Kelsey Finn’s blog

Congratulations to Kelsey Finn, PA-S for her recent selection to the GE-National Medical Fellowship Primary Care Leadership Program (PCLP). The mission of PCLP is to provide additional training for medical professional students in primary care and to help build capacity at community health centers.

This service learning fellowship takes PA students, medical students and nursing students and provides them with clinical rotations in one of 8 CHCs across the US. It also provides leadership training pertaining to administrative challenges facing CHCs and the fellows will do an independent project on a site-specific topic. They also participate in distance learning, program assessment and a concluding presentation of their independent project to PCLP officials and clinic personnel. Kelsey will be working in a CHC in Jackson, Mississippi for 6-8 weeks to complete the requirements of the fellowship.

This was a highly competitive process to become a PCLP fellow and we are all very proud of the work Kelsey is doing. This fellowship will enhance Kelsey’s already strong commitment to helping populations at risk as she completes her clinical rotations and prepares to graduate from the University of Utah PA Program.

Week One

Week one is complete and what a week it was! It started with a twenty-six hour road trip to Jackson. Upon arrival in the city (a Saturday afternoon) I noticed how empty the streets were, no one was walking about, it almost had a feeling of a ghost town. My mother and I stayed in a downtown hotel for the weekend and discovered that everything closed at 6:00pm and most things were not open on the weekend. It all seemed very odd for the capital city of Mississippi. We moved my things into a dormitory (the first time living in one) on Jackson State University, which is a HBCU; and then I dropped my mother at the airport and began my solo journey for what would be six weeks. Monday was my first day at the clinic and it started with an orientation and a little history of the clinic: Dr. Robert Smith who is the CEO, founded this clinic in the 1960's shortly after Medgar Evers assassination and this clinic is one of three to be the first federally funded CHCs in the United States. Dr. Smith is a legend it appears in Mississippi, his creed in life is to provide healthcare to everyone no matter who they are or where they come from and it seems that the entire state knows this about him. I was told later in the week by a FNP he was even invited to the inauguration of President Obama this year but did not attend because he felt his plans to lecture in New York that week held precedence. The first day I shadowed him we were seeing a patient together and the patient told me that Dr. Smith delivered him as a baby- the patient turned 65 years old this year. It is obvious he has given his whole career to the community and far beyond when someone would consider continuing a career. But to Dr. Smith he wants nothing more than to continue to see patients and ensure his clinic remains helping all those who need it. The clinic is small, just off campus from JSU; with a neighboring house that serves as the administration office. It sits in a neighborhood that I have been informed I should not walk through- day or night- because of safety issues. Windows are boarded up, cars broken down and stray dogs are an issue. It seems odd that the beautiful JSU campus is completely surrounded by a poverty-stricken city that by most is deemed not very safe. I have felt safe but have taken the advice of those in my clinic and been selective about where I go alone. The second day I was here I was at a coffee shop and upon leaving noticed I had a flat tire. Thinking two sets of hands are better than one and remembering a police officer was inside I went and asked him for his help. Without even looking at me he told me he was too busy. Fortunately another gentleman helped me out and the problem has since been resolved (unfortunately by buying new tires). When I told the clinic staff this encounter they were not surprised at all. Some of the staff said they would be six weeks. Monday was my first day at the clinic and it started with an orientation and a little history of the clinic: Dr. Robert Smith who is the CEO, founded this clinic in the 1960's shortly after Medgar Evers assassination and this clinic is one of three to be the first federally funded CHCs in the United States. Dr. Smith is a legend it appears in Mississippi, his creed in life is to provide healthcare to everyone no matter who they are or where they come from and it seems that the entire state knows this about him. I was told later in the week by

The demographics of the staff is now 100% African American (one of the staff who worked with them for twenty years who was White passed away suddenly at the end of our first week, it was a tragic loss) and 99.7% of the patients are African American, the remaining percent being White. The clinic gives healthcare to everyone, has a sliding scale system and will serve even those who cannot pay- though there is a homeless clinic nearby for that specific population. Even though it is a CHC, state senators and state judges will come to the clinic specifically to have Dr. Smith care for them- that is how respected and trusted he is.

