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MINUTES OF THE

SANTA FE COUNTY

HEALTH POLICY & PLANNING COMMISSION

July 6, 2012

Santa Fe, New Mexico

This regular meeting of the Santa Fe County Health Policy & Planning Commission (HPPC) was called to order by Chair Judith Williams at approximately 9:00 a.m. on the above-cited date at 2052 S. Galisteo, Suite B, Santa Fe, New Mexico.

Roll call indicated the presence of a quorum as follows:

Members Present:
Judith Williams, Chair
Kathleen Rowe, Vice Chair
Bertha Blanchard
James Bond
Shirlee Davidson
Catherine Kinney
Richard Rodriguez
Reena Szczepanski
Anna Vigil [9:20 arrival]

Member(s) Absent:
George Gamble [excused]
[One Vacancy]

Staff Present:
Rachel O'Connor, Health and Human Services Division Director
Lisa Garcia, Health and Human Services Division

Others Present:
John Cassidy, La Familia Medical Center CEO
Larry Martinez, PMS, North Central Region Director
Ramona Flores-Lopez, PMS
Lynda Longacre, Project Access
Lauren Hatcher UNM student
Laura Brown, MD, La Familia
Tita Gervers, SFPS

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COUNTY OF SANTA FE)
STATE OF NEW MEXICO) ss

I Hereby Certify That This Instrument Was Filed for Record On The 8TH Day Of August, 2012 at 09:10:07 AM And Was Duly Recorded as Instrument # 1677548 Of The Records Of Santa Fe County

Witness My Hand And Seal Of Office
Valerie Espinoza
Deputy Marcella County Clerk, Santa Fe, NM

III. Approval of Agenda

Mr. Bond moved to approve the agenda. His motion was seconded by Ms. Rowe and passed by unanimous [8-0] voice vote. [Ms. Vigil was not present for this action]

IV. Approval of Minutes: June 1, 2012

The following corrections were made:

Page 2, Matters of Public Concern, Reena was misspelled.

Page 3, first bullet, first sentence to read: The Health Division received approval for a full-time position devoted to providing staff support to HPPC and the MCH Council.

Page 3, second bullet, second sentence add part-time to clarify the nurse and driver positions

Page 4, first sentence delete

Page 4, second paragraph deleted in its entirety and replaced to create a transition with the following: The Commission discussed having Commissioners Gamble and Rowe collaborate with CSV and report back.

Page 4, second motion was seconded by Commissioner Rowe

Mr. Bond moved to approve the June 1, 2012 minutes as amended. Ms. Davidson seconded and the motion passed by [8-0] voice vote. [Ms. Vigil was not present for this action.]

V. Matters of Public Concern

None were presented.

VI. Presentation

A. Sole Community Update

[*Exhibit 1: Presentation by Larry Martinez*]

Chair Williams introduced Larry Martinez as the former chair and long-time member of the HPPC with professional knowledge regarding the sole community provider program.

Mr. Martinez said he currently chairs the Medicaid Advisory Committee for the New Mexico Human Services Department which is engaged in the implementation of Centennial Care, the Medicaid modernization effort. He also serves as a board member on the Christus St. Vincent Regional Medical Center board.

Mr. Martinez noted that the Sole Community Provider Program falls under Medicaid which is a federal and state funded program addressing the needs of low-income families and individuals. He defined Medicare as a federally sponsored insurance program primarily for the elderly population.

He offered the following facts:

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- The Medicaid program in New Mexico is going to spend approximately $3.7 billion in FY13 with 70 percent of that being federal funding coming through CMS (Center for Medicaid & Medicare Services)
- Approximately 565,000 New Mexicans are covered by Medicaid - approximately ¼ of the State's population
- There is an expectation that 175,000 individuals will be added to the Medicaid rolls as a result of the Federal Health Care Reform Act by the year 2014
- SCI (State Covered Insurance) is an insurance program for the working-poor providing generic Medicaid coverage Mr. Martinez reviewed the federal authorization for SCP and offered the following facts:
- The federal matching rate for Medicaid is determined in comparison to the state's per capita income
- New Mexico's federal matching rate has always been around 70 percent
- The purpose of SCP is to assist hospitals that are the only one in their area. Increasing hospital revenues ensures continued access for Medicaid and Medicare eligible individuals to receive hospital services
- SCP funding addresses the hospital's uncompensated care
- Fifty percent of emergency room visits are behavioral health related
- The County's Health Care Assistance Program administers the reimbursement for indigent health care
- Doña Ana County established the first pre-natal care clinic in the state funded with indigent funds and opened the use of indigent funds beyond hospitals
- The SCP fund was established in 1993 under the Indigent Hospital and County Health Care Act, and is administered by the NM Human Services Department

In 1992 New Mexico was facing a $240 million deficit in the Medicaid program, Mr. Martinez said, and the leadership of the Medical Assistance Division was looking for ways to offset the deficit, which was a result of expanding Medicaid eligibility. At that time New Mexico was 51st in the country in the provision of early and continuous prenatal care. New Mexico established the "Year of the Child" and prenatal care was expanded with the change in the poverty threshold over a period of years to 235 percent of the federal poverty standard. With the deficit in the Medicaid fund, the legislators decided to tap the counties' indigent funds for the federal match. In 1993 legislation passed that took 1/16 of counties' GRT and allocated it to the county-supported Medicaid fund. The SCP allocation is at a county's discretion.

Mr. Martinez said a county's contribution to the SCP is what they can afford to give and that is matched by the federal dollars. Santa Fe County allocated a high amount in FY 2009 and FY2010 of $9.5 million, and a low in FY 2012 of $1.9 million. He mentioned that other counties aside from Santa Fe provide SCP funds to Christus St. Vincent (CSV).

Regarding the supplemental match, Mr. Martinez said the supplemental was eventually worked into the SCP base budget. He explained that there has always been a requirement that the hospital report on how the funds are used. In the past Santa Fe County and CSV had a memorandum of agreement (MOA) defining the relationship. What complicated the relationship between counties and hospitals is the federal ban on *quid pro quo* arrangements and he

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mentioned a 2009 federal challenge on Santa Fe County's use of funds related to the jail health services. The MOA has since been eliminated.

