that's particularly important given the high rate of cervical cancer that's seen in Vietnamese Americans.

So while my focus is cardiovascular disease of blacks, clearly race and ethnicity matter in this current environment, the current system of health care. And there are differences then in not only health and health care, but in ultimate health outcomes.

My role as the principal investigation of the Jackson Heart Study has brought all these statistics very much into focus for me. However, I think we also, in this golden age that doesn't

glitter for everyone, face golden opportunities. And I see in this group the manifestation of one of those golden opportunities.

I hope that the message that you hear here in Mississippi will be one that will energize and invigorate your efforts.

I think when we talk about the approach to resolving disparities, clearly as someone involved in research, I have to put research on the list. But this is a multilayer problem, as has already been stated. We have to look at issues relating to the consumer of medical care. I think that's first and foremost.

And that revolves a lot around the issues of health literacy and health education. I'll be general at this point, but maybe we can get into specifics later.

We have to focus on the provider, the individual providers of that health care, how they approach their patients, how their patients regard them in terms of trust. And the issues of communication are very complex far beyond my area of

specific expertise. But clearly issues related to what is now generically referred to as cultural competence or cultural proficiency need attention.

But I think the focus on health care systems -- and both these gentlemen to my left and right have already brought to you -- brought before you some of the really tough problems that those systems face -- but I think a large part of the disparity ultimately will be found to be system based.

And as we correct problems with how our systems deal with different segments of our society, I think we'll get closer to resolving some of these disparities that all of us regret deeply.

Again, I think you for this opportunity and look forward to discussion.

CHAIR JOHNSON: Thank you, Dr. Taylor.

A quick question that I'd like to introduce to the three of you and then open it up for questions from the rest of our panel members.

And just to be clear, in this hearing it is only the panel members who are able to ask

questions of you who are speakers. And we'll want to monitor our time as effectively to get as much feedback from you as possible. So I'm going to ask you to be -- even though my questions probably could take all day to respond.

One thing if I could ask of you first, Dr. Taylor, and then each of you in the reverse order in which you spoke, if there's no silver bullet to covering what we want to do, but what in your mind would make the best investment of dollars to meet some of the needs that you have identified today?

DR. TAYLOR: The best investment of dollars?

CHAIR JOHNSON: Bring the best return on investment of dollars to meet the need of disparities, to cover those who don't have coverage, to improve the quality of care for those who are receiving coverage but it may not be the best coverage, to provide coverage in those holes that you identified where there aren't sufficient providers.

DR. TAYLOR: Okay.

CHAIR JOHNSON: And just very briefly so we can get others to respond.

DR. TAYLOR: I think the best investment is whatever investment broadens coverage, broadens the ability for people to pay for fundamental services from the health care system.

And I am focusing on the health care system. I think everyone knows the story. Forty-five million or so uninsured Americans, which is, as Dr. Jones has already said, a national shame. I think that is an important beginning to do something, to take some strong effort towards covering those individuals.

And personally I believe that preventive care should be a major emphasis of coverage in order to stop some of the processes far upstream before they get to be downstream catastrophes.

CHAIR JOHNSON: Thank you.

MR. MITCHELL: I think the best investment of dollars would be to utilize the existing infrastructure, the existing safety net

that's out there, again through coordination and including IT data management, coordination within the existing safety net. Also when I say "existing safety net," I'm also talking about non-profit providers out there that don't qualify as CHCs, allowing them to qualify and fully participate in the safety net.

CHAIR JOHNSON: Thank you.

DR. JONES: I believe the best investment would be in universal coverage then anything that does not provide universal coverage or a core basic set of preventive inherent services will leave us short.

The sad reality is that 20 years ago someone with advanced osteoarthritis of the knee was a very small expense on the health system because mild analgesics was the state of the art of care. We now have the option of replacing that knee. The difference in those costs is dramatic.

And we simply must come to terms with the reality that we have to as a society decide whether we will provide knee replacements for

everyone. Right now, we are again calling on health systems to make that decision for us.

As a society we have demonstrated that we want everyone to have a knee replacement who has pain in their knees to be improved by a knee replacement. We demonstrate that day in and day out again and again. But we've not put a finance plan behind that.

So we must have a rational, national plan of universal coverage with an agreed on set of basic health prevention and treatment elements. And nothing short of that will solve the problem that we have in my opinion.

CHAIR JOHNSON: Other Working Group members?

VICE CHAIR MCLAUGHLIN: If I had to -- I have a question. I don't know if any of you are familiar with the work that's been done by Sherman James and others on John Henryism studying cardiovascular problems starting in North Carolina.

But a lot of that work and other epidemiologists who have followed it have talked

more broadly about the causes of these disparities between African American and white community. Again as you point out, focusing on cardiovascular that's where -- and hypertension -- that's where they had most of it. And asking for much a broader view of how to reduce disparities.

And I wondered if in your research and your own personal opinion, what weight you think should be placed to that?

I mean Mississippi is one of the best places to think about those questions. And for those who know John Henryism, it really -- Sherman James is really -- was studying this whole issue of racism and stress and the weathering effect in the black community. Particularly he studied as his book is called Old Black Men in North Carolina.

And so that's why best return on investment coverage preventive, coverage for what though? Cause I think he would suggest we need coverage for more than just screening.

But we need coverage for access to care for depression, for stress, for family for a much

broader thing. Do you see that in your own work here? Or you know, sir, how do you see that -- what role do you see that playing?

DR. TAYLOR: That's a huge question. And I thank you for it.

I think specifically on the issue of the stress of being in a minority group in the United States, particularly African American. And Sherman James, he chose John Henry, if I may digress just a moment. He chose John Henry as the sort of image. And I think most people in the room remember who John Henry was.

Anybody not familiar with him? John Henry was a steel driving man, right?

He was a black folk hero who reputedly, during the era that they were linking the coasts of the country with rails, could hold a 40 pound sledge hammer in each hand to walk down the middle of the track and drive in nails completely to ground with alternate strokes with a 40 pound hammer. I don't know how true it all is, but it's --

VICE CHAIR MCLAUGHLIN: I believe it.

(Laughter)

DR. TAYLOR: I believe it too.

And of course there came a day when someone invented a machine to do the same thing and they pitted John Henry against the machine and had a big race which John Henry won. But he died on the spot. The stress, the high output to cope with the circumstances under which he was asked to perform in that story led to his death.

So Sherman James was trying to capture how it is to do everything you can just to get to the same level as the next person who may have fewer barriers.

I think you are right. I think there's a psychological, a social, a cultural dimension to the disparities.

To attack those social issues broadly would mean nothing less than a fundamental change in the American way of life in the way we relate to each other in systems that now have sometimes 200-year histories and somehow throwing off the legacy of all of those bad things in our past. I think

that's not going to happen in our lifetimes.

I think there's hope that things will continue to get better. And want to end that part of my statement on a hopeful note.

However, I think it is important for us then to deal with some of the consequences while looking hopefully to the future when things really are -- when there really is an even playing field when everything -- when race becomes irrelevant. Okay, when that fine day comes.

In the meantime, the stress of working against the system that at times seems pitted against you, clearly I believe has some physiological consequences.

And if we talk -- focus first on the psychological, not so much as on the depression and so on, should we pay attention to those disparities? Absolutely.

And do things like depression lead to heart disease?

I think that story has been told. Clearly it does lead to increased levels of risk

factors. And people who have had heart attacks who are depressed after the heart attack, whether it's because of the heart attack or because of other circumstances, have a much worse prognosis -- as bad as the difference between having a "mild" heart attack and a "massive" one. If you have a mild heart attack but you are depressed, you might as well have had a massive heart attack. Your prognosis is just that much worse.

So to the extent that race plays into these psychological parameters, I think that, yes, indeed attention to the mental health is very important. The conditions of society that feed into to that, that's a longer term effort. I think in the state of Mississippi, there has been significant progress and across the South in those areas (involving race relations). But I think anyone you talk to would also say that we have a long way to go.

That's not confined, however, to this region of the country as I'm sure that you are aware.

VICE CHAIR MCLAUGHLIN: In fact, Sherman was at Michigan for a while and, you know, studying that area. But we neighbors and James Jackson all of their work has also shown that -- and this is you're talking about the provider and educating the provider.

And that the African American community, particularly the male, African American male community, really has been badly misdiagnosed in terms of mental health. And in part it's because they use different labels to describe how they feel. The physicians often aren't trained in understanding what labels they're using.

And so that's why I was interested that you kept bringing up depression both for the Latino community and the black community. And normally when we think of prevention, we just think of cancer screening and taking your blood pressure. But it seemed to me that you were also suggesting that part of prevention is in fact mental health screening. And then educating the providers on cultural competency issues, you said, to more fully

understand that.

DR. TAYLOR: I think there is an epidemic of depression. I'm going to let the other speakers speak.

DR. JONES: I'll give you insight by telling you that Dr. Taylor's wife, Dr. Jasmine Taylor, is a psychiatrist --

VICE CHAIR MCLAUGHLIN: Uh-huh (affirmative).

(Laughter)

DR. JONES -- who is Associate Vice Chancellor for Multi-Cultural Affairs at our institution --

VICE CHAIR MCLAUGHLIN: There you go.

DR. JONES: -- and has the responsibility for being sure that the next generation of health professionals in Mississippi are better trained and more in tune to these issues.

VICE CHAIR MCLAUGHLIN: So she'll be happy to hear that I asked this question.

DR. TAYLOR: I wish that she was here right now.

(Laughter)

CHAIR JOHNSON: Any other follow up to --

Okay, Montye.

MS. CONLAN: Dr. Taylor, I was interested and you talked about preventative medicine.

DR. TAYLOR: Yes.

MS. CONLAN: I'm interested in educating and empowering patients. And I wondered about the current efforts to educate the citizens about risks. And then also about disease management. If you empower those patients, how that affects their management of their disease once they take charge of that.

And then if you could describe the current efforts and then talk about what you envision for what you'd like to see the changes.

DR. TAYLOR: Health education and empowerment of consumers through education, these are critical issues.

Now I'll very briefly describe some of

the things that we are attempting as an adjunct to our research in Jackson Heart Study. The Jackson Heart Study briefly included 5,300 who died in the Jackson Metro area. And it's patterned after Framingham in may ways. But it has other missions as well. One of them being health education.

We believe in a model that's called the Community Health Advisors Network. And that involves basically a trainer-to-trainer model where you take natural leaders in the community who are self-identified or referred and they volunteer. A lot of these folks are retired teachers, librarians, radiology techs, and others who people in the community naturally look to for their opinion for a variety of things.

But we train them in areas of cardiovascular disease and risk factors and how people can help themselves either avoid the development in certain risk factors or deal with risk factors that have already been established, like obesity and hypertension, or the tendency to eat a lot of fatty foods which was quite common here

and other places across the country. So we talk about diet. We talk about food preparation and so on.

And the idea is for each of these individuals that we train to then hold small group settings and take the -- in a way take the brochure up a notch. You know it's very good, I think, having a low literacy health literature is a very important thing. And it's very important to distribute that.

Nothing compares with the human interaction in getting someone to understand how to take a specific action for their benefit. So we like that model and we're using it here locally.

There are many models across the country for getting information out. I think also that the -- to make a larger call here. I think the NIH and it's all of this which need to continue their stated focus on translating information that has been gained from some of the great research that's going on across the country -- translate it into news people can use. Such that the information doesn't

just gather dust on shelves, but actually gets out there among the populace where it has an effect.

I don't want to -- maybe I will ask that someone else supplement.

MR. MITCHELL: Well, the Mississippi Advocacy Program, we're very concerned about education amongst the Medicaid population in terms of consumer education. We're currently developing a program.

We've done a pilot program in the past where we provide information on the rights and responsibilities of Medicaid recipients. We'd like to broaden that to Medicare as well as the private market as well.

In the context of Medicaid reform, which we have been going through the state in the past year and a half. It's vitally important in terms of access that Medicaid recipients be knowledgeable and empowered as to their rights and responsibilities under the state Medicaid program. That's the program we're developing. We hope to be launching it.

DR. JONES: And let me just sound like an administrator for a moment and point out that these kinds of programs are run from the margins that are available in systems of health care.

And if I could just contrast three places, the Mayo Clinic would ultimately be a place that does this as well as anyone. They have probably the world's best health site on health education for consumers for those who are literate, for those who know how to access it and so forth.

They have not unlimited resources as my colleagues there tell me. But compared to most places what we would consider unlimited resources, they essentially provide care for wealthy and insured people, and so they have lots of resources, large margins in which to do this kind of care.

Contrast that to a state institution in a state that has a low penetration of Medicaid and uninsured patients. And they have less resources than the Mayo Clinic, but more resources than a place like ours which has 42 percent of its patients as Medicaid patients that provide no margin at all.

A high percentage of Medicare patients which these patients provide no margin at all. And then a high percentage of uninsured and have a very small percentage of insured patients.

And so the dollars that fall from the dollars that are intended for treatment of health issues, which we do these kind of things now in our system, simply don't fall out in places like these, where the expenses are greater because you have a lower literacy rate etcetera, etcetera.

And so this is a plea as we reform our health system, which we surely will do, which we surely must do, we have to do it in a way to allow those who begin at a disadvantage not to be placed at a further disadvantage in the decisions that we make about financing these kind of important issues.

MS. HUGHES: Hi. Therese Hughes. I have a number of items that have arisen as a result of listening to you. And I just want to say that you don't have to answer them all to me. I'll give you my e-mail, and if you can answer me that way, that would be great.

But the first one is patient compliance. Having been a patient myself, I'm well aware of the fact that patient compliance would reduce the number of dollar costs to the system. And I wanted to know what you were doing about that.

