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Historical Introduction

The area of Mississippi now known as Jackson was once inhabited for thousands of years by the Choctaw Nation who occupied that area and surrounding states.¹ Under the Treaty of Doak's Stand of 1820, the Choctaw gave over the land to the US. Subsequently, so many European-Americans began to move to the area, the Choctaw under the pressure of the US government agreed to removal from the area and eventually gave up the land east of the Mississippi River.²

Present day Jackson was once called Parkerville during the time in which it was settled by a French Canadian trader Louis LeFleur along the historic Natchez Trace trade route.³ This area began to be called LeFleur Bluff and it was sought out after the state of Mississippi government decided to relocate the capital to the absolute center of the state.⁴ After the discovered the absolute center of the state was a swamp, they surveyed the area southwest of the center and came upon LeFleur Bluff. The state government decided to make that area the capital because of an abundance of resources in close proximity including good water and timber, as well as close proximity to trading routes.⁴ In 1821, the area became the permanent seat of government in the State of Mississippi and was renamed Jackson after General Andrew Jackson at that time who had won the Battle of New Orleans and later became a 7th US President.⁵

In the nineteenth century, the combination of the demand for cotton from Great Britain and the improvements in cotton gin technology lead to the states of Mississippi, Georgia, Alabama, and Louisiana becoming the four major cotton-producing states.⁶ These states created large scale

production by farming cotton on large areas of land in the states. Slaves were the most important asset in cotton agriculture. In these states a cotton planter with adequate financial resources could buy large numbers of slaves and cultivate large areas of land.⁶ Large scale-cultivation of cotton was extremely profitable leading to southerners being most of the wealthy men of America at that time. Vast numbers of Africans men and women were removed from their tribes and countries and brought to these cotton plantations to supply labor demands. So much so that by 1850, slaves were believed by make up 50 percent of the population in the four cotton states.⁶

Jackson was linked by rail to other cities in 1840, unlike other Mississippi cities, Jackson was not located on the Mississippi River so commercial trade relied heavily on the railroads, which would spark the growth of the city for decades to come. Jackson became a strategic manufacturing center for the Confederate States of the South during the Civil War. The Union forces of the North had to capture Jackson for a second time due to a battle in Vicksburg. After the Siege of Jackson by the Confederate forces for a week, the Union forces recaptured and completely the burned the city. A few antebellum structure remained one was the Governor's mansion and the other was the Old Capitol building.

The Old Capital building was home of the Mississippi state legislature from 1839 to 1903. In 1890 the constitutional convention for the state was held there at the capital where the Mississippi Constitution of 1890 was produced. This was the first of the constitutions and amendments of the slave states through 1908 that effectively disenfranchised African-Americans and poor Whites from voting due to poll taxes, residency requirements, and literacy test. Although, these constitutions survived Supreme Court challenge in 1898, in the 20th century the Supreme Court began to find their provisions unconstitutional and now the slave states had to devise new ways to continue to disenfranchise Blacks and the poor.^{7,8,9}

After the Civil War, freedom of the slaves, and decreased demand for cotton took a toll on the economy of Mississippi. Jackson continued to see growth in twentieth century due the discovery of nearby natural gas fields in 1930s. The promise of natural gas and oil cause many businessmen to invest in wells in Jackson further bolstering the economy. However, many attempts ended in failure and some of the oil was considered of lower quality due to its content of salt-water. However, the oil and natural gas industry did bring enormous amounts of business to Jackson and took the edge off during the Great Depression. However, by 1955 most of the city's wells were closed.¹⁰

During this period, Jim Crow laws were a convention of southern states of the former Confederacy. The laws included a term called "separate but equal" which included all public institutions and facilities. In practice this separation led to inferior conditions for Blacks and created a system of social, educational, and economic disadvantages. By the 1960s Jackson had grown dramatically and the Census of 1960 reported the population as 64.3% White and 35.7% Blacks.¹¹ Also being the capital of one of the southern states notorious for Jim Crow laws, Jackson became a site for civil rights activism during this time. The African-American Civil Rights Movement was in full swing in the 1960s. Boycotts, sit ins, and freedom rides were common place in Jackson as methods of peaceful protest to end Jim Crow laws, segregation and racist practices of discrimination against Blacks.

Interestingly, enough most of the historical account of the Civil Rights Movement focuses on the racist practices in the context of education, voting, use of public facilities, housing, and jobs. However, there were large ramification of discrimination and inequality in medicine and healthcare felt then and that still plagued Jackson to this very day. Many White physicians would not see African-American patients and some of those that did, only saw Blacks on a day out of the week or charge unfair prices for inferior service to what their White counterparts received. African-American physicians has a hard time maintaining practices in Jackson for many reasons.¹² Physicians, like Jackson's own Robert Smith were