The relationship between Association of Counties and the Hospital Association has been challenging. From a legislative perspective it's wonderful to appropriate $1 and get $3 in federal funding with the expansion of services or eligibility for Medicaid. From the federal government's perspective it's wonderful to appropriate 70 cents out of $1 and get back $1 worth of services because the states have to come up with matches. Thus, there is a lot of pressure in the states to leverage as much money as possible.

Mr. Martinez said the Patient Protection and Affordable Care Act is intended to expand access to insurance and Medicaid coverage by 2014. Since SCP is based on uninsured and uncompensated care, the amounts that can be put in SCP will be greatly reduced.

The NM Human Services Department's Centennial Care (Medicaid Redesign) principles are:

- Patients receive the appropriate service in the appropriate setting
- Patients must have a greater stake in the health care that they receive
- Administrative complexities should be streamlined
- Payment shifted to reflect health status/outcomes

The Department has come out with a proposal to establish two pools of funding known as the Delivery System Reform and Improvement Programs (DSRIP). The SCP will have to support primary care networks/operations. He said the future of health care will be in patient-centered, accountable care organizations. The hospital will be part of a much bigger network. The systems will become more interdependent.

Mr. Martinez said the current conventional wisdom is that there will be some type of Medicaid (??) expansion in New Mexico. He also expected a higher integration of primary care with behavioral health care with an expansion in contractual providers. New Mexico is last in the nation per capita in its expenditures on behavioral health.

Ms. Szczepanski asked whether there was an independent entity that assessed the SCP hospital's needs. Mr. Martinez responded the hospital demonstrates its own need. He said in the early 2000s the HPPC had an advisory role with the BCC on sole community provider requests from hospitals and developed the income eligibility standards and payment standards for the indigent care program.

Mr. Martinez was thanked for is presentation.

B. Suboxone Presentation
[*Exhibit 2: Presentation by Laura Brown, MD*]

Laura Brown, medical director for La Familia Medical Center Health Care for the Homeless, was present to discuss the drug Suboxone and the concept of harm reduction. She mentioned that the public awareness of prescription opiate overdose death rates in New Mexico –

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which leads the nation – is increasing. She spoke of the downstream consequences of addiction, diversion and overdose death. Upstream is the explosion of sales and supplies of prescription opiates over the last ten years. She cited the CDC: Enough prescription opioids are prescribed in the US per year to medicate every adult with Hydrocondone 5mg every 4 hours for one month.

Tita Gervers, Santa Fe Public Schools, mentioned that the biggest increase in adolescence drug use is in prescription drugs.

Dr. Brown said prescription opiate addiction and heroin addiction carry the same consequences – diversion, addiction, overdose, and overdose death.

The concept of harm reduction was defined as syringe exchange/needle exchange and Narcan distribution. The Narcan approach includes training people to recognize opiate overdose situations, provide rescue treatment and administer Narcan (Naloxone). Narcan is now in an intranasal formulation making it much easier and less frightening.

Harm reduction can be used as a practical, non-judgment, humane set of strategies for reducing the consequences of drug use. Managed use is also an integral component. Dr. Brown said New Mexico has 15 years of harm reduction implementation. She lauded Ms. Szczepanski as a champion of the concept.

The 1997 New Mexico Harm Reduction Act made the provision of clean injection equipment a right for all New Mexicans. Most of the public health offices throughout the state offer needle exchange and Narcan distribution. Over 12 million syringes have been collected and over 1,000 overdoses reversed with Narcan. New Mexico is considered on the "cutting edge" of harm reduction.

Opiate treatment fails to get the attention and resources it merits. The three options are abstinence-based therapy, opiate replacement therapy (Methadone or Buprenorphine) and opiate antagonist therapy with Naltrexone. Dr. Brown discussed the pharmacology of the different drugs. She stressed that the treatment of opiate addiction is effective; replacement therapy has an effectiveness rate of 40 percent to 50 percent in a one-year timeframe – better than treatment success rates for other chronic diseases, i.e., hypertension and diabetes.

Suboxone/Buprenorphine: The Drug Addiction Act of 2000 allows qualified physicians to prescribe Schedule III-V drugs for treatment of opiate dependence. The FDA approved Buprenorphine tablets and it is now in film-dosage form. Registered physicians with training can treat up to 30 opiate-dependent patients with Buprenorphine and after a year, the patient number can be increased to 100. She remarked on the irony of the tight regulations around Suboxone, allowing only specially trained physicians to prescribe it, while nurse practitioners and physician assistants can prescribe Oxycodone, Percocet, etc.

Dr. Brown discussed Buprenorphine as a partial agonist and suggested that is why it is not abused. She mentioned Naltrexone, an opiate antagonist used for both opiate and alcohol addiction. An opioid-sensitive person taking Suboxone will not get high; rather a sense of normality ensues. If an individual is taking Suboxone as prescribed and takes heroin, the heroin

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will have no effect because the brain receptors will not respond to it. Suboxone contains both Buprenorphine and Naloxone/Narcan. If injected, the Narcan, which is included as a deterrent, is activated and the individual is thrown into immediate, severe withdrawal.

Access to Suboxone is extremely limited in Santa Fe. As far as harm reduction, Suboxone is a better choice than heroin or Oxycodone.

The current Health Care for the Homeless Suboxone Program started April 2011. Suboxone education is provided, baseline lab work is done, and a treatment agreement form is signed. The program is tightly structured starting with weekly appointments, tapering off to two weeks, three weeks and finally no less than every four weeks. Random urine tests and pill counts are conducted. Two weekly counseling sessions are required. Counseling is paramount to recovery.

Dr. Brown has obtained grant funding to provide six months of free Suboxone which is a very expensive medicine for patients without insurance. Medicaid does pay for Suboxone and the manufacturer of Suboxone has a free program. The average cost is $11-$16 per pill. The program has a wait list of up to 100 individuals. She discussed success measurements.

At this time there are no adolescent Suboxone programs in Santa Fe but Turquoise Lodge in Albuquerque is developing something.

Opiate addition is a chronic, relapsing disease and patients need an ongoing relationship with a primary care provider (PCP). As a PCP, Dr. Brown said she is able to treat the patient's myriad other issues.