Second of all is that no mention was made of having an adequate number of providers that are racially and ethnically appropriate for the populations that you serve. One can assume something either way. But I would like to know something about that.

The third covers two areas and that's what I'd like to know a little bit about. And that is you mentioned early in your statement about Dish dollar loss as well as IGT dollar loss. And I was curious. I can't remember what Mississippi Medicaid redesign ,so to speak, involved.

And so, but I know that in California we're working on loss of Dish Dollars for our hospitals which is significant and can destroy the safety net that we have as well as the loss of the intergovernmental transfers.

And could you just give me an idea of what you've got before changes were made and what you're getting now and, yeah, because I know that involves the state match. I mean the state -- they're both interlocked. And I know it's very difficult to understand.

But just some idea?

DR. JONES: Okay. I'm going to look behind me and see if there's someone who can give me numbers. I don't think there is. (Laughter) I don't think anybody offhand is here. If I say something that's wrong, you'll tell them. (Laughter)

I can't give you dollars of what the state received or our institutions received. But because the match rate is high and because we have large numbers of uninsured and large numbers of Medicaid patients, our Dish dollars or upper payment limit dollars were helping in the past. And they are decreasing now. They were larger than in most places.

But it's always just a forward work. They're not intended to completely reimburse you for

uninsured care. But there were some dollars that went toward that. And those dollars are decreasing now and are part of the current challenge.

So I'll get you some particulars and send the actual dollar amounts for the state and for our own institution and the changes that have taken place. And I'll get those numbers.

In terms of the intergovernmental transfer, we still have an intergovernmental transfer. I think the -- what is the word that CMS is using to describe this now? A disingenuous scheme, I believe, is what the term that they're using. And of course the program that we have was approved by CMS, like all of the IGT programs.

But once they began using the term disingenuous scheme I think that we can predict that it's going to go by the wayside. And that will be bad news for our state. And it will be perhaps be bad news for our institution.

But right now in our intergovernmental transfer program, our state transfers to us that we give to Medicaid $18 million dollars less last year

than we received back in Medicaid dollars. And so our institution loses a large amount of money each year on the intergovernmental transfers.

When that goes away, the state will have less money and ultimately we'll have less money to provide care as well. But some of that loss will be adjusted. So the dollars, the federal dollars and the state dollars, that have been there that have helped forge the care of Medicaid and uninsured patients, it's decreasing.

In our state appropriations in the recent legislative session, the Medicaid budget was decreased from roughly $600,000,000 to $450,000,000 in the state portion. And with our match being what it is, that's going to be a loss of roughly $750,000,000 in our state's health care economy. And so much of that is in prescription drugs. But that's going to be $750,000,000 less in our health care economy.

And so those safety net parts of the system will suffer. People will have fewer drugs. They'll get sicker. They'll be in emergency room

more and so forth. So there'll be a price to pay for this. So we're heading in the wrong direction.

What we're doing now to control costs is disproportionate in the country. And when you pay more for health care than any other country, who wouldn't say that we need to control the costs. But the way we're going about doing it is going to disproportionately punish safety net providers and disproportionately punish the uninsured and the underinsured in the country.

The second question you ask was related to --

CHAIR JOHNSON: May I ask to follow up?

DR. JONES: Yes.

CHAIR JOHNSON: Can you explain that a little bit more, your last two sentences. Because I'm not sure what your framework is. If your framework is for care here in Mississippi --

DR. JONES: Right.

CHAIR JOHNSON: -- or if you're considering some of the what might call, some might call more innovative initiative. So your framework

for that would be helpful.

DR. JONES: The framework is both at the state level and the national level. If you consider that there's the intent to reduce Medicaid spending by 60 billion dollars -- is that the number(?) -- over the next 10 years.

If you take that 60 billion dollars and then take the state match with it and take that out of the health care economy, somebody is going to have less money to provide care. And it looks like it's going to be people that are providing care to Medicaid beneficiaries.

And so that would to me translate to less care for Medicaid beneficiaries. I don't see any other way to translate that.

CHAIR JOHNSON: Thank you.

DR. JONES: CMS plans to reduce care of payments to health providers by 26 percent over the next five years. To me that translates into less care for Medicare recipients and fewer providers that will actually see Medicare patients.

Right now our facility is one of the few

in the city that will see a Medicare patient who doesn't have any other form of reimbursement. And it's difficult for a Medicare recipient to get an appointment with an internist or a family physician in this city. And I suspect that it's true around the country.

CHAIR JOHNSON: Thank you very much.

Did you finish your response to the questions?

DR. JONES: I wanted to say about the number of providers. This state has fewer physician providers than any other state per capita. We train more than the national average in this state. And we retain a higher percentage of our graduates than the national average. We have fewer professionals that are trained other places come here.

Nationally roughly 40 to 50 percent of any state's health professionals will be trained somewhere else in another country or another state and migrate in.

It's simply the reality in Mississippi that fewer people move here. They don't understand

what a wonderful place this is and how wonderful Mississippians are. We have a burden of history that makes people less likely to choose to move here.

But we're training more health professionals than most states. We're retaining more than most states. But we simply still have fewer professionals than most states.

Our response is to try to train more health professionals. But in the economy that we're working with, right now it's very difficult to do. We've trained a 100 per class physicians over the last 20 years or so. And this year for the first time in about 20 years, we've increased that by five percent. We're taking 105 in our incoming class with reduced resources from the state.

We're trying to work with the state to get more dollars to train more physicians. And we have robust programs to try to make our student body more diverse in order to have a more diverse group of public professionals in the state.

Our dental school recently went over the

last five years from being one of the least diverse dental schools in the country to the top 10 percent of dental schools. Let me tell you that being in the top 10 percent of diversity in dental schools still makes you a very white school. And it's still not a very diverse place because dentistry particularly is -- has had challenges with diversity. But lot of efforts moving forward trying to do it.

In my most recent site visit from the liaison committee for medical LCME -- well, anyway our accreditation body -- we were noted. We were given a positive mark for our efforts at diversity in our school of medicine, not for our diversity, but for our efforts in diversity. We're working hard to try to do better.

VICE CHAIR MCLAUGHLIN: As you know you have to be careful. Coming from the University of Michigan, we just spent a lot of money defending the case for diversity at the Supreme Court. And you have to be careful.

On the one hand you're being asked to

make the population more diverse in terms of -- in our case it was the law school. But on the other hand you are not allowed to use if for admissions. So it's a problem.

DR. JONES: There's nothing I would like more than for the University of Mississippi to be sued for their efforts at diversity. (Laughter)

For being too aggressive. I'd love for that to happen.

CHAIR JOHNSON: We are closing in our scheduled time, but I'm wondering if each of you who have been willing to share time would have 15 more minutes. If it would take 15 more minutes for this session, since we started a little bit late. You're comments have been very helpful.

Are you able to do that? Or are you going to - are you able to go 15 more minutes to 9:30 instead of 9:15?

DR. TAYLOR: Yes, I do have a plane.

CHAIR JOHNSON: Okay. Since --

VICE CHAIR MCLAUGHLIN: So he can go now.

CHAIR JOHNSON: Who? Dr. Taylor.

We will go for another 15 minutes. I'll just preliminarily say thank you for coming. And if you have to leave, that's understandable. But it would be helpful to keep on for another 15 minutes.

DR. TAYLOR: Absolutely. And I understand it. I'm sorry the plane does leave at 10:15. (Laughter) I'd better go. (Laughter)

I would like to, if I may, just one, a couple of follow-up comments. One, on the issue of congruence with between provider and patient, that is racial congruence. That you raised the question.

I think it's an important issue that's important to have it to show that African Americans and other ethnic groups tend more than other groups to practice in communities of that same description. It is, I think, a positive thing in terms of impact and the disparities.

But, you know, but Mississippi is 40 percent black. By the time 40 percent of the physicians are black in Mississippi at the current rate of increase in the African American physician

pool, we'll be well -- we'll be at the end of the century perhaps.

So in the meantime, we really do have to focus on this issue of transcultural interaction in, at the bedside and all along the way in the medical encounter, the various medical encounters.

And last thing I would like to do before I leave is congratulate the organizers of this group and congratulate each of you for being part of it. I would urge you to carry a sense of urgency with your mission, and in particular as it relates to disparities. Because as -- I don't want to be overly dramatic -- as we meet the body count is rising we notice.

Dr. Satcher recently published, our former Surgeon General recently published, an estimate that 83,000 unnecessary deaths could be attributed purely to racial disparities in the last year. I don't know how many crashing 747s that would take to come up with that type of body count, but you can't lose -- we can't be numbed by the statistics. We have to realize and keep firmly in

front of us that each one of these 83,000 unnecessary deaths presents a personal tragedy.

And I think the mission of this group hopefully will impinge on that sorry statistic and help us get past some of these issues that have bedeviled us for the last several decades.

So thank you very much.

CHAIR JOHNSON: Thank you very much. And just before you go, if either -- any of you have additional information you'd like to share with us if you'd send that to George Grob and we'll be happy to share it to the rest of our group.

Thank you very much.

Okay, Frank Baumeister, you had a question you wanted to share.

DR. BAUMEISTER: I'm not so sure it's a question. I think that Dr. Jones has said a couple of things. One term he used was "our health care shame." And then he said, "It's a money issue."

And it seems like despite the fact that it's shameful that there's not a lot of money forthcoming for the indigent population, for the

working poor, for the Medicaid population, and for the disadvantaged portion of our society which is somewhat in chaos right now.

And one of the benefits of this small group is that we have a certain laissez faire to even pursue disingenuous schemes. (Laughter)

And I come from a state where we pursued a disingenuous scheme and really initiated an illegal Medicaid program where we had to fight and claw and scratch to get waivers from the federal government to supply all of our Medicaid population with health care in the Oregon Health Plan.

The issue of money is -- if you look at public and private monies and how they're devoted to health care, is that at one end of the spectrum you have starvation. And at the other end of the scale you have incredible wealth. And you have Medicaid starvation and you have Medicare in some areas exploitation.

There are tremendous disparities and expenditures for Medicare. Some areas are fat with specialists. Some areas the spending varies from

bottom line to over the top in Medicare. And the way our system is designed now with public monies, the burden goes to -- at least the majority goes to the Medicare population.

And in Oregon we have sort of toyed with the idea of how could you lump those monies and use them better, `cause there's a lot of public monies. For instance, in the employer based health insurance the money that's taken out of the federal government in terms of tax write-offs for both employers and employees to pay for employer- based health insurance, if that were put into the public coffers and used to provide universal care across the public spectrum, it would be ample money.

We spend 1.8 trillion dollars in health care, which Senator Wyden told us in our initial meeting, came to $24,000 per person. There's a lot of money in there. That's a new car in every pot, so to speak.

So I'd like to ask your opinion, if you were king, how you would best use those public monies?

DR. JONES: Well, I think you're exactly right in suggesting that it's not an issue of not having enough money in the system. It's how we make decisions about the money. And certainly I think all of us would like to be able to afford the health care that's provided at the Mayo Clinic. But I think that we all recognize that we can't provide everything to all people.

And certainly when Oregon took a bold move to try to define a set of basic health rights for people, it was, I think a bold movement beginning of where we will eventually to have to come as every other industrialized nation has come to the point of saying this is the defined set of health benefits that we will provide and we will use the resources to provide that for everyone.

I think taking the Medicare and Medicaid dollars that come to an individual state and trying to make those adjustments could work in a state like Oregon that has a relatively low number of poor people. In a state like Mississippi, it would be impossible to do.

So again I think a national approach to this of taking the dollars that we have and redistributing them in a more rational way to provide the health care is the approach that we need to take. I agree that we do invest probably enough in health care to provide basics for everyone.

My guess is that this country will decide that we want a higher level of health care than in some other countries and may be willing to pay for that and may have to increase our expenditure for health. But I think for us to more evenly distribute will certainly be a step in the right direction.

CHAIR JOHNSON: Thank you, sir.

MR. MITCHELL: In terms of a wish list for health care, I agree with Dr. Jones' comments. I think look at other industrialized nations, a single- payer system is ultimately where this country will go. If I could have a car, of course, ultimately. (Laughter)

CHAIR JOHNSON: Would you do other comments?

Dr. Jones, you suggested that we'd need to have a national program and spread the dollars. Can you share some more of your thoughts on that?

MR. JONES: Well, I think of universal coverage of a basic set of prevention and treatment services. That will be a difficult list. When we went through our attempted managed care, it was a lot of attempt at rationing care and this country rejected the idea of rationing care.

But we will either have to spend more money or come back and revisit the idea of in some way rationing care.

I mean we have invested huge amounts in medical research in the last number of years and continue to invest in research. And one result of that has been a tremendous improvement in technology.

As an example, when I first entered medical practice about 30 years ago, management of diabetes was very primitive. For Type 2 diabetes there was very little that could be done to help manage the patient. Today, there are wonderful

drugs to help manage the patient. But it typically takes three of those drugs. And that patient typically also has high blood pressure and typically also has elevated cholesterol.

And so the patient who has Type 2 diabetes in this state typically would be on seven or eight drugs at an expense, if they were paying for them at retail prices out of their pocket, somewhere between $500 and a $1,000 a month. Now Medicaid has provided that for poor people in this state.

But we just made a decision to reduce the number of drugs to five per month and the number of non-generic drugs to two. So there are many patients who have diabetes, hypertension, and dislipidemia who won't be able to receive ideal care.

So there again, we'll have to come to some place about deciding how we'll ration, how we'll support research in the future, whether we'll continue to do it through expensive drugs and so forth.