The clinic does have an EMR and basic resources though they appear to be scarce (often Depo shots and other injections are borrowed from the other affiliated clinics[which there are two of] or supplies run low, though this at times seems more to be related to not ordering frequently enough). They do not have specialist they can refer the underserved to but occasionally there are state programs that will fund screenings throughout the year (mammograms, colonoscopies, etc). The providers are excellent; all keep updated on the most recent evidence based medicine and screening guidelines. Most of the Providers (they are either MDs or NPs, I am told a PA worked for them but moved elsewhere last year) spend half of the day at the hospital and half in clinic. If any patient of the clinic goes to the hospital or a nursing facility the providers will go to that facility to care for them- with about four hospitals and seven or more nursing facilities in the area you can imagine how busy they are keeping up with all those patients! This leaves the clinic with one full time provider and many hours without a fully staffed clinic. I have had some interesting community experiences as well. Dr. Smith finds it very important
for me to learn about Southern Culture and Black History while I am here and has taken me to a couple events thus far. This week I went to a luncheon/presentation at Tougaloo College- a plantation in the 1800’s that was donated in 1869 to be one of the first African American education institutions in the country. The presentation was to recognize Medgar Evers and his wife. Dr. Smith spoke (he was Medgar Evers family physician) along with several individuals that worked with him during the civil rights movement (Medgar Evers neighbor, a secretary of another civil rights leader and a few others). It was incredible to hear about this history first hand and all the horrific things this culture went through. It shocked me how candidly they spoke about the police tracking their license plates so they could find out where their meetings for civil rights discussions were, or looking out their windows to see the KKK on their front lawns. It is so hard to comprehend one of those events happening to me let alone it happening so frequently that it becomes a daily occurrence.

Last night Dr. Smith took me to a retirement dinner for Dr. George Barnes who was a professor at Hinds Community College. Dr. Smith spoke at this event as well. I was introduced to Mississippi State Senator Hillman Frazier and his wife Jean. Mrs. Jean Frazier works on Jackson State, archiving history; where I am staying and has arranged for us to have dinner Monday so she can talk with me about Black Culture and History.

Today I attended the 90th birthday celebration of Ms. Willie Mae Shirley with two of the other scholars. Dr. Smith again spoke at this event along with several state officials. Ms. Shirley is well known in the community for her efforts to preserve the history in her area. She has grown up and lived in the same house since the early 1900’s. She has sat on what is called the Washington Addition Neighborhood Association for many years. This association’s goal is to help preserve the neighborhoods of Jackson despite some of the safety, drugs and other issues. She is a well respected woman and it was a wonderful opportunity to hear about her life and work.

Excited for week two and all the new adventures that are in store!

Week Two!
I have been so busy with meetings this week I spent very little time in the clinic. Monday I had lunch with Mrs. Jean Frazier (wife of State Senator Hillman Frazier). She works on Jackson State in Development and archives a lot of Mississippi's history. She also has worked with Dr. Smith since the age of 14 and is very close to him. She shared more history with me about Dr. Smith (He worked with Dr. Martin Luther King Jr a couple of times) and about Jackson State's history, which is filled with Civil Rights stories as well. She shared with me that there was a clinic on campus in the 1960’s that was the only health clinic Blacks could receive care in Mississippi. She also explained that in the 1970 students had a stand in on the walkthrough to protest the Vietnam War and the local government dispatched police and gave them instructions to open fire on the students killing some of them. It was fascinating to hear more history- though again with tragedy surrounding it, especially about the very campus that I am a current resident on.

Tuesday we had a Board meeting for the first half of the morning. There are about ten members on the board and they include prominent figures in the community- a reverend, a former professor from Jackson State, Dr. Smith, the District Attorney, Representative Alice Clark, a figure from Tougaloo College, a regional manager from Wal-Mart, a State Senator and a few others from the community. The focus of this particular meeting was the budget, provider evaluations that had recently been done and discussing the need for new providers. It was hard to keep up with everything as I have not reviewed budget sheets like that before and did not quite understand where all the funding was coming from or going to- but it seemed that the board was trying to determine those specifics also.

Wednesday I participated in an event called 'Conversation Cafe' at University of Mississippi Medical Center. This event had individuals from all different kinds of health backgrounds (providers, nurses, researchers, community representatives, health department, etc) and they broke everyone into 7 different groups and then we spent about 20 minutes discussing a pre-determined topic in healthcare. Most of these topics were about health institutions working together to better the population as a whole, and how do those institutions reach these goals when certain barriers are in place. The Office of Rural Health Disparities was hosting it and the goal was to try and find ways to improve rural healthcare by having larger institutions with access to more resources working together. It was interesting not only to participate in a topic that is applicable everywhere in the country but also I was able to learn a lot about how the healthcare in Mississippi has developed. There are a lot of trust issues not just on a racial level but between institutions as well. Participants were sharing with me that in the past large institutions have included smaller institutions in research but than taken all the funding for their own institution leaving the smaller facilities with no payout for the work they had done. While discussing mistrust that a large part of the African American population has felt towards the healthcare system one of the moderators shared with us that when her facility wanted to start a research subject they had workshops prior to the start of
the research that focused on the mistrust issues, exploring the barriers the patients had and working to find solutions that would make the patients feel more comfortable joining the research study. She said this helped immensely. It was encouraging to see about 100 people there to face those issues and try and better the healthcare of their state.