Dr. Brown advocated the implementation of a Project Lazarus-like program to address the issue of opiate addiction.

In response to a question regarding Methadone, Dr. Brown said La Familia does not have that program. Opiate replacement therapy can only be dispensed out of private, for-profit Methadone-only clinics. For chronic pain, Methadone can be prescribed by a PCP. As a full opiate antagonist it has a high risk of overdose death and is hard to kick, stated Dr. Brown.

Suboxone treatment is relatively new and lacks long-term data.

In consideration of the few physicians providing Suboxone and La Familia's wait list, Chair Williams asked whether HPPC could provide assistance. Dr. Brown said it's an expensive drug and there needs to be more funding to provide actual medicines and additional providers within the community. She mentioned that it's complicated but there are many physicians that have the training but do not prescribe Suboxone. She said it was challenging but greatly gratifying work.

A member asked, with more funding would La Familia be in a position to increase its patient count for Suboxone. John Cassidy, La Familia CEO, said they have a commitment to the Suboxone program and they clearly recognize the community need for the program. The

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question is why more providers are not getting involved and he speculated that without funding the program is not accessible to many providers. He hoped that when the County's finances improve the programming can be further developed.

Ms. O'Connor said she will be meeting with the County Manager to discuss what the County can do on this issue. The County Health Care Board has broached the subject of how its funded providers can address the issue of drug addiction.

Ms. O'Connor said a meeting was being scheduled to further discuss the drug overdose issue communicated by State Epidemiologist Mike Landen at a previous HPPC meeting. The meeting will be open with a focus on how the County can work to solve some of these issues.

VII. Matters from the Commission

A. Director's Report

Ms. O'Connor said the full-time position to work for HPPC and the Maternal and Child Health Council will be posted within the next few weeks. An additional indigent claims review position has been funded and that, along with the nurse's position should be posted very soon. She was pleased to say progress was being made to fully staff the Health Division.

Regarding funding for community providers, Ms. O'Connor recommended devoting a portion of the next HPPC meeting to that issue.

Public awareness of the prescription drug issue has increased and DOH has established prescription limits and requirements of a prescription drug monitoring program. Dr. Brown said there are new requirements for training clinicians around the issue of prescription opiates and use of the prescription monitoring program which she commended as an incredible resource.

B. Community Needs Assessment and Staffing

Chair Williams said she and Commissioners Rowe and Gamble attended a few meetings and a decision was made to collaborate as equal partners with the hospital for the community health profile.

C. Other Matters from the Commission

None were presented.

VIII. Action Items

None were presented.

IX. Future Agenda Items

The following items were mentioned:

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- CSV was slated to provide a briefing on Form 990; however, the hospital may not be ready to proceed
- HPPC members can arrange with La Familia staff for a tour [505 955-0310 or jcassidy@lfmctr.org] The main clinic is located on Alto Street and the south side clinic is on Caja del Oro Grant Road
- Pending the outcome of the needs assessment HPPC should discuss greater outreach for the mobile health vans (County and PMS), consider the question of whether there is a need for a mobile, episodic, nurse-driven service in the future of County health care and whether the current model fits
- Discuss issues regarding scheduling appointments with La Familia
- Invite the County van nurse to discuss the program at the next meeting. Consider a van advisory committee. The County Commission wants the van to operate seven days a week
- Pending the needs assessment results, schedule the County van to serve the south side of the county more
- Ms. Davidson advocated the creation of an advisory committee to support the van service.

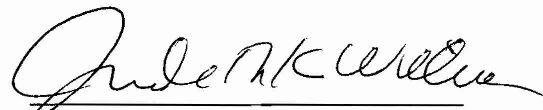
X. Announcements

A. Next PC meeting Friday, August 3, 2012, 9 a.m., 2052 Galisteo St., Suite B

XI. Adjournment

This meeting was declared adjourned at approximately 11:15 a.m.

Approved by:



Judith Williams, Chair
Health Policy & Planning Commission

Respectfully submitted by:

Karen Farrell, Wordswork

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Santa Fe Smoke Free Ordinance

Effective June 30, 2006

- Prohibits smoking in all enclosed public places.
- Prohibits smoking in all enclosed spaces within places of employment.
- Permits smoking only at a distance of 25 feet from an entrance and/or window in any area where smoking is prohibited.
- Prohibits smoking at all restaurants and bars, including patios and balconies

Smoke-Free Multi-Unit Housing The New "Standard"

- 300+ Smoke-Free Public Housing Authorities (PHAs)
  - 10% of all PHAs in the US
  - Including the Santa Fe Civic Housing Authority and the Santa Fe County Public Housing Authority
- Smoke-free privately owned multi-unit housing properties:
  - Increasing exponentially nationwide
  - Large numbers in California, Michigan, Oregon, Minnesota, and Colorado
  - Over 800 buildings in Minnesota (5%) vs. 50 in 2007

Why Promote Smoke-Free Housing

- There is no safe level of exposure to secondhand smoke (SHS) -- breathing even a little SHS can be harmful, especially to seniors and children.
- As much as 65% of air can be exchanged between units through ventilation systems, cracks in floors and walls, and electrical systems.
- The only means of effectively eliminating the health risks associated with indoor exposure to tobacco smoke is to ban smoking activity.

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Most New Mexicans Don't Smoke

- 81% of NM adults don't smoke
- 70% of low income residents don't smoke
- 90% of New Mexicans age 65+ don't smoke
- Most smokers do **not** smoke in their home

Health and Economic Impact of Tobacco in New Mexico

- 2,100 New Mexicans die every year due to tobacco use.
- 42,000 New Mexicans suffer from related diseases.
- Tobacco use is the leading cause of death in New Mexico.
- Tobacco costs New Mexico $976 million annually:
  - $483 million in direct medical costs
  - $493 million in lost productivity.
- Each pack of cigarettes sold in New Mexico costs the state $14.00 in tobacco-related medical costs and lost productivity.