But I think that ultimately in order for us to be fair to everyone, if we do agree -- and we may agree as a society that health care is not a right. That we're only going to give health care to the privileged. But I don't think we will.

And if we continue to take the premise that health care is a right that people have, we will eventually have to either spend a lot more money to provide the level of health care that's available for the wealthiest now -- those who can afford health insurance -- to everyone. Or we'll have to decide that we'll all receive some modified version of this wonderful technology that we have available to us now, but we'll apply it to everyone.

CHAIR JOHNSON: Thank you.

Go ahead.

MS. CONLAN: As a Medicaid beneficiary, I'm very interested in the story of the Medicaid beneficiary in Mississippi. I have a little bit of an understanding, but I'd like from both of you a little more information.

And also your efforts, your planned

efforts, to empower those Medicaid patients. I'd like to know a little more about that.

But we talked earlier about stress. And in Florida those of us who are chronically ill and dependent on Medicaid, particularly for catastrophic care, each year when the state legislature comes into session there's a couple of months of anticipation and anxiety over what will happen. We're in a very tenuous situation. Each year we feel that there's an attempt to balance the state budget on our backs. And then the two months, 60 days that they're in session, we basically -- we always seem to lose ground, but pull though in the end.

And I just wondered if you could tell me a little bit more about the Mississippi Medicaid status.

DR. JONES: We lost roughly a quarter of our state appropriations in Medicaid this year. That's certainly losing a lot of ground in Medicaid.

And the growth in Medicaid has put pressure on the state budget. And again for the

state, the more pressure that's been. And that's had a wide impact. And certainly this loss in Medicaid dollars is devastating.

But over the last few years many states have had dramatic increases in Medicaid costs that have put pressure on the dollars that go to other state entities.

I happen to run an institute of higher learning and so am intimately familiar with what's happened with that because of the growth in Medicaid and spending in our state. Even though we've had an increase in revenue in the state, we've had a decrease in support of higher education. This has happened in many states.

And this has -- because active health centers usually fall under that umbrella, it's had a negative impact on health safety net systems. And so there's this cascading effect that goes.

I think they will continue to put pressure at state level and the federal level for reducing Medicaid expenses as everyone sees that the rate of incline of spending on Medicaid, primarily

driven by pharmaceutical expense, is not sustainable. And so people are seeking. And the current administration things are based on costs and cutting costs.

And I'm not sure that there's been to this point an adequate understanding of the impact that that's going to have on individuals.

MR. MITCHELL: As the Consumer Advocacy Program, we very much understand the plight of Medicaid recipients in Mississippi in the context of Medicaid reform. The Medicaid recipient in Mississippi in which Medicaid reform and Medicaid cuts last year poverty level, age, and disabled category of Medicaid recipients approximately 65,000 individuals lost their coverage.

Public outcry was huge. The Legislature came in and reversed those cuts. Well, subsequent to a court injunction.

So life, like your statement, Mississippi's Medicaid recipients are very apprehensive when the Legislature is in town. Again in the context of Medicaid reform. But they do

wield a good bit of political clout when you factor in 750,000 of our population are on Medicaid.

And one thing the Medicaid cuts accomplished that we, as advocates, have not been able to accomplish was it put a face on the Medicaid recipients. The Medicaid recipient is not the welfare mother. The Medicaid recipient was Grandma, the one you go to church with, someone you see in the grocery store every day.

And so, if anything, the Medicaid cuts, the applied cuts, were subsequently reversed health advocacy in that regard.

And, Dr. Jones, I agree with him on the pharmaceutical means of the state. We don't know the full impact of that yet. Cutting the number of meds per recipient, I don't see that as a logical response to cutting costs in the Medicaid program.

What are we reimbursing pharmaceutical companies?

Why don't we look at that before we start cutting the number of meds per month. And that is something that needs attention in this state

immediately. Let's look at reimbursement of the pharmaceutical companies before we start cutting or make further cuts to the number of meds per month.

CHAIR JOHNSON: It's probably appropriate that our last comment or question come from Dr. Shirley.

DR. SHIRLEY: I just want to run an idea by Roy. You mentioned the Community Health Centers as a viable and valuable safety net for primary care. I want to run an idea by you. We've also talked about a patchwork system. I want to add another patch.

Typical Community Health Center receives federal dollars in the amount of about $300 per individual, per enrollee in the Community Health Center. That would be about $25 a month. And many of the organizations you mentioned are not eligible for that.

What if a -- but with that $300 a year the community health -- per individual, the Community Health Centers do a pretty good job.

What if an organization like similar to

the Sisters of Mercy could orchestrate an opportunity for individuals to buy into at $25 a month, a system that would equal the amount of dollars that the Community Health Center receives?

MR. MITCHELL: I'm not an actuary. That would take a lot of scrutiny, but I like the sound of it. I like the sound of -- again it's in keeping with expanding the existing safety net.

MS. BAZOS: Dr. Shirley, can I ask isn't part of the reason that the FUHCs are so successful is that, in addition to getting the $25 a month, they also get a great package for their Medicaid recipients that includes the ability to give comprehensive care.

But with that -- but what they've been doing, as I understand it, at least in New Hampshire, the FUHCs that I'm working with, is they've been balancing their books based on the income that they are able to obtain from the federal government and the state through their Medicaid match. And what's happening in New Hampshire is that cost shifting for the CHCs is no longer

working.

And in that regard we have private providers who are also very interested now because the Medicaid patients that can no longer go to FUHCs are going to private providers who are interested in becoming FUHCs or obtaining FUHC status so they can get this greater -- this more money through the Medicaid system.

So my question to you, Dr. Shirley, if we thought about or if you thought about this obtaining dollars, the $25 a month for the uninsured, how could we think about in the same context of obtaining additional dollars from Medicaid? And do we have to think about them both together?

DR. SHIRLEY: There is a provision whereby certain organizations would be eligible for what we refer to as a look alike status. And that gives them the same favorable reimbursement from Medicaid and Medicare as the Community Health Centers.

MS. BAZOS: So that said, there is a

possibility there to do that?

DR. SHIRLEY: Yes.

CHAIR JOHNSON: Well, thank you very much, both of you and Dr. Taylor as well, for your comments this morning, your input, very rich input for us and we appreciate it.

And if you have additional comments or suggestions, if you would get those to George Grob, that would be helpful.

MR. MITCHELL: Thank you for the opportunity.

CHAIR JOHNSON: We'll adjourn this panel and immediately ask the next panel to join us.

(Off the record at 9:38 a.m. and back on the record at 9:42 a.m.)

CHAIR JOHNSON: Thank you for coming back and joining us for this next panel.

Before we begin and ask our two guests to share their experiences with us, a word of comment regarding input from you who are not invited panel members.

The Citizens' Health Care Working Group

is in its first -- actually its first phase in our process which is hearing from invited guests. And so we're in the process of doing that over this next 90 days.

Ultimately we will be conducting what we're going to call Community Meetings or Town Hall Meetings throughout the United States. And at that time there will be opportunities for citizens to share your perspectives with some of the thoughts that are going to come out of these hearings. But today the input is going to come merely from those who are our invited guests in the first panel that we've already heard from, our second panel, then a third panel that will begin in approximately an hour from now.

We're pleased to have Richard Dye and Georgia Rucker here to share your experiences as folks who have been uninsured. And we would like to ask you to take about 10 minutes just to speak from your experience, if you would, each of you.

Georgia, if you would be first. And then Richard will be next.

And then as you saw in our last panel, we'll open the time up for questions. And if you'd be open to responding to those questions, we'd appreciate it. Okay?

So, welcome. And go ahead, Georgia.

MS. RUCKER: My name is Georgia Rucker. I am currently uninsured. I will have so been now going on a year. I'm on medical leave right now.

CHAIR JOHNSON: Georgia, I'm going to ask you to speak up a little bit. And maybe this microphone will pick up your voice, but we want everybody to hear. Okay?

MS. RUCKER: All right. I'm currently on medical leave from my employer. And my previous -- before this hit, I was an instructor. I became uninsured because my condition. I found out that I had a "herniated lumbar disk" that was pressing on the sciatic nerve on the left-hand side after they finally gave the diagnosis.

The first doctor I went to said absolutely no surgery. He would watch me and he did rule out injection therapy. When I went back to

that doctor for the third visit, he had decided before I came in that he was sending me back to work, no restrictions, and that I could work. I knew something was wrong because I was still in a great deal of pain.

My employer, I found out had only took the second -- get a second opinion, please. When I went to the second neurosurgeon, I found out my employer had canceled all insurance. I went to a "clinic" on a Saturday at that date. So that Monday I called. And what the administrator told me was my insurance had been canceled. They were well within their right to cancel my insurance because by federal law they had up until 30 days after they had canceled it to notify me.

And, yes, I was out on short term disability at that time and receiving pay. The only reason I received payment for that time was because I paid out of pocket for short term disability insurance benefits.

As a result that particular doctor knew voc rehab. He said try to get it in on voc rehab.

So I sent a letter. And fortunately I was accepted. So voc rehab that was November. Voc rehab accepted me in January, in January of this year.

They scheduled the surgery February 22nd. I did have the mycardiomysectomy for that. We're still going through tests and so forth because my disks are "still bulging." There is still a lot of problems and issues with that.

But the most interesting thing about not having insurance is that when certain conditions occur other things in your body go AWOL, point blank. And with those conditions being AWOL as well, I needed medical attention.

So the Jackson Free Clinic is where I go to get those "other non-neurological things" addressed. Yes, they provide excellent care. They're open on Saturdays from twelve to four. Without them, yes, I'd probably not be sitting here.

Yes, blood pressure went out of the ceiling. It got very high. My blood sugar went out of the ceiling. It got high, especially for me.

But because there is a myth that people

are either uneducated or poor or whatever, you can become uninsured as a professional. I'm a witness, living example. So there are things that you need to "become aware of." And there is not a lot of public information about where do you go when you are literally dropped from insurance and don't know it.

Pharmacy card no longer works. You can have prescriptions all day, but when the pharmacy card does not work, your benefits -- in terms of insurance benefits, you only get 60 percent of your income with the short term disability insurance thing I had. And it only lasts X number of days.

You need to know how many days that insurance lasts. You also need to know when does long term kick in. You need to know whether or not your employer has the right to cancel long-term disability benefits while you're on short-term benefits. There is a lot of "non-education," lack of knowledge concerning all those things.

Yes, I am fortunate because voc rehab does pick up some of the tab for a lot of the

things. There are a lot of things that they used to do that they can't do now because funding has been cut.

In terms of the Jackson Free Clinic, like I said, I get excellent care for the other things that are going on with the body because of that condition. But not knowing that there is one is a hinder. Not knowing other areas that you can tap into to get the assistance you need or get the help you need is a serious hindrance because a lot of people don't "end up on ER." A lot of them end up dead.

And unless you have some questions, that's all I have to say.

CHAIR JOHNSON: Thank you very much.

Richard, would you care to share your experiences and we'll open the panel up for questions, okay?

MR. DYE: In graduate school I had a professor accuse me of being awash in a bombastic sea. So I won't do that. I'm not that instructive.

(Laughter)

I guess the import of my message is that uninsurability transcends socio-economic status, culture, ethnicity. Oh, I never thought this would happen to me. I've always had a good job. I have a good education.

I suffer from a concurring illness which led me to lose everything, become basically homeless. For a while it led to a suicide attempt, led to a psychiatric period whereby I now have two anti-depressants and an anti-psychotic, which all three have no generic counterparts. Therefore, they are very expensive. The bill is hundreds of dollars a month.

Once COBRA ran out, then of course, my psychiatrist and the doctor couldn't see me any more because they're in business too. I had no way to pay them. I had to seek other means.

But as I said, I would never thought I would have been in this position. But I found myself in this position. And then it becomes a time element. So I sought help, as Georgia did, with free clinics and things. But the time element there

being in order to receive a Patient Assistance Program for medication which was extremely prohibitive, especially being at the time I was unemployable due to the levels of medication had me so confused I really couldn't think. Short term memory loss, things of that nature.

But my message being, I guess, that the time element was in order to get on Patient Assistance Program you had to apply for Medicare and be turned down there. And then at that time when I tried that in the state of Mississippi, it was in a real turmoil at that point. And it took quite a while.

Therefore, I had to rely on -- thank goodness I had the safety net of my family that helped bear some of those expenses. And of course, that's not fair to them in some regards.

The time element now is, thank goodness, I'm much better. I'm back in the work force. However, the limitations there are the time element again of the 90 days before you become eligible for insurance.

Secondly and most importantly is the pre-existing condition, which sometimes makes you quite uninsurable. There are some exceptions to the rule also, so that they may not cover this in the future.

The cost of private insurance, I simply can't afford it at this point. I'm in a rebuilding point in my life. Again I never thought that would happen to me. And again there has been a lot of wonderful people, a lot of wonderful institutions that have helped. But again the danger being now is I feel that I'm quite uninsurable in some respects.

Unfortunately the disease I suffer from doesn't stop simply because Blue Cross stopped. It doesn't stop simply because I can't strike my debit card, which I don't have at this point. I couldn't strike a debit card or a credit card and pay for my medication.

And I guess that's the brunt of my message is I never thought it would happen to me. At this point I'm trying to rebuild.

But I feel there are some limitations

inherent in the system that need to be addressed. Thank you.

CHAIR JOHNSON: Thank you very much, both of you.

If you were to make one recommendation to help improve the system, what would your recommendation be?

MR. DYE: To somehow increase the Patient Assistance Program. For the past two and half years I worked in a ministry that deals with people in the same situation. And the limitations of the Patient Assistance Programs and the Pharmaceutical Assistance Program are fading away. They're vanishing.