Thursday I had a leadership meeting with the scholars to interview Dr. Obie McNair. He has worked at the clinic for 30 years and been their Medical Director for 20 years. He talked to us about the many roles he carries in the clinic and the struggles to not only maintain staff and providers but to reach out to the community so the patients who need healthcare will come to the clinic. His current task that he has been focusing on is meeting the standards required to become a Patient Centered Medical Home. He gave us a copy of a summary of the requirements and there is a large amount of content to be considered and will take a significant amount of time to have them all accomplished. Dr. McNair also shared with us that even though they must fulfill numerous requirements to maintain their federal government funding; only 20% of their funding comes from federal government. Close to 80% of their funding is from revenue. This makes it important to have the necessary staff support to keep accreditation standards met while still focusing on productivity in the clinic.

Thursday we also had a clinic Strategic Planning Meeting. This was for the last half of the day and the whole clinic staff from all three clinics was present. About three years ago they had a similar meeting where they broke into groups and created goals and objectives they wanted to achieve in the clinic in the next three years. Thursday’s meeting was to assess those goals/objectives, revise them and make very specific and concise planning so those goals would actually be met. We were broken into five groups, selected randomly so any group had medical assistants, providers, board members, administration staff and scholars. It was a meeting full of heated discussion and exasperation but it was great to see everyone from every job description fighting to make the clinic a better place for not only them but also their patients. A total of five goals were created and a specific plan for each. The goals are summarized below:

- To expand services to meet the needs of the target populations and still be financially productive
- To provide a comprehensive staff program that includes social workers and has monthly staff meetings that will provide in-service training and CME.
- To become a highly visible health care provider in the communities we serve, and increase new patients while keeping our current ones.
- To improve facility and expand the use of technology in support of our health care services and outreach programs.
- To increase the financial reserve of the organization to 4-6 months in cash on hand to improve the financial stability of the Clinics.

These goals all had specific plans with timelines and committees designated that included staff and board members to help make these a reality in the near future.

Friday I attended an Accountability Care meeting for the last half of the day. Yes, Mississippi has developed an Accountability Care group! I was so excited to see this happening! The group providing these services is called Health Connect. The meeting was open to all in the health field and this group explained how they could help connect patients from hospital and specialist back to their primary care provider. One of the presenters pointed out that Mississippi sits 50th for most health measures in the nation and has a unique opportunity to save millions of dollars more than a state that already has more efficient care practices in place. Just to give an idea of where Mississippi sits compared to other states I visited www.americashealthrankings.org and found that Mississippi claims some of the lowest health measures in the following:

- 50th Outcomes Rank
- 49th Determinants Rank
- 49th Overall Rank
- 46th Smoking
- 50th Diabetes
- 50th Obesity
- 50th Physical Inactivity
- 50th Infant Mortality
- 50th Premature Death
- 47th Preventable Hospitalizations
- 48th Primary Care Physicians

The few measures they rank rather low in are binge drinking (6th in US) and violent crimes (16th in US). But I am unsure how that data is measured. Everyone seemed excited about making some changes though, and it felt like there was a lot of positive energy surrounding changing and improving the health care that so few have
This weekend was also rather busy scoping out Mississippi with one of the medical student scholars here with me. We went to Barnett Reservoir on Saturday where I was able to ride my bike along some paths. It was a beautiful reservoir that had mostly residential homes along the waterfront. Rather expensive looking homes and the shopping areas surrounding the town looked rather nice. We found a farmer's market in downtown Jackson that is open every weekend on the fair grounds. It had a large turn out and plenty of fresh produce to compliment our week of southern cooking that we have all been partaking in. We also walked Tougaloo College which has some incredible history. The college sits on 500 acres that once was a slave plantation and some of the original structures still stand. During the 1960’s it served as a safe haven for those fighting for equality and justice. It is a beautiful campus and known for its emphasis on high standards for equality.

Sunday we drove about two and half hours south to Louisiana to do a river float. I realized once on the river in my tube that I did not have to sign a release for risk of injury- surprising as there were so many tree trunks sticking up from the river I thought we might all become impaled on a log! Luckily it was a slow river and we all made it without any injuries- besides minor scrapes!