Health Impacts of SHS

- Over 50,000 deaths in the US
  - 1 non-smoker dies for every 7 smokers who die.
  - Causes about 300 deaths each year in New Mexico.
- Heart disease (46,000 deaths)
  - Immediate effects on cardiovascular system
  - Strokes and heart attacks
- Lung cancer (3,400 deaths)
- Sudden Infant Death Syndrome (SIDS)
- Asthma attacks (1 million children)
- Respiratory problems (300,000 children < 18 months)

More Health Impacts of SHS

- **Developing babies:** miscarriage, premature birth, lower birth weight, learning problems
- **Children are especially vulnerable (60% are exposed)**
  - More frequent and severe asthma attacks
  - More allergies and ear infections
  - More bronchitis and pneumonia
  - More coughs and colds that last longer
  - Increased risk of neurobehavioral disorders (ADHD)
  - More tooth decay
  - Poor lung development

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Health Impacts Continued

- **Adults**
  - More heart disease
  - More lung cancer and possibly other cancers
  - Increased risk of developing Type 2 diabetes and MS
  - Triggering rheumatoid arthritis and lupus flares
  - Associated with more major depression
  - Bone density loss and impaired bone healing
  - Chronic sinus infections
- **Seniors**
  - Increased risk of dementia
  - Triggering or worsening of pre-existing conditions

SHS Exposure in Santa Fe Youth

- Two-fifths of 6th - 8th graders report being in the same room with someone smoking cigarettes in the past 7 days:
  - Santa Fe: 40%
  - New Mexico: 36%
- More 9th – 12th graders report being in the same room with someone smoking cigarettes in the past 7 days:
  - Santa Fe: 54%
  - New Mexico: 51%

2009 Youth Risk and Resiliency Survey

Smoke-Free Policies are Legal

- Smoke-free policies for multi-unit properties are legal. Smoke-free policies are like any other lease provision, such as noise or pet restrictions.
- Smoking is not a legal right. Smoke-free policies do not infringe on the legal rights of individuals.
- Smokers are not a protected class under any state or federal law.
- An individual's addiction to nicotine is not a disability.
- Breathing clean air is a right, protected by the ADA and Fair Housing Law.

Steps to Smoke-Free Housing

- Build partnerships
- Educate property managers, tenants and the public
- Work with interested property owners/managers to draft, adopt, implement and enforce smoke-free housing policies
- Provide cessation support, resources and materials

How Can You Help?

- Pass a resolution supporting the vision of the Santa Fe Tobacco Free Coalition.
- Encourage multi-unit property owners to adopt smoke-free policies.
- Create incentives for multi-unit property owners to adopt smoke-free policies.
- We welcome your suggestions.

Thank you for all of your efforts. Very soon, Santa Fe renters will be happy, healthy, smoke-free and breathing clean air.

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The New York Times

July 27, 2012

What Can Mississippi Learn From Iran?

By SUZY HANSEN

One morning this spring, Claudia Cox, a registered nurse in Jackson, Miss., drove toward the countryside to visit some patients. She often has trouble finding their homes. "The rural people are the worst," she said. " 'Come to the oak tree.' Well, hell, I'm from the city, I don't know what no oak tree is. I know magnolia. I know pine trees." Cox referred to her seven-year-old Ford Freestyle as her "office," but it had the ambience of an arcade: the ding-ding-ding from her dashboard signaling an unbuckled seat belt, the whir of a phone charger in the cigarette lighter, the phone ringing with the opening of Cheryl Lynn's disco hit "Got to Be Real." Cox, a 45-year-old divorced mother of three, juggled phone calls and patients' charts and cigarettes like some serene octopus, always catching the steering wheel just before the vehicle veered onto the grass. After 20 minutes, she pulled into a pebbly driveway. It was time to find out why Vonda Wells kept going back to the emergency room.

Cox works for an agency called HealthConnect, whose purpose is to reduce admissions to the Central Mississippi Medical Center, a Jackson hospital where people routinely use the emergency room for primary care, sometimes multiple times in a month.

Wells's large figure filled the door frame of the tiny house. She was jovial despite the oxygen tube that ran to her nose. She held a baby. "Is that yours?" Cox exclaimed.

"That's my grandbaby!" Wells said and passed the baby off to a teenager who disappeared behind a closed door. The two women sat down in a dark living room cramped with couches.

"All right, Ms. Wells, we come out and check on everybody," Cox said. "You had pneumonia, right?"

"I went to Florida, and that's where I first got sick, at the Holy Land."

"O.K.," Cox scribbled, and then looked up. "What's that?"

"It's an amusement park out there, but it has Jerusalem, it has Noah's Ark, they did the play the Passion . . ."

"Now there's another spot for me and my baby to go!" Cox said. They laughed.

Cox doesn't know oak trees, but she knows how to talk to people. She knows when to ask if someone cannot

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afford insulin, or is not taking insulin, or is not keeping the insulin cold, or cannot keep the insulin cold because there is no electricity or refrigerator. Not having health insurance is a huge problem in Mississippi, but it isn't the only one. "So you good with doing your medicines?" Wells made a guilty face. "You oxygen-dependent?" She was.

Wells worked at a Jackson hospital as a certified nursing assistant for five years before she started getting sick with asthma-related illnesses. No one wanted a nurse who needed an oxygen tank, she said, so now she was trying to work a handful of hours a week at a Christian community center. "I stayed in Illinois for 25 years," she said. "I didn't really have asthma symptoms till I came down here."

"There's something in the house that's triggering it," Cox said. "I bet you need to get tested for mold." She made a note. The house was old, the rug thick, the air damp. "And I'm putting a little check mark down here that you got the basic light, gas and water. Your major problem is the asthma."

"And congestive heart failure."

Cox tilted her head. "Have you been taught how to manage your congestive heart failure? Because you should have a scale." She looked around the house gamely, as if she believed a scale might pop out from behind the TV.

"I need a scale?"

"You need a scale, and you need to do a weight every morning. Because if you get on a scale and there's a three-pound difference from one day to the next, you're starting to retain fluid. I see that your legs are already swollen."

Cox explained why people retain fluid. She then asked whether Wells had checked her blood pressure; her emergency-room chart indicated it had been 212 over 100, which is stroke level. Concerned about Wells's sodium intake, she asked her how many sodas she was drinking, and told her that some juice has a lot of sodium in it too. "Knowledge is power, O.K.?" Cox said gently. "Cause you're 40, and you're oxygen-dependent. We don't want you goin' on a date with an oxygen tank!" Wells laughed again.