And lots of people, like I said, that time element, the Mental Health Association is a great thing. They'll fill in one month's prescription needs for a patient.

But again if they have to go through that procedure of applying for these other agencies and being turned down before they're eligible for Patient Assistance, then they're without medication.

And in my case that medication meant maintaining a homeostatic, a normal level, so to speak. So it would be relieving some of the limitations, some of the requirements to get that assistance.

MS. RUCKER: There is an interesting way to look at that question. For the most part you are told as you come forth that if you get a good education, work hard, is that there are certain things that will not befall you. That's not true.

There needs to be more dialogue between employers and employees concerning the health care, medical benefits packages that are available to them. Because, yes, I have also been one of those who was told that they did not qualify for medical benefits. And you find out a year and a half later you did.

Also there needs to be some form of forums, workshops, educational television documentaries that address the issue of when you find yourself without benefits, insurance, and you are in "desperate need of medical care," where do you go in your state to at least start the ball

rolling.

The other way to look at this too is even take it to "churches and ministries." There are a lot of churches; there are a lot of ministries now coming forth. Let that be one of the platforms in terms of raising money.

There are a lot of "Fortune 500 Companies." There are a lot of billionaires who donate money to "worthy causes." Okay, we're a worthy cause. Set it up so that that particular part can be addressed as well. And, yes, we are a big tax write-off, yes.

So you might as well let them donate into the system up front before somebody like me or my colleague here comes along and says, all right, I never thought I would be in that situation. I did everything "you said."

I'm a Mississippi product, born, reared, and educated by the most part here. Yes, I do have an advanced degree. I chose to stay home. This is home.

And to see some of the things that I

have been seeing since this started is very disheartening. No, I did not know it existed even though I have two sisters that work in health care.

And fortunately for me, I do have a sister that is a case worker now. She was an RN. She went to case management. And because of some of the things she knows and is learning every day, because the laws are steadily changing, I didn't quite fall through the cracks.

VICE CHAIR MCLAUGHLIN: It seems that one of the messages that I got from both of you that I find very interesting. This group has heard over and over and over about the importance of patient education and consumer education.

In the previous session we talked about making individuals more aware of how the state health and -- you know, help empowering them, etc. But it sounds to me that you both are bringing up two other kinds of education that need to take place.

One is when people get sick, they need to have someone informing them about what their

options are. So that's down the road.

But the other thing that I find very interesting that both of you represent is it seems to me you're trying to ask us to start a public dialogue where we're educating the broad public that it can happen to them. And that's something, right, you just said -- neither of you are like we didn't have that knowledge. We didn't understand that just taking care of ourselves and getting an education and getting a job wasn't going to be enough.

And I think that what we're hearing is that you want the American public, all those young invincible, those healthy people, to hear that they need to start thinking about this because this could happen to them and that they're not aware of it.

Am I understanding that correctly?

MS. RUCKER: Can I re-direct some comments?

VICE CHAIR MCLAUGHLIN: Please do.

MS. RUCKER: It's not that it's "the young and healthy," because even though I've been obese, my triglycerides, my lipids, my cholesterol

are in normal range, if not lower. So it's not that you aren't necessarily healthy.

There comes a day like in my case, July 8th, the morning of July 8th, pain woke me up out of my sleep. I had one class that day, twelve o'clock noon class, math, test day. So they weren't too thrilled about seeing me that day anyway.

The pain escalated. I took some medication `cause I thought it was -- I can go on and say it -- PMS. I took medication for that, went back to sleep. Pain woke me back up. But it had escalated, got so terrible.

And I'm not one of those who is generally sick or sickly. Yes, I have sinus and allergies. When that season hit, I know what to do. That's about it. I didn't get the colds, the flu. I'd go walk. I had a membership at First Baptist. I'd go to the indoor track. I walked. There are different things that you do. Yes, so I was "educated" about things.

With my levels being low and so forth, that lets you know I ate right. It's not a matter

of "being young and healthy" and finding out about these as you go along. You need to know from jump.

I think one of the most disheartening things with me was that as I found out that I needed the surgery it wouldn't just to fix things. I went and applied for Medicaid -- excuse me -- tried to. What I got told when I walked up to the desk because I was not pregnant I did not qualify for Medicaid.

And I'm sitting there going I've been working all my life. I am single. I don't have any kids. I need some medial help right now. Why is the system set up this way so that at the one time in my life when I need some medical help from "the Government," I don't qualify `cause I'm not pregnant.

VICE CHAIR MCLAUGHLIN: That's actually the education that I meant. You just rephrased it. And that's what I was trying to articulate that both of you were saying that people aren't aware, just as you weren't aware that, if something did happen to you, you wouldn't be eligible, right?

MS. RUCKER: Yes.

VICE CHAIR MCLAUGHLIN: Or that when you had your problem, COBRA ran out, that you wouldn't be eligible for insurance because the pre-existing conditions. And that it could happen -- I mean I think that's sort of what I was saying.

But also this issue that -- and I know some members of the Working Group have articulated before in their own personal history that all the education about health behavior and everything else doesn't protect you from something all of the sudden happening which is what I think both of you articulated very well.

MR. DYE: There's a lot of information out there, lot of help out there. I think it boils down to until you need that information you don't seek it.

But, yeah, I agree public dialogue, faith-based initiatives, I think, is a great idea to promote the message and to try to help others. Yeah, I think that is the key is education.

And there are a lot of great programs

out there. There's a lot of great help out there. But again until you need that information, you really don't -- it's just not important to you. So, yeah, I think what you're saying is very essential.

MS. CONLAN: I want to thank both of you for coming today. I feel that you're my peers with all the people in the group. I know exactly what you're saying because my story is very similar.

And I think one of the message -- well, two messages I hope everyone in the room gets is it could happen to all of you as well. Comes from nowhere sometimes. And whatever plans you have had, there's a possibility that you could slip through those plans.

The other thing your stories tell me is about the resourcefulness of yourself and also many people like us. When you're at your sickest and your lowest point in your life, you have a rude awakening and you need to start working.

Sometimes there is a support group, family members that will help you. Sometimes you have to do it alone. And it's a challenge. And I'm

glad that both of you are survivors and here to tell the story.

I'm wondering if you then -- I have felt a responsibility once I got through the gauntlet, so to speak, and things got a little easier to turn around and extend my hand to others to help them through the maze, navigate through the maze. And I'm wondering do both of you participate in that and help to educate others?

MR. DYE: Yes, very much so. I said in the last two and a half years I served a ministry and we dealt with the homeless, alcohol, and drug abuse people. We helped many of them. There is a wonderful place called the Stubbs House here that really helps a lot. One of the limitations there is a lot of time they see a nurse practitioner, a psychiatric nurse practitioner, rather than a psychiatrist.

I work closely with my church and we have some outreach groups. I stay in touch with the mental health people and I refer a lot of people to there. And I'm currently -- one of my graces is I

always go back to school, but I'm currently taking classes to hopefully become certified in drug and alcohol abuse counseling.

So, yeah, I try to give back as much as I can because I've received a lot from not just churches and individuals, but from the government itself. So I'm very grateful.

MS. RUCKER: In my case I will be setting up a ministry. I have talked to my pastor concerning it. And one of the summits -- it's going to be done through summits -- will entail where do go when everything "hits the fan," when you are uninsured, when you become ill. What kinds of support groups are there? What kinds of assistance are already in place? Where do you go to get funding? How do you get housing?

Because I had to move back in with my mom. Fortunately she is alive and well and has her own house. Otherwise, that would have been an issue as well.

No, I don't get any income per month. So where do you get assistance? Yes, my family

kicks in a whole lot. That is a rescue. But there are some people who don't have family who can help support them or kick in or any of that.

So, yes, he's already looked at it in terms of my pastor looked over everything and he told me it's the most different ministry he has seen. Yes, they will work with me.

And we have a new bishop. I'm United Methodist. And she sent me a letter which said I will be looking at the development of this ministry with "prayer and interest."

So, yes, there is a base in terms of this will benefit more than just me. And, yes, it hurts that in my case right now my doctors do say I will come through and be restored. There are some people who "don't come through and be restored."

So that is another whole set of criteria that you have to look at in terms of treatment and the "more abundant living where you are." And our protocol will look at all of it.

MS. CONLAN: I just want to say one more thing. You mentioned about prescription drugs. And

this is something I want to bring forward. And I think you're helping to bring it forward. There are some diseases and some conditions where there are not generic forms of drugs. And so the plan, well, we'll just reduce cost by providing generic drugs, that's a very intimidating situation causing a lot of anxiety as well.

And so I thank you for bringing that forward. I think that's maybe the first time we've heard that.

And I was wondering if you could just talk a little bit how you feel when you hear that discussion, oh, we'll just give everyone generic drugs. It's cheaper.

MR. DYE: Well, in the mix of anti-depressants and anti-psychotics, from my own experience -- and I'm certainly not a psychiatrist. But it took a while to find the proper mix of and the proper drug to countermand or alleviate those symptoms.

One of mine is Resperdol and Resperdol is a very expensive drug. Effects are it's one of

the anti-depressants. It's a very effective for me, but it's very expensive.

And I'm seeing this now that guys that I take to the Stubbs House and they're getting help there, seems like they're always prescribing one generic drug now. Whereas there used to be other drugs which were more expensive prescribed, but I'm sure they're probably going with the axiom that, well, they can afford this cheaper drug. They can't afford this other drug. My fear or my caveat would be maybe that drug doesn't work as well as the other drug.

And if you've ever suffered from mania, a manic phase is quite disturbing, quite frightening, and quite debilitating. And that Resperdol countermands that for me and makes me able to function normally, so to speak.

So I think the danger is that maybe you're trying to -- maybe they would match a drug that doesn't do what it should do for the patient simply because it's an economic quotient. And I don't see that that would be very advantageous for

the patient, for the person with the illness.

CHAIR JOHNSON: Deb?

MS. STEHR: I would just like to thank both of you for sharing your story today. I too am uninsured and I'm here, I guess, representing the uninsured population also. I've been very fortunate that I haven't had any major problems. I've been uninsured the majority of my life and probably living on the edge as I get older.

I appreciate the fact pointing out that, yes, you work hard, you're educated. Because I have heard that excuse when I've shared my story to like viciously get attacked by, well, if you'd work hard and if you had a better education and if you went to college and if you'd move.

I get tired of being told if you'd move and go find a better job. Well, you live where you live because you choose to live because family is there. So I just really want to thank you for sharing your story.

And have either of you tried like any of the indigent drug programs, not injected through the

pharmaceutical companies, to get any of your prescription drugs you need?

MR. DYE: Yeah, I was on the Patient Assistance Program. But once now being employed again, then that's -- well, not only that, but I mean I don't feel like I should do that. I mean I should support myself. But it helped at a time when I couldn't do that.

But those programs are fading and fading fast. Pharmaceutical companies, I think, in the last -- the last time I talked with the psychiatrist about the Resperdol, they just weren't that amenable to doing it any more. So the programs are being cut back.

MS. RUCKER: In my case I fall into that you're slightly over income that when you "don't have any income" and you're in need of meds, that's no help. So you run into that "economic thing" whereby, oh, you made too much money.

I worked up until July 7th of last year. Between January and July 7th, I made too much money to qualify for "that program."

MS. STEHR: I guess it kind of shows even though we're led to believe those programs are out there and they'll benefit people, they're still too hard to access and not available.

MS. RUCKER: And in some cases you are already "over the limit," even though you don't make that much money. Because even as an instructor, I did not clear $28,000 a year. So the half year I was up to 17, a little over 17 K. With short term disability that went up to by the end of the year 4,004. So that's like 21 something. I'm over the limit. I can crunch numbers; I have a undergraduate degree in math. (Laughter)

MS. BAZOS: Richard and Georgia, thank you again for coming and sharing your story. What I'm hearing from you is that both of you have spent an enormous amount of time and energy first trying to learn about our health care system when you really needed it, negotiating how to get benefits that you needed, and now trying to help others to learn it, to access it. It's an inordinate amount of energy.

When we asked Dr. Jones if he would think about what an ideal system might look like, he felt that we really needed to have universal coverage for all.

My question to you is if in the United States everyone had access to basic health care, to health care when they needed it, how would that have changed your lives?

You have access now to health care services. You're getting health care that you need although you're struggling to get it.

But if our system were changed, if we actually had a system where everyone had health care, what would that have done to your lives? Where would your energy have been? How do you think your lives might have been different?

MS. RUCKER: In my case I would be well because with a herniated disk pressing on a sciatic nerve, that's a great deal of pain, period. It took a very long time for them to "diagnose it." The doctor came to the ER at a certain institution. I was just told sciatica. Take ibuprofen. Yes,

ma'am.

I had elevated blood pressure, blood sugar. That's what happens with me; my blood sugar goes up first, then my blood pressure. High. Sent home. Told to make a appointment with my doctor and get the blood pressure and blood sugar issue addressed. Okay?

I still did not get out of pain. And I went to "my doctor" two weeks later. That doctor referred me out while listing a referral. In one of those referrals I was fortunate. It was a foot doctor. She had "sciatica." So with her having sciatica, she called her doctor and got me an appointment for the next day.

They did an exam and said, no, this is more than sciatica with the things that are going on with you. She ordered up an MRI. Went for the MRI. It came back at the end of the week.

Referred me to a neurosurgeon. I had an appointment two weeks later. They sent me a notice in the mail saying that we've moved your appointment -- we've canceled your appointment. Call back to

reschedule. I called immediately. My appointment was moved to the middle of the next month.

So what I'm saying is that now it's a matter of referral. And there is "not enough doctors" or a shortage of providers, or they can't "immediately look at what is going on with you." So it was the next month.