Week Three
Week three I spent mostly in clinic and working on my project. Every GE-NMF PCLP scholar must pick a topic that is relevant to the CHC they are working in and create some kind of project to target that topic. I initially planned on creating policies for the clinic regarding chronic pain management and specifically opioid management. Upon my arrival I discovered a scholar from last year had done just that and had a beautiful binder at the clinic with updated guidelines, screenings assessments and a sample contracts. However I was informed that these guidelines were never put into place as she did not leave a plan on how to use the binder and it thus collected dust on the shelf. So this gave me the great opportunity to put these guidelines into practice, see what works, what doesn’t and revise the binder and leave the clinic with a working program that they can and actually will use. This has also been great because I have essentially been given full independence with the chronic pain patients- supervised by the physician that treats the most chronic pain patients but he has wanted me to create plans and do follow ups on my own so I can see first hand what works and what doesn’t. I can say that the largest difference I have noticed with treating chronic pain here compared to Utah has been the source of pain with patients here tends to be related to trauma and not just car accidents- a large amount of gunshot wounds. I found this surprising since last week I mentioned violent crimes was considered low here. Also the amount of poverty and often it seems related depression/anxiety seems significantly increased here.

This physician I am working on this project with is a surgeon by training who was trained and practiced in the army for Desert Storm. He also did surgery for many years upon returning and has now worked in the clinic for many years and works one of the ERs in the area twice a week. (he also has a business on the side and a radio spot once a week on a local station). He manages most- if not all- of the chronic pain. He knows the guidelines back and forth and is up to date on how to manage pain but can be rather rough around the edges at times. We worked together for several days last week and he said that being 70 years old now and working with the underserved all these years in one of the poorest states in the US he is about ready to be done working. I have learned a lot from him and even though his patience wears thin at times he is only frustrated by the limits of what he is able to do for the community he has grown up in and tried to serve at his best all these years.

I and the other scholars at the clinic had the immense joy of having lunch with Dr. Smith this week. He took us out on Thursday and shared with us the things he has seen and learned throughout his career. He had some wonderful stories about him and Jack Geiger working together over the years to expand healthcare centers to the poorest areas of Mississippi. One of the scholars asked him during lunch how he felt when President Obama was first inaugurated after all he has seen with civil rights. He told us that he has seen a lot of change in his lifetime with the Civil Rights movement and several other policy and society changing reforms that helped to advocate for groups that before were persecuted. When he received a call from his son a few years prior to President Obama running for office; his son told him he wanted him to help develop a fundraiser event for the next man to be president- a black man named Barack Hussein Obama. Dr. Smith said he literally thought his son had gone insane and needed to be committed. “Just listen to what I am saying to you.” He said as he looked at all of us, “ a black man named Barack Hussein Obama becoming President.” I realized that to someone who had lived through so much turmoil and tragedy surrounding the rights of Black individuals the notion his son was proposing probably seemed impossible. Needless to say, Dr. Smith said it was a great day when he became President. It was a great time for the four of us ladies- I guess I should mention in our clinic we currently have 4 scholars, three medical students and myself. All female. One other female medical student will join us in a few weeks. We have been told they have never had this many women scholars before and
It has been a month. In some ways I feel like I have been here only a week and in other ways I feel like its been a year since I have seen home. Sounds dramatic, but I think I have seen, learned and experienced so much in such a short period of time that it makes every day seem a little longer.

Race has been a common topic- as I'm sure seems obvious by the history of Mississippi. With Medgar Evers assassination anniversary recently and learning about the history of Mississippi it has come up frequently. I don't even know how to sum up all the things I have learned and heard but I think it is interesting and important to say that while the clinic is mostly African American and I am staying on a HBCU and Jackson is majority African American- when you move to some of the other cities only 20 minutes away it is very obvious that segregation still exists. Certain towns, areas and restaurants are either mostly white or mostly black. Some of them are mixed but it is very rare that it even comes close to 50/50. It has been talked about at some of my meetings and on individual encounters that there is still a strong divide between races, a lot of trust issues and some very large hurdles to overcome before things get to where they should be. It has been such an opportunity to be allowed into individual's personal lives and have everyone be so frank and open to discussing such sensitive issues.

Speaking of sensitive issues I had a very interesting discussion with a provider and student-provider today. We had a patient come in for a pregnancy test and it was positive. I was seeing another patient and they saw the young woman together. When they came out and we were talking in her office they were telling me how distraught she was. I asked if they had discussed adoption and abortion options. The provider said no, she never brings those up with patients and has only talked about it if they bring it up (which she said has only happened to her twice). I asked if she minded if I enquired as to why- she said even though she probably shouldn't be bias she knew she was. (If you have kept up with recent events MS has one abortion clinic and the state is working to shut it down) The student (who is from MS) asked me why I would bring it up. I said if we as providers don't list the options available to patients then probably no one they know will and they have a good chance of being misinformed or not having the opportunity for making a decision that was a better fit for them. I said similar to asking a patients if they have ever been abused at an initial or yearly health exam- if we don't bring it up and give them the opportunity to receive help then who does that responsibility fall to in their lives? They both said they had never thought of that. The student looked up educating patients on options for pregnant women, found the clinics in the area that could help her and also found evidence stating that having conversations about pregnancy options reduces the likelihood the patient will access unsafe measures for terminating pregnancy. It was a very positive conversation. It was great discussion, I don't know if it will change anything but it was great to have the dialogue.