Cox said she would try to find a company that would test the house for toxins, and she made an appointment for Wells to visit a medical clinic that HealthConnect operates. Wells got up, the oxygen tube dragging behind her, and walked Cox to the door. Cox paused at one of the photographs on the wall. "You got a beautiful family!" Cox said. She focused on a slim woman. "Now, is that Mama?"

"That's Grandma," Wells said. "She was 95 when she passed. I moved down here to help her out."

One of the people responsible for HealthConnect's holistic, intensely personal approach is Dr. Aaron

Shirley, who three years ago found inspiration for health care reform in an unlikely place: the primary health care system created in the 1980s in the Islamic Republic of Iran. The main issue in Iran back then was "disparities in health between its urban and rural populations," he told me recently. "In the U.S., these disparities exist. The Iranian model eliminated the geographic disparities, so why couldn't this same approach be used for racial and geographic disparities in the U.S.?"

Shirley created HealthConnect in 2010 because — and, in part, to prove to others that — poor people in Mississippi still have health problems, even if they have Medicaid or health insurance, even if there are clinics in their communities, even if they get home health services. They don't get better, and the diseases born of poverty and obesity are not prevented; thousands of people frequent emergency rooms for illnesses that could have been tackled by primary care. They need something more.

Shirley is a civil rights-era hero who for a long time was the only black pediatrician in the state, the type of activist who, he says, wasn't necessarily of the "nonviolent persuasion" and who, upon hearing that the local Klan was headed to his home, would warn the Police Department that both his boys knew how to shoot. He was the first black resident at the University of Mississippi Medical Center and, in the 1960s, worked at the state's first community health center, in the Mississippi Delta. He did things that don't end up in history books, too, like build wells for poor blacks when they didn't have clean drinking water and travel through the countryside treating malnourished babies. In 1993, the MacArthur Foundation identified him as a "health care leader" when it gave him one of its "genius" awards.

Shirley, now 79, spends his days at the Jackson Medical Mall. For decades, the site was an actual mall, with a JC Penney and a Gayfers, but the area around it began to decline in the 1980s as middle-class families fled to suburbs nearby. Historic downtown Jackson emptied out altogether, and today Capitol Street, the bustling shopping avenue that Medgar Evers boycotted in 1962, looks shuttered and ghostly. The mall, just five minutes from downtown, was well on its way to the same fate, so in the mid-1990s Shirley and others created the Jackson Medical Mall Foundation to buy it and turn it into a center offering various health services for the poor.

Since then, Shirley has observed up close what so many Mississippians point out: millions of dollars pour into the state every year — both public and private funds — but the lives of Mississippians do not improve. "I've been coming here for 40 years," he told me recently, referring to the Mississippi Delta, "and nothing has changed."

In 2008, Shirley was introduced to a consultant named James Miller by a public health professor at Jackson State University, Mohammad Shahbazi. Miller and his wife live in Oxford, Miss., where they and other family members run a consulting firm and other businesses. In 2004, Miller learned about Iran's primary-care health system during a meeting in Germany with a delegation from the Iranian government. But it wasn't until 2007,

when a struggling hospital hired Miller's firm to conduct an assessment of its operations, that Miller fully grasped the extent of Mississippi's health care crisis — and recognized how much it resembled prerevolutionary Iran.

"When the Iranian system was developed in the 1980s, there were no doctors in rural Iran," Miller says. "And this is similar to the problem in the delta today."

The Iranian reforms were relatively inexpensive to implement there. It was the early '80s, just after the Ayatollah Khomeini's return and the Iranian revolution, which had promised the country's rural villagers the kind of social justice that had been lacking under the shah. At the time, more than half the population lived outside major cities, in or around more than 60,000 villages. The Iranians built "health houses" to minister to 1,500 people who lived within at most an hour's walking distance. Each house is a 1,000-square-foot hut equipped with examination rooms and sleeping quarters and staffed by community health workers — one man and one or more women who have been given basic training in preventive health care. They advise on nutrition and family planning, take blood pressure, keep track of who needs prenatal care, provide immunization and monitor environmental conditions like water quality. Crucially, in order to gain trust, the health workers come from the villages they serve.

People who become very sick, or require surgical procedures, are referred up through a single, multitiered system: from health house to rural health center to district hospital. The integrated nature of the system is what makes it unique. Today, 17,000 health houses serve 23 million rural Iranians. Health disparities between rural and urban Iranians have narrowed; the Iranians have reduced rural infant mortality by 75 percent and lowered the birthrate. Iran's reforms won praise from the World Health Organization, which has long advocated preventive, primary care.

To Miller, the model's great appeal was its simplicity. He approached several academic institutions in Mississippi and told them what he'd learned. Most people looked at him as if he were nuts. The United States and Iran haven't been on good terms since the hostage crisis in 1979. It is not a country Americans tend to think of collaborating with. But Miller, who loves Persian history and doesn't disguise his desire to see the United States and Iran mend their fences, spoke to Gail Harrison, a public-health professor at U.C.L.A. She suggested he call a former student of hers: Mohammad Shahbazi, who was not only Iranian but also a professor at Jackson State University, a historically black college right in Mississippi.

Shahbazi moved to the United States in the 1980s for graduate work in cultural anthropology and became fascinated by its health care problems. He recognized the similarities between the conditions in Mississippi and those in Iran, where he grew up as a member of a nomadic tribe, the Qashqai, that was discriminated against under the shah. "We were considered the wild, smelly nomads," he says. He decided that Mississippi offered the best opportunity for his work on social determinants of health, and settled into a between-worlds

existence in Jackson, where he is neither black nor white but privy to racial slights and resentments from both sides. "I consider myself bleached black," he says.

After joining Jackson State's public health program, he often wanted to discuss Iran's health care reforms in wider policy circles, but feared doing so in the post-9/11 climate. Shahbazi, who is animated and friendly and tends to make jokes like "we don't have pharmacologists, we have *harm*acologists," was once pulled aside by a federal agent at an airport because he thought Shahbazi was on a most-wanted terrorist list. When the agent showed Shahbazi the list, Shahbazi exclaimed, "But I am not Shabaz Mohammad of Pakistan, I am Mohammad Shahbazi of Iran!"