My sister got me in to another one before then. But that one just looked at it and said, okay, we're just going to watch it.

So in my case what I'm trying to get you to see is that you can have some initial benefits. You get caught in a "system" that is understaffed. You get caught in a system that is over booked. And you still end up getting "delayed health care," even with insurance. That was with Blue Cross/Blue Shield of Alabama. It didn't work.

So to get a system in place that would address -- I call it -- "socialized medicine" to a degree would be wonderful. But it has to be the one whereby you can be seen in a timely fashion to address what is currently going on with your

illness.

Because, see, that also goes back to a patient that is -- or a client that is 64 and a half. If they get sick or if they're not quite 65, but because they're 64 and a half, they don't qualify for Medicaid, and it's too early -- I mean so, you know, they won't put them on Medicaid. And it's too early for Medicare. They won't give it to them. So you've got to wait six months before you qualify.

That system still doesn't work. So it has to be a better way that you can get the attention when you need it.

The other example is the stroke victim. When you are uninsured and you have a stroke, you have to wait three months by federal law before they will process your Medicaid application. It still doesn't work.

So there has to be some better guidelines, some laws changed so that when you are in dire need -- I'm sorry. I just don't of anybody who'd fake a stroke; I just don't. You need that

attention right then.

And that's what I'm hopefully pointing out that, yes, even putting one in place, there's certain things that you have to make sure that you have included.

And mental health is another whole area by itself because of all the stigma from years gone by concerning mental health. Oh, that's a whole nother issue.

And, yes, some of it I know from experience because there are family members who are manic depressive. So I've had to deal with certain parts of "the health care system" anyway. There were some things I was fortunate that I knew. It was unfortunate that there were people in my family or close relatives, friends that were going through it.

But there were parts of this "system, medical health care system" that I knew about firsthand. Yes, she's taken them to appointments. Yes, she's set with them. It's just not working.

MR. DYE: On a general level I think

universal health care would expand and maybe keep things from happening to people that didn't have to happen.

In my case, being uninsured at this point, there were a couple of procedures that at my age I need right now. I haven't had them in a few years. But I have to save up right now to even think of a colonoscopy. You know that's something that -- I'm 51. That's something I should be taking heed of. I can't do that right now because I simply can't afford to live and pay that physician what they charge for that procedure.

So secondly again the time lag. I think that if I had had more access to the health care more expeditiously then I would have been, again, more productive and employable at a greater rate than what it's taken.

And now universal health care, I guess, I always think of socialized medicine and that scares me. It has a negative connotation for me for some respects. There is a lot of help out there. It's just accessing it. And I'm sure it's not

perfect. But by the same token, I don't think the system failed me, so to speak. I think there was actually a safety net there that helped me. Could be better always, yes. Anything, yes, everything can improve.

Again the time lag and the prohibitive cost of some of those medications, there's where there needs to be some help.

And you know on the employer's side, when you go to an employer, that health care costs so much that it sometimes makes them they can't be competitive hiring people there. And so they don't have a lot of control, especially a smaller employer.

I think there needs some reform with the health insurance companies themselves. Again not to climb on a platform, but health insurance companies have been rather lucrative for 80 years. So maybe it's time for them to give back a little bit. And I'm digressing, so I'll --

VICE CHAIR MCLAUGHLIN: Thank you.

CHAIR JOHNSON: If our Working Group has

no other questions regarding your uninsureds, may I ask a question that relates to our future communication. One of the things that we're expected to do as part of our project is to communicate with citizens generally about the health care system.

What suggestions would you have to communicate with the average citizen?

In other words, how do we get some of the messages out that you have kind of indicated we need to get out in such a way that there will be listenings, reading and then potential feedback from citizens nationwide?

I think one of you said that oftentimes you don't read the materials until you have a need to read the materials. And that's some of our experience, as well, as an employer.

So how would you suggest we get information to our U.S. citizens so they can give feedback to the Citizens' Health Care Working Group? Any suggestions?

MS. RUCKER: Town meetings are

wonderful. And that is a avenue that can be used. Yes, give it a catchy title.

CHAIR JOHNSON: I'm sorry.

MS. RUCKER: Give it a catchy title. Usually with all of us when we go to read an article what attracts us to that article is the title. So, yes, give it a catchy title. Do not give it one that you will look at and say, yes, go to sleep on.

Save that for when I'm in bed at night and can't quite get to sleep, need something to put me to sleep. Give it a catchy title. (Laughter) I'm an instructor, okay? So I've probably heard it all. And I come from a family of tricksters. Yes, we have big fun.

Go through faith-based initiatives. Go through your churches as well. Also have a summit, workshops and seminars that find that sometimes on those particular weekends or days you have a meeting you must go out and have. That's your weekend to work.

So if you announce the summit several months ahead of time and let it be "a week long or a

day long." Put the brochures out there. Like when you open them up and say, okay, for continuing education unit or for upgrades, I'm going to pick this destination. Of the topics that they're covering, these are the ones I possibly want to go to. Do it in that type of format so that, yes, people will have time to plan.

Yes, in some cases go on and make it as upgrades or continuing education units so that they can get credit for it. Their employer in some cases can pay for it and help afford, so it's an option.

On a personal basis each employer should, when a person comes in, send them over to Human Resources and go over with them the various things that they collect in terms of if you're paying for your own short-term disability, it starts X number days after you're sick. This is how you go about filing for it. It will last X number of weeks. And long-term disability starts so many days or so many months after.

Know what your medical benefits package has. And, yes, that's something you have to do

through Human Resources, go over it with them. That is not something that is done in every case.

And like I say, in my case when I first went to work where I was employed, I didn't receive benefits because my supervisor told me I did not qualify which was a story. It was an untruth. And I found out a year and a half later I did and I signed up for it. And, yes, it was about a year and a half later before this hit. So, yes, being informed through those kinds of ways is very helpful.

MR. DYE: I think you touched on one thing too is that if you educate the youth who think they're invincible to reduce your discretionary income by purchasing long-term, short-term disability, things of this nature, saving a little bit more money because there do come times when you do need a nest egg.

Secondly it seems like in our information age we could somehow form a referential network so that there are central locations that this information could be dispersed and perhaps

start at the level of the health care people. When somebody comes in to you into your office if you're a physician and you can't -- you know, they don't have insurance. Then perhaps you would have some numbers you could provide them with to call and get information so that they could garner these resources.

To me that seems, that network would seem to be -- and like she said, you could develop it easily in the churches and community meetings, community associations, mental health associations. But even the health care providers -- and I'm not meaning to burden them with that. I know that's a cost. But seemingly in the information age, we could form this network to where it would be easily accessible.

CHAIR JOHNSON: Well, thank you very much, both of you. We appreciate your input this morning. We have learned from you. It's been very helpful. You've made some very positive suggestions. We appreciate those.

And again reiterating even though we are

unable to provide an opportunity for feedback through this hearing, there will be some community meetings later on. And there is also a website. If anybody would like to write down the address for this website, it is citizenshealth -- that's one word -- citizenshealth@ahrq.gov. I'll do it again.

VICE CHAIR MCLAUGHLIN: That's the e-mail address.

CHAIR JOHNSON: Thank you, thank you. It's an e-mail address. I've been correctly addressed here. (Laughter) citizenshealth@ahrq.gov. Okay?

We will take 15 minutes and reconvene promptly at 10:45 with our next panel.

Again thank you for your attention.

(Off the record at 10:30 a.m. and back on the record at 10:45 a.m.)

CHAIR JOHNSON: We welcome everybody back to this third session as we continue to hear from our friends who are here in Jackson. And we have a really fine opportunity at this time to hear from three new people: Bill Croswell from the

Chamber of Commerce here in town, Dr. Janice Bacon from the G.A. Carmichael Community Health Center, and Primus Wheeler from the Jackson Medical Mall. And we are just delighted that you're here.

If you'd give us about two minutes, we'd like to do some Working Group business. Because one of the things that we wanted to do when we came here to Jackson was have an opportunity for some of our Working Group members to make a tour of one or two of the facilities here. So if you'll give us two minutes before we ask for your testimony, we'd appreciate that, and I'll ask George to make his comments and ask his questions.

MR. GROB: This part of our hearing is to learn more by going places, too. And this is available to the members of our Working Group and to the staff. Here are the options that you have.

CHAIR JOHNSON: Could we ask for the lights, please? Thank you.

MR. GROB: For all of those who would like to visit the Community Health Center nearby, that will be available at 12:00. And we will leave

promptly at 12:00. And we'll go there from 12:00 to 1:00. So if immediately when this meeting is over without further adieu, please be ready to march out smartly because we have to take in the tour and then we have to get back here at 1:00.

DR. SHIRLEY: Get back here before 1:00.

MR. GROB: Now at 1:00, there are three options for people at that point.

One, you may then have an extended tour of this facility. Some of you have seen a lot of it, but this would be a more methodical tour of it for those of you who want to do that from here.

Also at 1:00, another option for you is to attend the Medical Museum which is nearby.

DR. SHIRLEY: Civil Rights Museum.

MR. GROB: The Civil Rights Museum, excuse me, which is nearby.

And then we know that the third option that some of you are on a tighter airplane schedule. So your option would be to leave for the airport at 1:00.

So that's how it will work. And please,

if you could be ready to leave promptly, so we could give you all of these opportunities as much as possible.

CHAIR JOHNSON: Okay, thank you.

Well, thank you, Bill Croswell, Dr. Bacon, and Primus Wheeler. And potentially we can hear from you first, Mr. Croswell, and then Dr. Bacon, and then Primus Wheeler in that order.

MR. CROSWELL: Ladies and gentlemen, thank you very much for recognizing Chamber Plus and the things that we're doing with the business community. We're proud to be part of these proceedings.

Chamber Plus is the subsidiary of the Metro Jackson Chamber of Commerce. You all have flown in and are going to be flying out. Metro Jackson, as we look at it, is basically a tri-county area of approximately 500,000 population in the Metro Jackson area.

Chamber Plus was formed because we determined as a Board of the Metro Jackson Chambers that there was a need for health care for small

businesses. For whatever reason they eschewed having health care, either for expense or didn't understand it or what have you.

It was in 1996 a group of us got together and at the request of some of our members to investigate the possibility of developing a insurance program that we could have for small groups. It was no problem getting coverage if you're with a big factory or whatever, but a lot of our members are two people, three people, very small groups. And most of them, real or imagined, didn't believe that they were able to get group insurance for a group that small.

So we set about visiting with a lot of the Human Resource people around town. We had some consultants from Ohio came in to guide us through the process we went through. And again in the `96 and kind of drew up a request for proposals of the things that we felt like that we needed and we put this out and received proposals from several companies.

And we elected at that time to go with

Blue Cross Blue Shield. They saw the potential of our membership. We're one of the larger Chambers of Commerce in the state. And we set about then to market this product. We were able to leverage the potential number of members in order to get a discounted rate to get our program kicked off.

And Blue Cross worked with us on that. And using the agents, they always like to have a better mousetrap, so we came up with a better mousetrap. And as you can see later on, I can tell you that we started from zero. Like any other business it's -- it was tough cash wise getting started. But we knew that we - there was a need. And we worked hard to fill that.

In nine short years, we now have some 1,400 groups and we are covering almost right at 20,000 lives. Interesting statistic about this is the fact that based on what we could determine, approximately six percent of these people did not have any prior coverage. So we make it available in these smaller groups and these business owners and through the promotion and so forth that they were

able to take on the health care.

And out of twenty -- twelve thousand people that didn't have coverage now have coverage. And we're quite proud of that.

In 1998, seeing the success that we were having with the small businesses, several other Chambers of Commerce throughout the state from small towns to large towns inquired how could they do this. How can they bring this to their members, groups of one, groups of two?

And we worked with Blue Cross and we currently now have 54 Chambers of Commerce that are offering health care to their members. And that's -- we think that's quite an accomplishment. I couldn't name you 54 towns, but we've got 54 other Chambers of Commerces here.

So over the period of time, things change. We have to modify the program. We work with Blue Cross in order keep us competitive and to be sure that our members are served from the members of one little life per company or up to 50. We don't get into the over 50 part there.

So that's a short story. It took us nine years to get there. And we're still growing. And we think it was a -- I feel as a business person myself that it's a classic example of what business can do working with the community and providing -- solving a need.

CHAIR JOHNSON: Thank you very much. Our practice has been to ask each speaker to talk for about 10 minutes or so sharing your perspective. And then we'll come back and ask questions.

And at this time we'll go to you, Dr. Bacon, and ask for your input.

DR. BACON: Good morning. I'm very happy to be here today. And I'm going to go through these slides and if I'm speaking -- if it's too fast, please just let me know. Slow me down. I have a tendency to really talk fast at times.

Just a little background so you know about my perspective. I work at G.A. Carmichael and we are known as a Community Health Center. Our Health Center started work in Mississippi back in `72. We are currently in three rural counties in

the state, Madison, Yazoo, and Humphreys. We have a user base of over 26,000. We define the patients as users by making at least one visit to our Health Center per year. So in 2004 we had over 26,000 users, 92 percent African American.

What's unique about the Community Health Centers is that we're governed by a Community Board. And that board must be made up of members of the counties that you serve. At least 51 percent of your board must be users of clinic services. And at our last analysis, 82 percent of our board members were users of clinic services.

In terms of patients that we serve, 40 percent are uninsured. As I mentioned about the UDS, this is just a little breakdown about our locations at the bottom. We have three main clinics, 11 school-based clinics, and one outpatient clinic that we started at the hospital in Madison county in August of 2004.