For lunch one day this week the student-provider took me to a local spot called Mama Hamil’s. This is an all you can eat buffet of southern style cooking that all the locals go to- including state officials. For $8.00 you get access to four different huge stations of food: cold ‘salads’ (macaroni salad, coleslaw, corn salad, etc), hot ‘vegetables’ (corn, candied yams, beans, collared greens with bacon), hot sides (mashed potatoes, mac and cheese, chicken dumplings, etc) and then the meat section which includes fried chicken, fried pork cutlets, fried turkey necks, and meatloaf. There was also a section I mustok (and was hopeful) was a salad bar but alas it was a baked potato bar with the fixings. And don’t forget a full dessert bar with cobbler, cinnamon rolls and ice cream. We talked as we ate our food on picnic benches how this is part of the issue with talking with patient’s about healthy eating- how do you tell someone with low income to eat fresh fruit, vegetables and lean meat when they can come here for all you can eat for $8.00 but have literally no options for healthy eating. Even eating there in small portions you still would not be anywhere close to a healthy meal. It was quite the experience. I found out I quite liked fried okra and peach cobbler at lunch is pretty great but finding a way to change a patient's diet when the culture they are surrounded by does not support change or encourage it all can be a difficult battle.
feels burned out because she is handling the clinic alone. This has been brought up at several meetings and it sounds like they are deeply considering hiring hospitalist to round on the hospitals and nursing homes and pull the other providers back into the clinic. I could definitely see the difference in how the FNP was able to make decisions for these patients compared to my internal medicine rotation where hospitalist were used. The FNP knew all but one of these patients personally, could recall every hospital visit they had had and was able to make not only decisions for their stay but knew what services or follow up they needed once they went home because she knew exactly what their home situation was like.

Tuesday I and the other scholars attended a meeting hosted by US Representative Bennie G Thompson and lecture given by Dr. Renard Murray, Regional Administrator for the Centers for Medicaid and Medicare Services of the Atlanta Regional Office. The goal was to explain upcoming and important dates related to Healthcare Reform, what plans would be available and who would qualify for which services. Dr. Murray also spoke about how patients can sign up for these services - through the web (www.healthcare.gov), over the telephone which is available 24/7 or in person which I believe will be available at the public health department. A couple interesting things he mentioned that I was not aware of the details at this point: if you do not get health insurance in the year 2014 you will be penalized about $90.00 on your tax return that year, if you do not get insurance by 2015 you will be penalized about $290.00 on your return for that year and if not by 2016? The penalty will be close to $600.00. I think I can say with almost complete certainty that I am a supporter of Healthcare Reform but I had to ponder to myself - if families who are 133% below the poverty line not able to qualify for Medicaid (as told to us by Dr. Murray) and have to purchase insurance on their own or be penalized $600 in the year 2016, how likely are they to find insurance that is affordable for them? What is the likelihood they can find an insurance plan for their whole family that will cost them less than that third year penalty? I currently pay about $160 a month for individual insurance let alone a family. It seems impossible that anyone will be able to afford that who is already struggling to make it by. We also were informed that in Mississippi as of October 1, 2013 (the day individuals will be able to start signing up for insurance) 32 counties will only have one plan available to sign up for. There are 82 counties in Mississippi, this means 39% of the state will not have the options that they other 61% have. As brought to the attention of everyone during the discussion, one of our administrators from the clinic said essentially the insurance companies are red lining these 32 counties by making their plan available for that 61% but not for the other 39% because they are the most sick and poor in the state (and probably in the country too). Representative Thompson stepped in and said if things do not change the state will file a formal complaint for this. It was another active and heated discussion, showing again how interested everyone is in change and improving the lives of those in Mississippi.

Wednesday the other PCLP scholars and I interviewed Dr. Marvel Turner, the current chairman of the board for CMHS. Dr. Turner has been on the board for fifteen years but this is his first as chairman. A CPA for many years before, he returned to Jackson State University for a PhD in Public Policy and became a professor. He said he has served on the board in mostly a financial position and finds this a strength he can now bring to being chairman. Meetings at CMHS often have a strong social component as most members of the board have known each other for decades and have a strong interaction with the community and while that has been a positive focus; Dr. Turner has tried to guide the meetings to a more efficient and productive focus on budget and policy. He feels that the clinic could make more progress if there was a firmer push for compliance when it comes to policy, budget and expectations. When asking how members are chosen for the board he shared that they have a diverse representation of the community and about thirty percent of the board is required to be patients of the clinic so they can have a patient perspective represented. Dr. Turner seemed very dedicated to the clinic and its mission and wants to help the clinic maintain its legacy while moving forward.