Shahbazi suggested that he and Miller approach Shirley. He arranged for the two men to visit Shiraz, Iran, and meet some of the people responsible for creating and administering the country's health houses. The two groups decided to establish an official academic partnership between Shiraz University and Jackson State, and Shirley returned to Mississippi a convert. Later that year, several Iranian doctors and administrators and their wives made their own trip to Mississippi. They were surprised by what they saw: "This is America?" they asked. In 2010, the Iranians returned for a month, calculating how many health houses Mississippi would need, as they had done in Iran. Shahbazi began work on a program at Jackson State for the training of community health workers. Using resources from the Medical Mall Foundation, Shirley started HealthConnect to show how interventionist, door-to-door community health workers might save hospitals money and began the process of putting health houses in Jackson schools. Eventually they hope to build the Mississippi Community Health House Network, a pilot version of their project, in the Mississippi Delta.

"We are not saying just trust us," Shahbazi says. "We are saying give us $10 to $20 million and three years; we'll implement 15 health houses in the delta, and we will prove two things: We will show you that we are changing the health outcomes, and we will show we can reduce the cost of health care in the state."

Mississippi has some of the worst health statistics in the country. A Mississippi black man's life expectancy is lower than the average American's life expectancy was in 1960. Sixty-nine percent of adult Mississippians are obese or overweight, and a quarter of the state's households don't have access to decent, healthful food. Adequate grocery stores can be 30 miles away. In one of the country's most fertile regions, people sometimes have to shop for their groceries at the gas station. Consequently, Mississippians are dying from diabetes, hypertension, congestive heart failure and asthma. Shirley points out that in the 1960s people starved, and today they die from food.

The state has the highest rate of teen births in the nation. Currently there is one abortion clinic in Mississippi, and Gov. Phil Bryant, a former deputy sheriff, is working hard to render it inoperable. Until this year, schools taught abstinence. In the United States, the black infant mortality rate is more than twice that of white infants, so Mississippi, which is 37 percent black, has huge neonatal intensive care units. Caring for the thousands of

premature babies (weighing between one and four pounds) costs millions of dollars. According to Dr. Glen Graves of the University of Mississippi Medical Center, these tiny, deprived babies grow up to be plagued with chronic illnesses.

Human Rights Watch calls the Deep South "the epicenter of the H.I.V. epidemic in the United States, with more people living and dying of AIDS than in any region in the country." Blacks in Mississippi are dying from AIDS at a rate 64 percent higher than the nation's average. In the delta, which stretches north and west of Jackson and is home to 560,000 people, H.I.V./AIDS is an immense but silent crisis. The state Department of Health estimates that half of H.I.V.-positive Mississippians currently don't receive treatment.

Many delta hospitals complain that their emergency rooms are overrun with nonpaying patients. Dr. James Keeton, the vice chancellor for health affairs at the University of Mississippi Medical Center, says that 14 percent of the center's patients are uninsured, or "self-pay," and the hospital recovers only a small part of what they owe. "Now, I say to you as a businessperson: How would you like to work at an auto company and give away . . . cars before even opening your doors?"

Of the state's population of nearly three million, 550,000 are uninsured. At the moment, Governor Bryant is claiming that the state might not accept federal money to expand Medicaid under the Affordable Care Act. But even if it does, there won't be enough doctors to see all the Mississippians who need them; the state has 176 doctors per 100,000 people, the lowest such number in the country.

Sixty years ago, Mississippi, the country's poorest and most racially divided state, was "the standard by which this nation's commitment to social justice would be measured," the historian John Dittmer wrote. Talk to those in Mississippi's health care community, and they all whisper the same thing: It's not rocket science; we all know what needs to be done. In short, as one Mississippian put it to me, "hand-to-hand combat" — hiring folks whose sole job is to ameliorate the problems in poor people's lives — and a tremendous amount of money could change the situation. But the political will does not exist. So the status quo endures: generations of people who can't afford fresh tomatoes, and who don't understand that when a doctor says take this pill three times a day, he doesn't mean all at once.

In May, Shirley, Shahbazi and a black pediatrician named Eva Henderson-Camara piled into Shahbazi's car and headed to the delta to talk to two nurses at a small hospital in Belzoni, more than an hour north of Jackson. The first thing you notice on entering the delta, especially when you're expecting to find poverty, is that you don't see many people. The farms are vast and empty. So much of the area is bucolic and sun-dappled that it doesn't seem poor. When I said as much to Claudia Cox about Mississippi in general, she replied sternly: "That's because poverty in America doesn't look like what y'all think. It used to be bare feet, now it's Nikes. If I miss two months of work because I get sick, well, guess what? I'm in poverty. This is the new poverty." Yet in delta towns like Louise and Midnight, the poverty is impossible to miss: desolate commercial

streets in the shadow of a rotting mill, shotgun houses wilting on one side of railroad tracks, houses almost buried under possessions on the porch and in the yard.

Henderson-Camara, now 60, grew up on the plantation her grandfather owned. Children at the time worked much of the school year as part of the sharecropper system, which lasted until the '70s, as corporations bought and mechanized the farms. ("Imagine waking up every morning and this is all you see," Henderson-Camara said, looking out the window at the flat fields stretching to the sky. "And you think, Should I shoot myself now or later?") Thousands of displaced workers found jobs at the Jockey factory, or the Schwinn plant, or on catfish farms, but those shut down in the early '90s. Henderson-Camara got out by winning a scholarship for a fifth year of high school at Yale. Today she lives in Jackson and works in HealthConnect's medical clinic.

In Belzoni, everyone sat down at a rectangular table, and the director of nursing, Dee Ann Brown, recounted the hospital's troubles: emergency-room readmissions, obesity, inadequate insurance. Shirley then explained the role of community health workers and asked Brown if she thought that service might be helpful.

"What you are describing is home health, isn't it?" Brown said.