We're strictly in primary care in terms of our full-time employees. But we do have sub-specialists rotating at times to work at our sites

in neurology and nephrology and cardiology. This is what we were trying to work on. We have all these issues that we deal with on a daily basis.

And it looks like it's a tall hill to climb, all the issues around staff turnover, reimbursement, travel distance, problems with Medicaid and the costs. But we're trying to come up with a way to take care of that and do planned care at the same time.

The Institute of Medicine put out a report a few years back. And it talked about things that need -- things that would need to happen to improve the health care system. And these were some of the key aims that they talked about during that report.

In addition to that, they talked about some rules for care. These are just some of the rules for care that you need to focus on if you want to really achieve the outcomes you desire.

The Bureau of Primary Health Care is our governing body for Community Health Centers. And we are under the division of Clinical Quality. And

there are certain strategies that they put into place. One dealing with disease management, the other with accreditation, the other with risk management.

Under this Quality Management strategy, they developed the concept known as Health Disparities Collaborative. In it there is a significant disparity between the health care in terms of diagnosis, treatment, and outcome for certain groups within the country, whether it's based upon race, economics, gender -- those types of things.

So this model was designed to try to look at some of these issues and come up with effective ways to redesign how we approach the care of patients. It was quoted in the article that the current system we have can't get the job done. And even though we may try harder, it won't do it. So what we've got to do is change the care system that we have in place.

So Dr. Ed Wagner was the creator of a model known as the Model of Chronic Illness Care.

It's a population based model. And this is a quote from him talking about that model. This is the model. It's known as the Chronic Care Model. There are plans underway to really call it the Planned Care Model. If you will notice the number of loops along with certain arrows, the idea is that you take all the components involved in delivering care which would be the community, the organization, the patient, the team in order to get the outcomes you desire. You can't do it in a silo and only focus on one component of care.

The key part of this gets down to the type of interaction you have. The patient has to be activated and really be a part of the team in order to get what you want. So focus on patient centered care is key in that the goal is to make the patient realize they are in control.

These are just some of the missions in terms of achieving goals and excellence in practice. We want to generate a document in our house for the patients concerned. Transform how we practice medicine. Develop our infrastructure and expertise

and make sure we have the right type of leadership. Build strategic partnerships.

What was thought to be some of the advantages is that if we use this model, we can build preventive and chronic care services. And it was thought that once you learned this model by being in the Health Disparities Collaborative, you could apply it to any system within your organization.

Unfortunate part of this is -- this is an example of how the learning would occur. The Institute for Health Care Improvement, IHIs, is an organization partnered with the Bureau of Primary Health Care to conduct these learning sessions. And they are anywhere from eight to thirteen months, and you learn key components about how you drive improvements in care.

And I can go into it a little bit later, if you have questions about it. To go along with it there is also a model for improvement known as PDSA, Planned To Study Act. And this is the concept that you apply to any endeavor you want to achieve

whether it's directly tied to patient care or an improvement within your organization. It is the core concept that we utilize in terms of structuring our program.

So the question is what is reality for us here in Mississippi. And what is happening is that the Community Health Centers of Mississippi are actively participating in the Health Disparities Collaborative. And we are using this model to make a business case for what needs to happen to improve care for the clients in Mississippi.

And this is just an example of some of the data from G.A. Carmichael in terms of documentation of health outcomes for our underserved population.

And keep in mind what we're doing is measuring ourselves against national standards, whether they're set up by by employers, by any organizations. These are the collaboratives that we participated in. We did diabetes, asthma, self-management as a part of a collaborative. We're currently in a perinatal and patient safety

collaborative.

This is our diabetes data. And what we did for diabetes is that the average hemoglobin A1C is a marker. And if you have this test done, it gives you an idea how well your diabetes is in terms of control. The goal is to get it less than 7.

In Mississippi we're considered one of the largest countries -- one of the largest states in the country. We have a lot of risk factors for diabetes. So our incidence of diabetes is quite high. To control your diabetes, you want the goal, your value to be less than 7.

As you can see in 1998, the average hemoglobin A1C for the patients we had in the registry was almost 14, which does lead to bad outcomes -- dialysis, amputations, those types of things.

But by implementing this model you can see over time -- and unfortunately I don't have the slide in that has 2004 data -- but it still maintaining an average of less that 8.5. We are able to add more patients into this registry, track

this data, and still maintain improvements.

And this is the population based focus, so this is not just an individual patient. This is all of our patients with diabetes in the registry.

And some of the key things that we did, we had to build and work on our solid relationship with our state Diabetes Prevention and Control Program. It's located within our state Department of Health. We also work with the state Department of Health Cardiovascular Division.

We did a unique thing in that we were able to get a contract with every eye care provider in our three-county service area to provide dilated eye exams to all diabetic patients. And this is crucial to get that done on a yearly basis to prevent blindness.

We also work with the elected officials. We have what's known as the Stepping Out Campaign. And we always invite our mayor and other elected officials to come in and greet our clients as they go through the various stations. And this helps to show the value of the health care services as part

of the whole community.

We also work with all the Ministerial Alliances we have what's known as a self-management model. And we work with the Family Life Centers. And at the Family Life Centers, we give educational classes along with cooking sessions. And this is -- this goes over quite well because the ministers from the pulpit will tell and inform the clients of the importance of getting this service.

Also by having the onsite specialist for nephrology and cardiology is key because transportation is a problem for patients in our rural areas. So bringing the sub-specialists to them works out quite well.

We also have funds from a program known as Mississippi Qualified Health Center. It is a Mississippi State House Bill 1048. And under this -- under these guidelines if you apply and qualify, we've been receiving approximately a $170,000 a year for five, going into the sixth year. And this money we've dedicated to our Health Disparities arena.

Some examples we've used it for. We're

buying shoes for diabetic patients who can't afford to buy them. And we pay for their lancets and supplies for testing. We also are underway to develop a diabetes center in partnership with the local hospital in Madison County.

This an example of asthma. We also had some key measures and aims for our asthma program. Again, asthma has a guideline where you want to put all asthmatics on medications on a daily basis if they have what's known as persistent asthma.

So back in `99 we looked to see were we doing that. We were only doing that in about 30 percent of the time. Once we implemented this Health Disparities Model and the Learning Model, we were able to increase our percentage and adherence to above 95 percent.

And again this is the goal that you can look at the American Lung Association, the Asthma Coalition and to say that we're able to maintain this for an underserved population is remarkable.

Same thing for self-management. I'm sorry this slide is not good.

To show you that we are also partnered with other agencies, we partner with American Lung Association. And we conduct a number of activities at the school. The number one cause of missed school days for kids is asthma as a chronic illness. So our goal is to administer the medications at school, improve the educational learning for the clients at school.

This is an example of our staffing featured in an article about the way we're conducting asthma care for the kids in Madison County.

We also did a pilot program. It's ongoing; it's Healthy Foods, Healthy Moves. We found that a number of our clients didn't understand and still don't understand the value of making adjustments in terms of how to prepare food and also exercise. So this program we started. This was our aim to work on diabetes and obesity, to really work on the knowledge base, ability to understand lifestyle changes. And try to overcome some of the barriers that we have to deal with on a regular

basis.

And these are examples of our key partners that we've been working with our Healthy Foods, Healthy Moves Program. In fact with our exercise class, the superintendent and the principal agreed and we are able to hold exercise classes in the gym at the school.

With the local day care facility, they have vans that they're not using at the time that we need them to transport the kids from the middle school -- from the elementary school to the middle school. So we have an arrangement where they will help us pick up the kids from the elementary school and bring them to the middle school for their exercise classes.

And with the Ministerial Alliance, what we've done is we get them to let us advertise about the program, get the appropriate consents for the kids to attend, and get the parents involved. And what we're going to do is to work on creating a community based fitness facility for children and parents by working with all these entities involved.

And as a matter of fact, the superintendent for the school district just got back from a session because there is a big concern about obesity in children and the effect it has on their learning. So we're gung-ho about this project that we're trying to work on.

Just an example just to show you how severe the problem is. If you have a BMI above 25, you're considered overweight and obese. If you look at this data that we have, this is just a snapshot of some of the kids we have participating in the program. We have BMIs above 40. And that puts you at a significant risk for all types of health outcomes. And it's a significant problem that we are trying to address.

Unfortunately this is cut off, but this is the aim that we have for our Prenatal Patient Safety Program. Again this is a community based project that we're doing with our key partners: the hospital, Mallory Community Health Center, and G.A. Carmichael. This is just some of the goals that we set for that program in terms of, you get better

outcomes for your prenatal clients if you enroll them in the care during the first trimester. And what we're trying to do is work on these goals for our perinatal clients.

And it's the system changes that we're trying to invoke. So we always involve all the key partners in the community.

The reason why we're doing this in Madison County is because 40 percent of our clients deliver there. We're working with Mallory because the OB-GYNs on staff are employed by that Community Health Center. And the goal is to really try to improve and strengthen the community linkages that we have.

CHAIR JOHNSON: Well, thank you very much, Dr. Bacon. We're going to go right now to Primus Wheeler, and we'll look forward to your comments as well.

MR. WHEELER: Morning. Thanks for all the help in getting this started. I'm a health care administrator and not too great with computers, I guess. I'm here to talk a little bit about what the

Jackson Medical Mall Foundation is doing to improve health care in this community and all over the state of Mississippi. The Foundation actually is a big landlord.

I started to tell a little bit about the history of the Foundation. This is an old shopping center. It was the first shopping center built in Mississippi back in 1968. And it was the place to be.

And I would tell people that I ended up kind of meeting my then girlfriend but my wife here. And we were college students and didn't have any money. So we walked to the place and window-shopped and threw money into the wishing well. And never knew that I would be working here someday. So I have a lot of history with this old mall. We've been married 30 plus years now. So it was a good meeting and a good long-term relationship.

But the Mall started to decay in 1978, as is the story with most malls. They're going to. They have a short shelf life of 10 to 25 years. And this one happened just pretty much the same as

the others. It started to die in `78 when the big anchor store moved. And then after the largest anchor store moved, then the rest of the stores kind of started to follow the process.

So it became an eyesore to the community. And just never really could be used for anything. Lots of programs came. Lot of folks talked about doing things. But thanks to Dr. Shirley's vision to overcome this big old eyesore in that -- in the community here, and his ability to lead and make partnerships and collaborate, he brought three institutions together to purchase this property: Jackson State University, Tougaloo College, and University Medical Center. And obviously if you're from the Jackson area, you know they don't really have a whole lot in common. So how do you end up making those three people partners?

Thanks to Dr. Shirley, he was able to get it done. And I could thank him because with the story, the rest of the story is already told. But they really put all of their differences apart and

came together with one single goal in mind, and that's to improve the health care in this community and the state of Mississippi.

We started renovating this place in 1996. And a lot of times we get questions about how much money did it cost to renovate the place. Upwards of $60 million dollars was spent to renovate the mall and make it totally beautiful and very pleasing to the clients that we serve here.

We opened our first clinic in 1997. It was actually renamed Thad Cochran Center in 2001.

And we have a very simple mission statement. It's a two-fold mission statement. And it's to foster holistic approach to health care for the underserved. That's the first component. We focused on that part first seven years very diligently.

And then we have a second component now. It's to promote community and economic development in the Jackson Medical Mall District. We do have a full district here now. And this mission is so important to us because it set up the whole program.

You've got to treat the whole man. You can't just treat the medical needs. There are lots of things going on in families and socioeconomic problems that cause us to be a very sick population. So you got to deal with all of those things. So economic and community development, rebuilding and reclaiming this community is just as important as building this big beautiful building here to provide direct health care.

Financial Organizational Structure -- and as I said earlier, we're just a huge landlord. We have 900,000 square feet, 50 plus acres of space. We have five major anchor tenants and have about 40 other tenants here. But our annual revenue is about $10,000,000 a year.

And folks ask me all the time. What are you all doing with all that money that you collect for rent?

We pay those bond issues down. We have $60 million dollars worth of debts to pay off. So we're very busy paying our -- paying those notes down.

And at some point in time, those are 15-year notes. Those notes are going to get paid off. Then you can ask me what we're going to do with the money. I'm sure by then Dr. Shirley will come up with something else and we'll spend the money buying another mall or building some else bigger than that.

Our health care tenants -- and we'll focus on the tenants. Obviously University of Medical Center is our largest tenant. And we're very happy to have them.

And I can tell you when we started talking about the Mall in the early days, it became very evident that we had to get the community totally involved in this project to make it work. And there were some concerns from the community that the big city on the hill has come to our community to take it over.

And so we had to overcome those and had to do a lot of talking and preaching and teaching to make the community understand that this is going to be a collaboration. This is going to be a partnership. And we'll all work together to make

this happen.

I've been here -- I came here with the Mall in 1997. And I can tell you that this is one of the most beautiful partnerships that I have seen. The community has really rallied around University Medical Center. And University Medical Center has really rallied around the community.

This is their first major push to become a community based health care provider. And it's really worked out to their good and to the community's good.

We don't have those conversations anymore. When we come to the table to talk now, we're talking about how do we do it together.

We have a State Department of Health here. They were the first thing that opened up in `97, State Department of Health.

And the Hines County Health Department started and consolidated some of their clinics that were all over the city. This was a central location. Had nice, safe, and quiet parking. So they wanted to consolidate their programs here. So

they started the process, and everybody else kind of followed.

We have the Blake Clinic for Children at the State Department Health Clinic.

Professional Eye Care Associates. This is one of the few private clinics that are here. Most of the clinics here are public, either run by the state, University Medical Center, or the county.

McKessan Health Solutions -- and this is a disease management program. And they are primarily managing a portion of the population that's in diabetes, asthma, and they're a Medicaid kind of disease management process. And I think they are also stepping the program up to do some Medicare stuff, too.