Wednesday evening two of the PCLP scholars were invited to guest star on a local radio show that one of the doctors from our clinic hosted weekly. They spoke about our program, its focus to teach the PCLP scholars about underserved communities and how we can become leaders in the clinics we become a part of. They also discussed the prevalence of minorities in medicine, specifically African American men. The doctor from our clinic felt that less African American men were going into medicine than African American women. They talked about whether this was related to primary education not preparing these populations adequately and other possible factors. As they finished and our doctor signed off he commented that he was proud that the girls (both African American) were going into medicine to serve those who need it most since most young white folk go into medicine to perform research and not to help those who need it most. My heart sank. I was shocked. I was confused. I wondered what experiences had happened in this doctor’s life that even when he worked closely with us scholars (including myself, and I am White) who were here for the sole reason that they wanted to make a difference in underserved family medicine he still had his mind set that we had another focus. Even after several days of contemplating the comment I am still unsure what to make of it or how it affects the outcome of my experience here.

Thursday I was able to take some time for myself for the holiday and participated in a sixty-five mile bike ride through what is called the Natchez Trace Parkway. This parkway is 444 miles long and connects Natchez, Mississippi to Memphis, Tennessee. American Indians and bison used this trail originally.

Friday the PCLP scholars and myself interviewed Dr. Robert Smith and his role as an administrator and clinician for CMHS. He shared with us the difficulties balancing the two roles and his desire to always be in clinic more with his patients than having to complete administrative requirements. When asked his most difficult obstacle he faces he told us it has for the most part always been the same: being able to get comprehensive work-ups and
even the basic needs completed for the everyday patient who cannot afford the costs of our healthcare system. Discussing healthcare with Dr. Smith has become a favorite thing for me in Mississippi, he always has an inspirational story to share of what he has seen, experienced and done for healthcare over the last five decades or so.

Friday night we had a clinic party and BBQ. While we sat around a couple tables we naturally came to discussing healthcare. We were discussing the tragedy that the United States fell last in health care measures for first world nations, and Mississippi falls last in the United States and someone chimed in saying that means that The Delta probably has the most unhealthy and needy individuals in all first worlds. When asked what or where The Delta is we were told that is the area that had the highest concentration of cotton plantations and depended greatly on Black slave labor. Over the years the area has struggled to support much business and has been one of the poorest areas in Mississippi. This is the location we were told the first CHC in the United States was built. And that settled it. One of the other PCLP scholars and I decided we better make a trip out there.

Sunday Rosie and I packed up early in the morning and planned our route for The Delta- approximately two and half-hours from Jackson. About forty-five minutes into our drive the landscape changed from industrial lined with heavy wooded landscape to flat crop fields dotted with occasional small businesses and tiny farmhouses. The farther we got the less businesses we saw, more crops, and tiny homes. Some houses were boarded up, some even abandoned or collapsed on themselves- no attempt to remove the demolished homes, and some even had foliage growing into the wreckage. Most of the crops were corn or soybeans; one may have been young cotton field. We discovered later that what cotton fields are left were in two areas that we did not make it to on our drive. We eventually came to the small town of Mound Bayou and just half a block off the two lane highway we came to a small building with an official plaque in its front lawn- the first Community Health Center in the United States, opened by Tufts University in 1967. The next-door neighbor to the clinic? Crop fields. There was a small town down the road we explored before heading back to the highway and taking a different route home that took us through more crops along the Mississippi river and eventually to Vicksburg and back to Jackson.

The drive seemed pretty rural to both of us, it is hard to image what the area looked like over forty years ago when Dr. Smith and Dr. Geiger worked with their colleagues to build that clinic. It is an experience that will stick with me forever.

Week Five!

Getting near the end of my stay now but still experiencing new things everyday. Monday morning on my way into work I was listening to the local NPR station (I could write a whole separate blog for the local station, with so many changes in healthcare and political changes in the last month this station has been filled with interesting discussions) and I happened to catch an interview with Mayor Chip Johnson. This is a Mayor from Hernando Mississippi who has made it his mission to change childhood obesity. Mississippi ranks 50th in childhood obesity and I was able to find articles back to 2009 about Mayor Johnson and his active role in changing this statistic. He has attended a large number of conferences, local and national, all focused on obesity and different ways to reduce the prevalence of this disease (yes, obesity has controversially been coined as a disease now in just the last couple months). The Mayor has made what we would think obvious changes like looking into public school lunches, increasing recreational centers and expanding programs for children but he has also made some less obvious ones. I read an article where he talked about how you cannot force healthy lifestyles on individuals but if you make it easier for people to be healthy then they tend to move in that direction. With that thought he made sure new developments were all required to build sidewalks in front of their businesses making the communities and neighborhoods more exercise friendly. Has any of this worked? In fact it has, while Mississippi is still 50th in the nation for most obese the numbers are falling. Mayor Johnson said that it might still be some time before they no longer sit last in the rankings but when you look at the numbers, the population is declining in obesity and with time will hopefully catch up with the rest of the country.