Home-health agencies dispatch nurses to do clinical work in patients' homes. But they are not obligated to take your phone calls at midnight or steer you away from eating fried food — and you have to have insurance to get their care. Often for-profit services, they are also the hedge funds of the health care community: potentially lucrative, largely unregulated, producing bad results as often as good. Sanjay Basu, a physician and policy expert at the University of California, San Francisco, says that while he has seen some remarkable and devoted home-health agencies, "if you're in it for a buck, you could have a terrible home agency and make a ton of money." Many towns in the delta have them — yet the delta's problems persist. Why? Shirley offered that the hospitals need a third party trained to discern what exactly will help a patient, and that party must come from the patient's world: talk the same, share similar fears and frustrations and life experiences.

"Most home-health nurses build great relationships with their patients," Brown said.

"But there's a lot of distrust," Henderson-Camara said, leaning forward. "We don't trust people who don't look like us. Having grown up in a very segregated community, I know this for a fact. You may think that you're in with that patient, but when you walk out that door, they will laugh and say, 'I just told her that so she'll stop asking me questions.' But if you live in that community and sister Edna tells you something, you say, 'Now, Edna,' and she will say, 'O.K., you got me.' And she'll tell you the truth. People do not trust people who do not look like them."

"I don't feel that's a problem here," said Brown, who happens to be white. "I may be way smoozed."

"I think you're smoozed."

The friction between them highlighted a problem beyond a distrust of outsiders: the fractured nature of American health care. It was easy to dismiss, or misconstrue, the health-house network as just another addition to a market glutted with for-profit businesses and nonprofit services looking to patch up the holes in — or take advantage of — the health care system. What Shirley and his colleagues saw the need for was something holistic and aggressive that would take root in the community, get into homes and alter the course of future generations, before obesity, say, or diabetes sets in. The Iranian system they admire is a preventive health care system. American health care is not preventive, and it's not a system.

The practice of community health workers going door to door has been applied everywhere from China to Mexico. According to Carl H. Rush of the University of Texas Institute of Health Policy, in the United States community health workers have been used on a small scale for decades. More recently, he says, hospitals around the country are realizing the potential for community health workers to lower their costs.

The Iranian health houses, too, resemble the original mission of America's community health centers. When Dr. H. Jack Geiger founded the country's first federally qualified health center in 1967 in Mound Bayou, a small town in the delta, the goal was to confront the many aspects of people's lives that were contributing to their ill health. "We built wells and privies and housing and started a 500-acre vegetable farm," says Geiger, whose work was inspired by what he saw in South Africa in the late '50s, "and that probably had a bigger impact on the health of the population than what we were doing as doctors. The indigenous people we trained were among the most useful people on staff."

Today there are 8,300 centers serving 20 million people throughout the country. Over the years, however, community health centers, needing to compete in the marketplace, have evolved into more conventional medical businesses, focused on the delivery of personal health services rather than the social and environmental determinants of overall health.

To help them return to the original mission, the Affordable Care Act will give $11 billion to community health centers, a sum that will double the numbers and capacity of centers nationwide. "It would be effective if community health centers were given the budget to return to the interventions that characterized almost all of the first health centers of the 1960s and 1970s," Geiger says. "Every health care provider in this country is under pressure, because of the incentives in the system, to churn out patients as fast as you can, because you get paid for visits. That just doesn't work for people with the kind of complex problems you probably saw in Mississippi. You can't fix these problems in 10 minutes."

Shirley says he believes that the problems of the American poor — living conditions, deficient education, harmful behaviors and the lack of family support and access to healthful lifestyles — demand house calls. This approach was used by groups in Atlantic City and Camden, N.J., profiled by Atul Gawande in The New Yorker last year, which identified the worst offenders of emergency-room readmission and deployed social workers

and nurses to figure out the myriad sources of ill health. What was clear above all else from Gawande's account is that what these people needed was constant attention. Because one stumble — an unpaid electricity bill, for example — can lead to cascading health setbacks.

The Iranian model goes a step further by making the community health workers responsible for their villagers' well-being from birth. It's an approach very much at odds with the American ethos of self-reliance. But in Iran, the seeming intrusiveness is required, according to Dr. Kamel Shadpour, one of the architects of the Iranian system. "If you go to one of these community health workers and ask him or her how many people they cover, they won't tell you around 2,000," Shadpour says. "They will tell you exactly 1,829 people. If you take out the family file with the No. 62, he or she will know which family that is, and she will tell you that the father is this old, and they have five children, their ages, their vaccinations, how they were doing family planning, everything."

The Iranian model also differs from many others because of its integrated delivery network: the way a patient is referred up through a chain of hospitals according to their needs. "The overall system is the key," says Miller, the Oxford consultant, "not just community health workers."

The American government has been moving toward more comprehensive solutions. The Affordable Care Act has created "accountable care organizations" that include doctors, social workers, nurses and pharmacists working together to serve patients. Since May, also as part of health care reform, the Centers for Medicare and Medicaid Services announced more than 100 multimillion-dollar grants to organizations that proposed new ways to prevent illness and save money. Its Innovation Center awarded grants to a large number of experimental programs that involve community health workers.

"There's a renewed interest in them, in part because of the nation's increased focus on prevention," says Dr. Richard J. Gilfillan, the director of the Center for Medicare and Medicaid Innovation. "Eighty-four percent of our health care dollar is spent on managing people with chronic conditions. . . . We know preventing obesity can help prevent other illnesses such as diabetes, hypertension and kidney disease — so how can we prevent these conditions from occurring in the first place? Likely not with more procedures and X-rays. Some of the winners' programs harken back to the way health care was delivered long ago. The things we learn by going into someone's home tell us so much about the patient's life and how they manage their own diseases."

One morning last spring, Shirley took me to see one of his new health-house facilities at Blackburn Middle School, which is on the edge of Jackson State University's campus and across the street from where Shirley grew up. Walking with him through the neighborhood, or stopping in with him at the Penguin, a nice restaurant on the Jackson State campus, is like being with the mayor. Over lunch, the people who came to shake his hand included the state's new director of Medicaid and the president of the Mississippi NAACP.

Shirley reasoned that opening health houses in the schools was a natural way to gain access to families. Many

public schools in Mississippi don't have full-time nurses, and Blackburn Middle School is attended almost entirely by students who live in poverty, so it welcomed the chance to have health care on the premises.