University Medical Center is the largest provider, as I said earlier. And people have a difficult time sometimes understanding what the Mall Foundation really does. And I want to say this over and over. We're the landlord. We make sure the place is safe and clean and operable so that the University Medical Center and Hines County State

Department of Health can come in and do what they do. We manage the property and we lease it to them and they come in and provide the services.

So I, as the Foundation, don't provide any direct services to any patients.

But the University Medical Center has several offerings here. Primary care clinics are here. And when we first opened, the primary care clinics were in a separate location. But as time passed, we have actually combined primary care and specialty care into the same space. And it's a very efficient use of the space now. And we've actually taken the Primary Care Clinic and converted it into the Cancer Institute.

But the same physicians working across the hall, going back and forth. It just didn't really make sense. And it made sense when we were building it. But once it became operational, it didn't make sense. So we've learned as we've gone along.

We have diagnostic and rehab programs. The Jackson Heart Study is here. And I think Dr.

Taylor talked about that one this morning.

Our Cancer Institute -- we're real proud of the Cancer Institute here. It is going to be an MCI designated cancer institute. It has about 170,000 square feet associated with it. And the people have been in Jackson for a while. It's in the old Woolco space.

So we are -- there are three phases of the Cancer Institute. Phase one is the Hematology, Oncology Clinics. And those clinics opened up in January. And now we're down to the Radiography. The Radiography opened up in April of this year.

And the research and faculty offices section will be completed next week. And they will start to filter into those places in December. And at that point, we'll have a full operational research, medical, and Radiography Center set up here.

And it could have been set up anywhere in town. It could have probably been set up at the University Medical Center. But the idea was to put it here, and we reserved a space for it for several

years to make sure that that institute was placed here.

The social services programs here offered by University Medical Center. Metabolic Clinic and our Diabetes Management and Lipids Programs are very popular. And as Dr. Bacon said, our diabetes is eating us alive, pretty much. So we have a very aggressive Metabolic Clinic here that manages diabetes. And they have some very great success stories with their management of hemoglobin A1C also. If you look at he map, it's difficult to see on here, but I do have a handout in the packet. It shows that our patients come from all over the state of Mississippi. About 70 percent of our patients come from other places other than the Tri-County Area. The Tri-County Area is Hines County, Madison County, and Rankin County.

And you can also see from looking at the chart there that about 40 percent of care that we provide here is uncompensated. We always get questions, well, how do you afford to provide the care for uncompensated. We've just been lucky so

far I guess.

But there's a formula to make sure that the patients that come here, whether they're coming from Tupelo in the morning to Hamilton County in the afternoon -- and you can actually stand at the gate in the morning where the security guards are and just see car tags from all over the place.

And when they first started coming, I thought they were coming for specialty care. But as time passed on, we learned that there are just as many patients coming for primary care from 200 miles away, 150 miles away in the morning, coming down for primary care as they are for specialty care.

I think that's wrong. And I think that we've got to figure out a way to make sure that primary care is available in the local communities. More available in local communities. Not that we don't -- we have a primary care center here, but it just doesn't seem real smart for a patient to drive 170 miles to get primary care.

Collaborative and Support Services -- we have Jackson State's School of Public Health

here. Very important component. They will be driving most of the research as we go forward to improving health care disparities.

The United Way first called for help. They are always here helping to make sure that our clients have transportation to places they need to go, and their utility bills paid, making sure they have places to live when they have been put out of their homes.

Improving quality of life -- it's a drug intervention program -- counseling for alcohol and drug,

Partnership for a Healthy Mississippi is a program sponsored by some of the tobacco settlement money. It's a smoking -- anti-smoking program primarily for children, teenagers.

Stork's Nest -- and this is a group, a sorority that has partnered with a group to open up the Stork's Nest. And they primarily focus on young ladies in their pregnancy who are having difficulty complying with their doctor's suggestions, rules, orders. And they counsel them to make sure they

start to comply.

And they, from what I understand, get no money from us. They're kind of internally funded. But it's a very successful program. One of our employees actually was one of their first patients to go through the program. And she had nothing but high marks for them.

We have retail shops here. And if you drive from Tupelo, three hours this morning, you need a place to relax if you're bringing your family. And what we found our research shows that for every patient that shows up at the clinic, that means that 2.8 people show up here at the Mall that morning. It's an event to come to Jackson to the Mall. And so we need the retail shops to keep our people entertained while they are here. You also have to have a place to eat. So we have restaurants in the place that allow that patient -- that family members can get food while they are here.

In conclusion, this is an outstanding place for health care. I mean we have removed the barriers to health care. And we think we're a

shining example. We've got a long way to go, but we've made a lot of progress. And we're moving on improving access.

It's an outstanding example of what one man's vision and leadership can do. This wouldn't have happened --- and Dr. Shirley said a lot that he was just the idea. I work with him every day. I know he's more than the idea. He brought the idea. He made the idea happen. He led us through the difficult days and he continues to lead us. He's my inspiration. Every day he works harder than I do. But I still come and try to keep up with him.

It's an outstanding example of a successful partnership. And I'm talking about a partnership between those three institutions that decided to come to the table and also the partnership with the community.

The community makes sure that everything that we propose here is contingent upon what the community wants. We discuss. We talk. We have a Community Advisory Board here that keeps us very in tune with what the community expects of our

existence here. And that partnership has been tremendous to the success of this program.

We do more than 250,000 health care accounts a year here. We also have lots of challenges. And as I said earlier, 40 percent of the care we provide here is uncompensated.

So we need more creative funding, systems, sources, programs to support current demands for uncompensated care. We need money to support health care education. We need something that helps us do preventive health care. We need more chronic disease management drug availability. Lord knows, we need more research.

This program has made a great start, has made a great dent in the access problem that exists in the city and the state of Mississippi. But it's got a long way to go.

And we're looking forward to collaborating with this group to make sure that any input that you need from us to help make your work easier, we're here to help you get it done.

Thank you very much.

CHAIR JOHNSON: Well, today has been just an excellent day in our hearing input from you.

And Dr. Bacon, if you would return to the front of the table here, it would be helpful.

Earlier today, we had a rich discussion of some of the issues that we're facing and some potential suggestions. But you really have identified some real creative solutions and have demonstrated by your initiative and by your leadership and, of course, that of Dr. Shirley, what can be done when people such as you take action.

So my first comment is to thank you and commend you.

And then, Dr. Bacon, if I could ask you to start our questions. I couldn't help but think that as you were speaking first, it's people from the South who are supposed to speak slowly. And we Yankees are supposed to speak so fast. I think I ought to trade places with you.

But similarly, the material you presented is just a huge waterfall of creativity and

results. Share a little bit with us -- without feeling like we're trying to flatter you, how is it that a clinic such as yours can take the action that you've taken with such superb results that you've been able to achieve? What are some of the factors that have helped you attain that?

DR. BACON: I think there are a couple of things. One is the idea that we recognize that we couldn't do it alone. That it is not a stand-alone activity.

And the second thing is that we got away from the notion of we were just dealing with one patient each time. And that it had to be more of a population based focus.

The third thing would be the fact that we realize at all levels within our organization we needed to look at and try to make some changes to really encompass all the aspects of care. We tried to get away from the concept of something going wrong and blaming the individual. If something is not going the way we want it to go, we look at the system and how we set it up and where did we break

down in our system and take it from there.

The other thing we did is really -- I think it's true of health centers here in Mississippi that we do get a good amount of longevity for staff members. And I think that's beneficial because they are there for a while and they're also from the community. So once you see what you want to achieve and you can empower those staff members to help achieve that, I think that goes a long way.

And one lesson I think that we have learned is that it doesn't hurt to ask anybody anything. Because at one point we wouldn't have approached some of the eye care providers, because they make -- oh, I don't know -- a couple million dollars a year probably. And here we are asking them to see somebody without a paying source.

We just didn't take those steps, the initiative, but we do now. So we will approach anybody with a project to see how willing or what we can negotiate to come up with -- to achieve some good outcomes.

CHAIR JOHNSON: Mr. Wheeler and Mr. Croswell, would you like to comment on some of your thoughts regarding factors that have led to your success, as well?

MR. WHEELER: I can tell you that the amount of pathology and the amount of need in the general area around us is just so tremendous. You were just stumbling over it all day.

So you think that somebody else is doing it until you actually start working on it. And you find out that everybody else is working on it. But they're getting their little bit and you're getting your little bit.

But we start to collaborate. And once we start working together on projects, then we start getting this energy, how one plus one starts to equal three. And we start to get more results. So it's just become a normal part of our process to collaborate and find partners when we get ready to do anything.

And this project, the whole Medical Mall Project, is nothing but one big partnership. We

partner with everybody who'll come to the table. And I think the original leadership, the Board of Directors, saw the need for partnering with the key components from day one. And so it's a lot been done, but it's because we've had such great partners in the process.

MR. CROSWELL: Well, I think there's a common thread among the three. And it's that the whole is stronger than the separate parts. And that's what we were able to do is to get our groups together and combine the individual businesses together in such a way that they would all benefit. They could not have benefitted on their own.

And though we don't have any $10,000,000, a figure to throw upon the board and so forth, but we again are proud of what we've done. And we are expanding that. And we are offering other plans to these businesses for dental and disability income and all these other things that businesses need to have for their people to make them competitive. So it's a growing -- we're young at this.

CHAIR JOHNSON: Thank you.

Deb.

MS. STEHR: My question is for Bill.

MR. CROSWELL: Yes, ma'am.

MS. STEHR: Approximately how much are the premiums for the plans offered by your --

MR. CROSWELL: Well, most of the groups are individually underwritten, but primarily I think for an employee using what they call a Comprehensive Blue, it's about $250. And that is with about a $500 deductible, 80/20 after that. You go to $1,000 you can probably get it for $178, something like that. That's $2,000,000 major medical.

MS. STEHR: I come from a rural area in Iowa where a lot of our people are self-employed, either farmers or they own small businesses on main street. And I do hear a lot. You know that's a big problem for them paying for health insurance. It's why my family doesn't have health insurance because my husband is self-employed in small business.

And I was wondering have other states tried to do that? Or is there any move by the

Chamber of Commerces to reach other states?

MR. CROSWELL: Well, we didn't. We set out, again not to reinvent the wheel, but there's an organization called COCI out of Cleveland, Ohio that has done a terrific job with the Chambers of Commerce. And they are one of the largest. And we had them come and consult with us as to how to do this, how to get it set up and what to do, what the people wanted and what they needed.

So, yes, but again the same with small groups. These smaller Chambers of Commerce didn't have the resources and so forth to do this on their own. And that's consequently why we have 54 of them that have taken our program and offered it to our members. They might only have 50 members, some of them. Some of them might have 500 members. At least it's been made available to them. And some of the smaller towns, they might not even have anyone in the small town who would come by and offer any kind of health insurance. We are basically a rural area. So this has been an incentive for the people who distribute this to the sales people for the

agency to get out and to see the coverage.

There's a need the Chambers of Commerce promoted so that they -- part of this education process is that there is a need and they want to take a look at it. And it's been successful.

MS. STEHR: Would you be able to forward more information to this group?

MR. CROSWELL: Sure will.

MS. STEHR: I'd like to check it out for my state.

MR. CROSWELL: Yes, ma'am. Certainly will.

VICE CHAIR MCLAUGHLIN: I have also a clarification question for you, Mr. Croswell.

When you said you went to Ohio, I assumed it was Cleveland --

MR. CROSWELL: Yes.

VICE CHAIR MCLAUGHLIN: -- for the COCI Program. And I wondered if, like the COCI Program, how strict is your underwriting?

Because COCI Program, when we looked at it in the `90s, was able to keep its premium low not

just because of the deductible and the co-pay, but they had very serious underwriting. So that a lot of the small business members of the Chamber of Commerce were not eligible.

What percent of members end up not being eligible? Do you have that figure?

MR. CROSWELL: We have it. I don't have it with me today. Like I say, I'm not full-time Chamber Plus. I'm just one of the volunteers who spent nine years trying to get this thing going.

But I know that from out of the 1,400 groups, we keep up with those that are no longer there, either they dropped it for whatever reason. But there's not -- the underwriting has not been a major problem for us so far down here for whatever reason.

VICE CHAIR MCLAUGHLIN: You've been lucky.

MR. CROSWELL: Yes, ma'am, we understand that from talking to other people.

VICE CHAIR MCLAUGHLIN: Because that's one of the problems of the Cleveland Program, that

they found that they have about 30 percent underwriting.

MR. CROSWELL: Thirty?

VICE CHAIR MCLAUGHLIN: Yeah.

MR. CROSWELL: I wouldn't think we're anywhere -- it's -- we could not have grown to the size we are --

VICE CHAIR MCLAUGHLIN: Right.

MR. CROSWELL: -- if that had been a major underwriting problem, because each of these Chambers as well as the Metro Jackson Chamber have a finite number of members. And for us to end up with 1,400 out of this population, that's, as we say in the South, "That's a bunch."

VICE CHAIR MCLAUGHLIN: That's a bunch.

MS. CONLAN: Dr. Bacon, as a former public school teacher, I was interested to hear about your partnership with the local schools. And you talked about it in terms of an exercise program.

Do you -- do they assist you with disseminating information? Have you ever used the

partnership in that way?

DR. BACON: We have. Actually we have a clinic located on the campus of 11 schools. And our clinic is staffed by a mid-level provider. Usually it's a Pediatric or Family Nurse Practitioner with a Licensed Practical Nurse and a receptionist.