It was a good reminder that it takes patience and determination to make an impact on such a large and cumbersome issue. When I read the past articles about this Mayor they were over four years ago. He has had this passion for so long and been able to see the changes he can make even when no one around him was able to envision it.

This week I decided to tackle the clinic’s Electronic Medical Record and create a template that could be used for the patients with chronic pain. I wanted to incorporate the screening assessments that guidelines suggest you use for chronic pain patients to help monitor depression/anxiety/addiction and narcotic misuse. The clinic had copies of all these assessments in the binder that the PCLP scholar put together last year but they were rarely being used. I thought if I could figure out how to put them into their EMR they could be used with ease at visits
and it would help increase consistent care from one patient with chronic pain to the next. A well intended thought. The EMR the clinic has is rather old- in the land of technology at least. They have had the same system since about 2000 and it is anything but ‘friendly’. I spent a good part of Monday reading what looked like three dictionaries put together on how to make a template and then spent most of Tuesday attempting to build one only to find out Wednesday I had done it incorrectly. The only thing that has kept me from quitting is that several of the providers are looking forward to the template. While the EMR has several built in templates for pain, diabetes, women’s health issues and such, it is obvious when you read through them that someone who has never practiced medicine or understands the concept of Evidence Based Practices built them. Which is why most of the providers just use a generic template and free-type a lot of the information. But after several attempts, mistakes and failure I think I have figured it out and will leave them with what will hopefully be a helpful tool for collecting useful information from patients with chronic pain, help create realistic goals for attempts, mistakes and failure. I think I have figured it out and will leave them with what will hopefully be a tool that will help streamline screening assessments and make future visits more efficient because past information will all be easily accessible in the EMR.

This was also a week with more meetings. We had another monthly provider meeting- it was strange to realize I had been there long enough to attend two of these. The clinic I have become a part of here is full of dedicated individuals who truly want to see the community around them have access to healthcare and be taken care of. But when you sit in one of these meetings you quickly realize why they come across barriers and hurdles that they haven’t been able to break down. Everyone at the table knows what needs to be changed or is of highest importance but no one seems to be listening to each other and there is a loss of order and organization. The PCLP scholars sat on the fringe of the meeting and being an outsider who wasn’t in the throngs of the discussions at hand gave us this advantage to see why things weren’t being accomplished. But I am not sure that anyone sitting at that table could truly grasp why they were having such a hard time accomplishing anything.

After the provider meeting they went straight into a quality assurance meeting. Each provider was handed paperwork that broke down their individual goals for quality measurements and how close they were attaining them in the last month. The dreaded EMR played a role into this meeting. Most of the measurements were being met but the one measurement that everyone had a zero on was ‘patient reminders’. This would be reminding or updating records on health measures that have been defined by many organizations like preventative services task force, patient centered medical homes and other organizations. Many EMRs will have a ‘reminders’ tab that will alert providers that patients need their annual pap, and A1C check for diabetes even a yearly discussion on obesity or smoking. This clinic’s EMR does not have that feature so even if providers are reminding patients on their own there is no way to measure that data and judge how well it is being done. This spurred more discussion and arguments and in then end there was little progress on how to fix this.

The last meeting that day was on Patient Centered Medical Homes. The clinic is trying to become accredited as a Patient Centered Medical Home and will be reviewed for this qualification on August 15th. This deadline is fast approaching and several things need to be accomplished in order to meet these qualifications and be able to receive additional federal funding. Some of these qualifications are:

- Patients have access to culturally and linguistically appropriate routine/urgent care and clinical advice during and after office hours
- The practice assesses and documents patient risk factors
- The practice identifies patients for proactive reminders
- The practice works with patient/family to develop a self-care plan and provide tools and resources, including community resources
- Practice clinicians counsel patients on healthy behaviors
- The practice uses performance and patient experience data to continuously improve

This is only a small fraction of the basic guidelines. What we discussed Monday was how this was going to be accomplished. The clinic has hired a company whose focus is to help clinics make these changes and be able to meet the accreditation standards. A gentleman from the company joined us and we had a conference call with their main office that discussed the ‘whats and the whens’ of how this would be done. A crew of about three would show up next week, pull charts, run surveys and basically work all night to see if the clinic had all the materials to make the changes and then teach the staff how to implement them. It honestly sounded exhausting but if they could kick everyone into gear in a couple weeks it may help bring some things to order that until now they haven’t been able to do.