One community health worker on the staff at Blackburn was Tiara, a single mother on Temporary Assistance for Needy Families I first met almost nine months earlier. A not-so-obvious benefit of training community health workers is that doing so creates jobs for unemployed people; advanced degrees are unnecessary. In our first interview, Tiara told me how much she loved her job. At Blackburn, she seemed quieter as we talked about how she counseled young girls about sex. "As someone who had a child at 17, I am so against it," she told us. (She is now 22.) "You have so much potential."

As a HealthConnect employee, Tiara also made house calls before being transferred to work in the school. Her life is a kind of full-time HealthConnect anyway. "I had" — she said, counting — "six people in my apartment last night. Because they don't have electricity. And one was a real bad diabetic who can't see how to pull her insulin, can't see anything."

These are the sorts of stories you hear repeatedly in Mississippi. During five days driving around with Cox, I saw what health workers were up against, and what they were capable of. Cox comes from a middle-class family, the product of a stable home. She went to college, became a funeral director and then decided to go to nursing school, using public assistance to make her way through it. Cox had worked as a nurse for 20 years — Shirley and the Central Mississippi Medical Center decided to use licensed nurses at HealthConnect until their community health workers are trained — and she could intuit that a patient's life might be crumbling in surprising ways.

There was Regina Huggins, who had been in the hospital 20 times in eight months since her heart attack. She was a smoker with chronic obstructive pulmonary disease who lacked energy and had lost 50 pounds. One of the reasons she kept calling ambulances to go to the E.R. seemed to be that she had no transportation; she couldn't even afford a taxi. She did not qualify for Medicaid. Without insurance, she couldn't get an oxygen tank or inhalers or fill her prescriptions. She had $300,000 in medical bills.

There was Mamie Marshall, who was dying of bone cancer in the back room of her house. None of her doctors had put her in hospice care, and she said she had been told that no one could do anything for her. She was a licensed beautician and had worked for Packard Electric, a subsidiary of General Motors, and as a public-school bus driver and as a nanny. "I worked," she said.

And there were Carolyn Brewster and Melvin McGee, 29-year-olds whose baby, Justin, was born prematurely, most likely because Brewster had high blood pressure and pre-eclampsia. Both Brewster and McGee have learning disabilities, but they had jobs and had earnestly embraced parenthood, paying $450 a month for a two-room apartment in a motel-like apartment complex where everyone seemed to be under 30. When we called on them, Cox decided to take Brewster's blood pressure and discovered that it was 149 over 100.

Brewster wasn't doing anything to reduce it except taking vinegar, a common home remedy. Cox made an appointment for her at the medical clinic later that day, told her how to catch the bus and which pharmacy to go to and emphasized that she needed to go right away. "You are only 29, and you are going to end up on dialysis," she said.

On our way out, Cox said she wanted to stop by to see Tiara, who lives in the same apartment complex. She had just had her second child.

Shirley, Shahbazi and Miller haven't had an easy time getting large-scale financing for their health-house network. They enlisted a Mississippi congressman, Bennie Thompson, to write a letter to Kathleen Sebelius, the secretary of Health and Human Services. They applied for (but did not receive) one of those grants awarded by the Innovation Center; Jack Geiger wrote the recommendation letter. They talked it up in Mississippi.

The three men — and many Mississippians I spoke to — complain that a lot of federal and grant money goes to research, not actual services. "The delta people have been studied to death," Shirley says. Also, as they point out, funding rarely goes to entire systems. But the group is hoping that the idea of Iranian-style health houses in the United States might inspire good will between the two countries.

"If they can get the resources, then why not give it a try?" said Shadpour, the architect of the Iranian system, when I called him in Tehran. "The situation is not worse than Iran. To the contrary, it is much better in many ways. The infrastructure is there."

Until someone finances the pilot for 15 health houses, Shirley will establish them in 11 schools — where there are already rooms, electricity, water. To keep the houses running, Shirley says, they are staffed with certified nurse practitioners whose services can be billed to Medicaid. "So the revenue that the nurse generates will go to paying her and the community health workers, too. We say, 'O.K., how much money is already out there?'

"The only outside money that we've gotten to contribute to our project has been $75,000 from United Healthcare, the insurance company, because they see the potential to save them money," he continued.

His methods are scrappy and scattershot, but Shirley is used to working around the system. After 60 years, perhaps the main reason he's turning to an Iranian model is because, unlike everything else in Mississippi, it worked. In one year, HealthConnect cut the rate of readmissions to the Central Mississippi Medical Center by 15 percent.

Meanwhile, Miller is trying to find yet another way to generate money. With support from Jackson State doctors and advice from their counterparts at Shiraz University, he has begun discussing the idea of Americans and Iranians working together to implement the Iranian model in other needy countries. He hopes

that a major international aid project might be a way to get financing for Mississippi.

A few weeks after her first visit, Claudia Cox returned to Vonda Wells's house. Wells, who is now 41, hadn't returned to the emergency room, but she seemed sadder. She hadn't been paid the $5 a day she was supposed to get for working at the Christian community center, but despite doing all her paperwork and leaving messages for her caseworker, she had not heard back.

And because Medicaid limits the number of doctor visits in a year, she couldn't see one now.

"How you going to follow up with your pulmonologist and cardiologist?" Cox asked.

"I had to cancel," Wells said. "I already have a bill in there for $240 I have to pay."

She couldn't keep up with her medicines. "Medicaid can't pay for it, and I can't pay for the medicines, not at $90 a pop," she said. "I try to wean myself off of medicine. If I feel good, I don't take them."

But Wells spoke of positive things. Her 19-year-old daughter, who played in the next room with Wells's grandchild, was talented enough to be a fashion designer, she said. Her youngest daughter, 16, wanted to join the military "to see the world." Her mother helped out with the bills at times. And her uncle had offered to come by and do some repairs, rip up the carpet, fix the kitchen. In many ways, Wells was rare among Cox's patients: she still had family.

In fact, the house had been her grandmother's, and she had spent some of her childhood there. She was lucky to have a rent-free home full of so many memories. But Wells would have to wait to learn whether that house was giving her asthma problems.

"We couldn't find anybody to examine the house" that was affordable, Cox said. "It was $1,300 for one day — just to test. Just to come out here and pull a couple of pieces from the attic."

Suzy Hansen last wrote for the magazine about the art scene in Istanbul, where she lives.

Editor: Dean Robinson

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