We also have a group of social workers and outreach counselors. And they -- we have a total of four to cover a two-county area in terms of social work and outreach.

We work quite closely with the teachers for all of the activities. We help them with hand washing sessions. We help the gym teachers assist in various programs. And then we attend PTA meetings, as well, and disperse literature.

And actually in a number of the settings, we also see the teachers and the principals as patients. And so it's been a good partnership and we do use them quite a bit to help disseminate information.

MS. CONLAN: I was wondering, you know, the old flyer in the book bag, do you disseminate

information that way?

DR. BACON: Well, we do it both ways. But what we, because we have a policy with reference to prescriptions or meds for the kids. We have the parents sign up front how they would like to receive that information.

So what we do, for example, in the elementary school at the end of the day, the nurse will take that designated information, give it to the teachers to go in the book bags for those clients if the parents said, yes, this is how I would like to receive that information.

Now just in terms of flyers and activities in general, we do book bags. We also do a newsletter for each school. And that newsletter comes out at least three times a year for the school because we have a number of activities going. We have an abstinence program we do in two counties. And that's a class we teach in six-week intervals in Madison and Yazoo Counties. And we start with fifth grade, go up through eighth grade with that.

We also have an Open Airways, which is a

Lung Association class that we teach with the school. And that's a six-week class. And we start with second graders on up with that. And we have to recruit for that, advertise with the -- and I keep trying not to say Obesity Class, we changed it to the Healthy Living Class.

But with that we utilize distribution of the flyers and consents with the book bags and teachers.

CHAIR JOHNSON: Dr. Bacon, your focus is health care.

DR. BACON: Yes.

CHAIR JOHNSON: To what extent have your colleagues in the education system done studies on the effectiveness on the education of those kids who are participating in those programs?

DR. BACON: Well, we've done -- the biggest thing we've done is probably around the concept with asthma and the kids with asthma since that's a chronic illness, the number one cause of missed school days. And since we've implemented the asthma component, we have seen an increase in the --

an improvement I should say in the attendance for the children involved in the program. And that has helped out quite a bit.

Also for all their acute illnesses. And a good example is say somebody with ringworms. And the way the guidelines are set up if someone has a ringworm, they have to stay home until they get treatment. And what used to happen is that the mom would keep the child at home for seven days, ten days until it cleared up. Didn't necessarily go to a health care provider. So we have been able to improve the average daily attendance in grade school.

VICE CHAIR MCLAUGHLIN: I have a question. Just to keep on your theme, Mr. Wheeler, about outstanding. I echo Randy's comments that this is an outstanding example of a local initiative being able to expand coverage and reach out. And we all saw all the plaques on Dr. Shirley's wall last night when he treated us to a wonderful meal and Southern hospitality. And it deserves recognition.

It brings me to two questions. One,

there are a lot of local initiatives all over the country. And certainly researchers for years have been talking about the great man theory.

I wonder how important is that and what about communities that don't have an Aaron Shirley? How -- do you have thoughts about how it could be energized?

And my second question is that this morning, we heard from Dr. Jones who was talking about limits on resources in this community to expand further, to do more. And it seemed to resonate with the fear this saying that while the delivery and consumption of health care is local, the finance is not.

And so he was saying that he really didn't think the local community could, in fact, have the resource either in terms of manpower or dollars to, in fact, to do this.

What is this tension between local initiatives that can do so much, such as this Medical Mall did, but the realization that in some communities it's not going to be enough and in some

communities they'll never be able to do it? Help us try to figure that out a little bit, if you could, of what that balance is.

MR. WHEELER: I'm no expert. And the expert is sitting right over here and can probably answer that question with all due course.

But I can tell you that we can't duplicate this program in every community in the state. And resources are tight. We are a very rural state. And resources here are going to be tight.

And I think in my last slide I talked about the need for more creative funding. We got to have resources come from other places to help solidify this base. And we can take portions and pieces of this.

And we've got to learn how to work better with Community Health Centers. Community Health Centers are dispersed all over the state. And there are lots of pieces together, but as we form those partnerships beyond our fence here, I think we're going to be more effectively using the

resources that are out there.

Now that's a major undertaking because everybody thinks that what they're doing is exactly the right way to do it. And so a lot of times, we start to protect what we have and don't really come to the table and aggressively look for ways that we can cross the lines and help each other. I guess in a nice way, I'm saying we got to better utilize resources that are available to all of us.

And then, number two, we've got to start to look for ways to find resources that do the things that keep us from spending money on catastrophic health care. We've got to get into preventive health care. We've got to get into teaching patients how to help take care of themselves.

But when I talk to my providers here, they talk about you got to do what you get reimbursed for. And it's not necessarily a whole lot of teaching and developing. You've got to give people services, provide them some care.

So some resources have got to come from

other places, number two. Number one, we got to work better with what we have.

There's going to be a day when another community will have something like this set up in it. But we know smaller communities are talking about it. It's never a day goes by that somebody doesn't call me from Texas or someplace in the Caribbean talking about setting up using an old dilapidated mall to do a project like this.

But we've been talking probably six, seven years to folks, and I don't know of another that has actually sprung up. And we spent a lot of time with some folks trying to get it done. But finding the funding mechanism and the collaboratives to come together to make it happen is where the talk is about.

VICE CHAIR MCLAUGHLIN: We need to clone Aaron Shirley.

MR. WHEELER: Well, that's the only way you can get him.

DR. BAUMEISTER: The efforts that you all have put on have been miraculous, really. And

the accomplishments are certainly deserving of great praise. And we do have a great man, here.

But my concern is that the commonality here is that you're both dealing with a situation that's very difficult. And it's an adjustment reaction to a somewhat unsustainable situation. Small businesses are dealing with insurance companies that wield all the clout. So you have to come together - in numbers there's strength - and negotiate with them.

You're dealing with vast under funding in a population that's in great need, and so you had to adjust by putting forth amazing individual effort.

Which I have trouble seeing how you can -- how we can, as this group deliberates over these issues -- I have trouble seeing how we can extrapolate these individual accomplishments to a nationwide health care system.

And I'd like you to comment on that, if you would.

MR. CROSWELL: Like I try to tell my

people, I guess, you just have to decide to do it, and set a focus and do it. I see what you -- I understand what you're saying. This is remarkable what these folks have done. And I think it's pretty remarkable what we've done right here in the state. But you just have to take it that 'no' is not an acceptable answer.

And a good plan executed is a lot better than a great plan that is never executed. Don't get involved in the bureaucracy of finding a great plan. Just get you a good plan and start it. And then tweak it. And that's in essence what we did.

We could have waited until we had the most perfect deductible schedules with exactly what's going to be in the wellness portion and so forth. We didn't. We took a good shell and we got on the street with it. And in the ensuing years, we've made modifications and adjustments for the benefit of our membership.

And so if you ask me, that would be a way is that, when you see what they've done, it's a daunting task.

As you asked the question, how would you replicate this somewhere. And it's obvious that people have tried to replicate it. And they just hadn't quite gotten there yet. Well, I'm a can-do guy. So obviously they haven't decided yet that that's what they wanted to do. Because if they wanted to do it, they'd figure out a way to do it, in my opinion.

MR. WHEELER: We kind of think that way because hindsight's always 20-20. I'm sure we didn't feel quite as aggressive when we were talking about this thing in the early days. And I can tell you that success breeds success. And we've just got to figure out a way to, when these other groups come to us, to try not to clone what we have here and send it into that community, but try to find out what things they could put together to make something similar to this happening.

And I think when they come a lot of times, they just want the model. They just say give me your thing. Let me carry it back home. And that thing won't work back at home because we are

fortunate enough that we have one medical school in the whole state, and a lot of the other cities will have two in one little city, one big city.

So there are a lot of things that were very easy for us to put together because of just our circumstances. And then we just had such tremendous need.

But you really do have to get started. And I can just think back on a lot of things that Dr. Shirley and the Board did here that, it was just do it.

Can you imagine buying this facility, and I think they owned it three or four days by themselves for $2.8 million dollars because they hadn't put their partnership together. They just bought it.

And you know, it could have burned it down. Anything could have happened in those two or three days when they were waiting to get it put together.

Then going to the banks in the local area to talk about borrowing $60 million dollars.

And the banks said that's bigger than us. We can't do that. And you had to go to a bank out of state to borrow -- to get the bond funding to do it.

So you have to have great vision and great leadership. And you got to just do it at some point. And put your plan together and keep walking, keep working, and keep talking about it. And keep executing the plan.

And I think that's, when we do follow-ups of when people call us back to say, I still haven't gotten started yet. I want to come back for another visit. As sitting here now, it is very obvious that they aren't just doing it. They're finding obstacles that they can't overcome. And our model may not work in their neighborhood. And so I -- at least I'm sitting here now learning that. That may be where we're going wrong sometimes.

MR. CROSWELL: Dr. Shirley decided to do it. That was my point. He decided this is what we need to do and he did it. Figured out a way to do it. Make your plans flexible and stick to them.

DR. BACON: I just have one comment.

One thing I think we're not doing is we're not saying who is in control of health. And what we're doing is that the controlling person is really the patient. As patients we need to be the ones in control.

And a lot of times when we act as a patient, we really take instructions from an individual and we may not comply with them, but we never say anything. Or we know we're going to a doctor so we start taking our medicines three days before we go. And taking a pill is not the answer.

But it's the empowerment piece in realizing who does control your health care. And the fact that you think you're not making a decision because you don't take a certain medicine. You're always making decisions about your health care. I think we're looking at it, and the patient is not being empowered in that whole scheme.

And so some way to really empower the patient. Because if you truly invest in yourself as a patient, then there are certain questions you will ask, certain things that you will try to look up,

certain ways that you will approach it on a long-term basis. I think we need more of a patient focused approach.

CHAIR JOHNSON: We have time for two more questions. One from Dr. Shirley and then another from Therese. I think you wanted to go.

DR. SHIRLEY: You touched on it, Dr. Bacon. I liked the statement you made about the patient must be activated. Kind of like throwing a switch.

How do you do that?

DR. BACON: Well, what we did is we did a variety of things of treating the patient as special, one and only. But that was for everybody.

We treated them in such a special way when we start with the diabetes program as an example. We would do a variety of incentives whether it was T-shirts, putting their pictures on the wall, putting their name in the newspapers, taking a picture with them shaking the hand of the Mayor.

And it got to the point where we were

doing that for the diabetes patients that one of our providers asked another patient to write a complaint. And she said that she was upset because she didn't receive attention when it was time for her blood work. How come she didn't get a pair of shoes? Why didn't she get a T-shirt? And our provider told her it's because you don't have diabetes. But she thought it was -- So part of it is that we shift some of the -- because a lot of times we have a tendency to just say this patient is non-compliant or we blame. But the idea is to empower by giving them knowledge, rewarding, and really making it a big event. Because when we have the Stepping Out Campaign, and we have balloons and all the distinguished individuals there.

But we're going to provide health care, but just in a different way than we have been. So we just really try to get them truly involved.

MS. HUGHES: I want to thank you for coming and speaking with us. I think that, like everybody here, I agree that what you have here is truly phenomenal. And I do recognize, because I

come from an entity where people come and they try to replicate it in their own community. And I think that -- I agree with you that the idea is not to replicate in your own community, but to find that the agencies that can come together to work.

But I also recognize the high degree of barriers that do exist in other places. And that Dr. Shirley cracked open the universe at the right time which kept doing it. Which is perhaps part of what you say -- just make the plan and do it. But what occurs to me is that if other agencies had an idea like this, that the biggest barrier that they face is a financial barrier to whether they want to take a part of your program and replicate it, or the whole program and replicate it, that the financial barrier from the outset as well as the sustainability, financial barrier exists and that comes back to where we are in our pursuit of understanding the health care system and ideas that could make future health care different in delivery and making a whole system instead of a patchwork of clinics but -- or malls or insurance plans, but a

whole system of care that's available to people.

And I would like to just ask that as you go forward and we go forward in what we're doing ,would you think outside of your boxes. And I know that you can't say that Dr. Shirley did -- he did do this.

But now it's time for you to think outside of your boxes for us, because you're running the situation. You're creating the opportunities on his coattails. And I'd like to ask just that you think about a wild idea you may have which you think is possible to be appropriate. And then when the -- we have the total availability on the website to put it in, give us input. Would you please do that?

Because this was a wild-hair idea. I mean anybody that looked at it, you know, back years back probably said, how is it going to be done?

But those ideas are ones that make the difference in the lives of many people. And we're doing this so that we can hear the wild-hair ideas and call the ones that seem to be that they could be workable so that we can present them to other powers

that be with the idea that maybe they should be seriously given the opportunity to grow.

So that's what I wanted to ask that you think like that.

And I don't have the answer. I believe that clinics are very essential because they pick up what other people don't have, what other people won't serve. And they give people who don't have at least some opportunity. But clinics aren't the whole answer, because clinics can't serve everybody because we don't have enough of them. And so, you know, I'm in quandary in that area.

And so if you wouldn't mind doing that, I'm sure your experience has some ideas that can come forward and maybe be able to help us. So thank you. And I hope you'll do that.

CHAIR JOHNSON: Thank you, Therese. I'm sure you sense the respect and admiration that we as Working Group have for what you have done. And Therese's last comment about continuing to share your ideas is one that we would like to encourage you as a full Working Group to do.

In the last meeting in which I heard you speak, Dr. Bacon, you had lots of questions and we ran out of time. We've run out of time. But we could learn a whole lot more from all three of you today. But we just want to thank you very much and commend you for what you've done.

And for those of you who have been with us, thank you for your participation this morning, as well.

And good afternoon. We'll adjourn our hearing.

(Whereupon, this hearing was concluded.)