This was my last weekend in Mississippi and also my birthday. I booked a hotel in Jackson that had an outdoor pool for a little relaxing time and then six of us girls (PCLP scholars and Nurse Practitioner Student) went out to dinner. It was such a great time and funny how all of us women from all over the country and with different backgrounds could sit down at the table and talk with ease about our lives, our careers and our passions. It was a great last weekend to prelude my last week.
Week Six!

My last week in Jackson. It feels like time flew by. It was a bittersweet ending. I have made a lot of connections while I was here and feel like I am abandoning the clinic a little bit perhaps because I came here to make a difference and really what difference can be made in six weeks? Truly the difference made was with myself and I guess I feel a little bit like I am taking something home with me but maybe not leaving much behind.

I met with my advisor this week that was matched with me for the PCLP program- Dr. Bob Philpot, the Program Director for the Mississippi College Physician Assistant Program. It was a great visit and enlightening to learn about the challenges the program has been facing. The PA Program at Mississippi College is the only program in the state and has only been in place for two years so far. Mississippi was the last state to license Physician Assistants and as I learned from Dr. Philpot in a nation of about 80,000 practicing PAs- Mississippi has 80 of them. The amount of PA students in Mississippi is almost more than current practicing PAs. This has created some challenges when it comes to finding sites for clinic rotations as it appears not even many healthcare sites know what a PA does, what their level of education is and how they fit into the healthcare setting. Dr. Philpot- a Physician Assistant himself, was telling me that when he becomes discouraged at times he remembers what it was probably like for Eugene Stead when he started the first Physician Assistant program at Duke in the late 1960’s. While Dr. Philpot has the ability to give example of thousands of PAs in neighboring states, Dr. Stead had no one to give as example but himself. He was blazing a trail for all of us and I am sure it had many discouraging and difficult moments. It was inspiring to see Dr. Philpot have such a motivated and optimistic outlook on what at times sounded like a challenging situation. The program itself was beautiful with the latest technology and a lot of similar teaching styles that I had experienced myself here at the University of Utah’s PA Program. It was an educational experience and we had a great discussion about his personal experiences working in Community Health Centers as well which just furthered my desire to pursue a career with Community Health myself.

As I finished up my last week in clinic and said my goodbyes several of the staff asked if my perceptions about Mississippi turned out to be true or not. I told them that I honestly did not know what to expect. I thought it would be very different from Utah in terms of demographics, which turned out to be completely true. The religious aspects of Mississippi compared to Utah surprised me. Utah is generally known for its large LDS population and some subsequently contrasting counterparts that often times create heated discussions in politics and social aspects. In Mississippi there was just as strong of a religious influence but there seemed much less arguments about it because the vast majority of the population shared this practice. Often a prayer was said at office meetings prior to starting and even at my bike race they said one. Dr. Smith even asked me to say a prayer at a restaurant one day prior to our lunch. It surprised me that the culture was so different. Growing up in Utah and not being a part of any religious organization I always felt Utah had a very strong religious influence and it made me smile that Mississippi was just a couple steps beyond that. I am sure as social practices continue to change throughout the country that Mississippi may start to feel some friction like other states have when it comes to changing policy and law but keeping their religious roots.

One of the providers and I were talking about how she felt about the social aspects of Mississippi and her concerns with raising her children there. She had enrolled her two daughters into a science summer camp and was discussing her hopes that the camp would be educational for her kids. She said she realized that even thought it was the twenty first century she knew that her two black daughters would still not have every opportunity or the privileges that are often afforded to white children and she wanted to prepare her kids as much as possible so they could make opportunities for themselves. She said if she wanted me to take anything home with me it was to understand and share with others that no matter what preconceived notions individuals have about the South or even African Americans in general that people should understand that they want the same things for themselves, their family and their kids as anyone does. She wants her children to succeed, to be educated and to be respected just like anyone else would want for their children.

I think that shows a little bit just how impactful this experience has been. I was only about 1,600 miles away from home and still in the United States and yet it was at times like I was in different world. Sometimes I wondered to myself how I had missed all this history and did not realize how things that had happened there impacted so many things in our country. It will be an experience that I take with me everywhere and I made friends that I will stay in touch with for probably a lifetime. And I have learned that no matter where you are in our country there are always those who have no healthcare that need advocates and primary care providers to help bridge them into our healthcare system and give them not only medicine but education so they can be empowered to care for themselves.