on the frontlines in protest for social justice in healthcare. Those involved in politics felt pressure from the White community in Mississippi one way or another and many had to close their practices down due to threats or financial ruin. Life was even difficult for those that stayed clear of politics. Black physicians had to face Jim Crow laws as well and they had a hard time making money because a majority of their patients were poor and indigent.¹² One of the most sticking facts about Black doctors is Mississippi is that there were so few of them, only fifty five in 1960 and the number continued to dwindle. Fifty two of the state's eighty two counties had no Black physicians at all. Although, Mississippi had the largest percentage of Black citizens they had the fewest Black health professionals. Most Black physicians stayed clear of Mississippi because of difficulty inherent to practicing medicine in the nation's most segregated state. The problem was most evident in the scarcity of hospital facilities for Blacks. Many county hospitals would not accept Black patients and the few that did provided only had a few beds available for inferior services including ridiculously long waiting times.¹² For example Jackson's Baptist Hospital at the time only admitted Black patients to a cramped and segregated annex where every type of health care from, surgery, dentistry, child births, etc, occurred for every age group. To make things even harder, many state hospitals would not give Black physicians privileges to their facility.¹² They maintained this practice by not allowing Black doctors into local and state medical societies, which was necessary for the Black physician to be involved members, in order to obtain admissions to the American Medical Association to which members were granted privileges.¹²

Some local, but a majority of medical students and physicians from the Northern states came to the aid of the Black Physicians in the trenches during the Civil Rights movement. They came to protest with civil right advocates against segregation and racism in medicine and against Black physicians. They also supplied much needed healthcare to other citizens involved in civil rights movement who were injured or needed care for their families.¹² The Civil Rights Movement did bring about many changes to the treatment of African-Americans and their rights as citizens. In medicine, the AMA eventually begins

to support Black physicians and demanded open access to hospital facilities for their patients. However, the pervasive undertone of racism that once advertently existed in the 1960s still plays in the background in the communities of Mississippi today and is evident in by the socioeconomic state of African Americans in Mississippi and availability and access to quality healthcare to this large population of citizens.

Demographics of Jackson, MS

The capital city of Jackson, Mississippi has the largest population in the state. It is one of the two county seats of Hinds County. Over the past 12 years the population in Jackson has decreased slightly from 184,256 at the 2000 Census to 173,514 at the 2010 Census. The Jackson metropolitan area is composed of Hinds and five other surrounding counties including; Copiah, Madison, Rankin, and Simpson. The overall population of the Jackson metropolitan area at the 2010 Census with a little more than half a million people.¹³ The majority of the population in the city of Jackson are Black at 79.4% compared to Whites at 18.4% in the 2010 Census. Most of the population are working age adults between 18 – 65 years of age.¹⁴ Interestingly, although the percentages of individuals with high school diplomas and college degrees, at 81.8% and 26.5% respectively, is higher in Jackson compared with the rest of Mississippi; the median household income is less in Jackson at \$34,555 than the state average at \$37,881.¹⁴ This indicates a relatively highly educated community with less opportunity for jobs or jobs with incomes that are comparable to other areas of the state. The state of economic struggle in Mississippi is confirmed by the higher percentage of people below the poverty line in Jackson at 26.6% compared to the state at 21.2%.¹⁴

The historical undertones of Mississippi, in addition to the current economic and impoverished state of Jackson has a profound effect on healthcare. Compared to the US average, Mississippi had less people insured by employers by almost 10%, more citizens on Medicare and Medicaid and a larger

number of uninsured at 19% compared to 16%.¹⁴ Combined more than half of the population in Mississippi is uninsured or using government subsidized insurance. The Blacks access to health care is clearly an issue because the distribution of non-elderly uninsured in Mississippi is 43% compared to 15% in the US.¹⁴ Unemployment puts health at risk. Evidence shows that the unemployed and their families suffer a substantially increased risk of premature deaths, most likely linked to effects of mental health, for example anxiety and depression. Effects are also linked to increases in self-reported ill health, heart disease and risk factors for heart disease. The unemployment rate in Mississippi is higher than average in the US, at 9.1% compared 8.3%.¹⁴

The Centers for Disease Control and Prevention developed indicators in response to the objectives of Healthy People 2020 that are used to assess and compare the health status of states and local areas. Among these indicators of health statuses are: infant mortality, low birth weight newborns, life expectancy, prevalence of diseases and death rates. In comparison Jackson and Hinds County have a lower health status than the state that already has an overall lower health status than most states in the US. The infant mortality rate in MS is significantly higher at 10.6 per 1,000 births compared to 6.8 the national average.¹⁵ In Jackson and Hinds county the percentage of low birth weight newborns was lower for whites at 7.3% and higher for Blacks at 18.2% compared to the state percentages of 8.9% and 16.1% respectively. The life expectancy in MS is also lower than the US average at 74.8 years compared to 78.6 years.¹⁵ Chronic diseases such as cardiovascular diseases and cancer make up the highest proportions of deaths in Mississippi. The leading cause of death for Blacks and Whites in Jackson was heart disease, which typically is manifested from chronic diseases such as hypertension, coronary artery disease, or diabetes.¹⁵ In Jackson, more Blacks had a higher mortality than Whites in the area with the same disease at 294.6 per 100,000 versus 203.2 per 100,000 respectively. Mississippi as a whole has a substantially greater number of death due to heart disease at 244.9 per 100,000 compared to the national average 180.1 per 100,000.¹⁵ Chronic illnesses that lead to heart disease and heart disease

itself can be prevented or successfully managed with adequate and consistent care. However, access to primary health care is a significant problem in Mississippi and Jackson. The county in which Jackson resides and seventy-five of Mississippi's 82 counties are designated by the federal government as primary care and health shortage areas.¹⁵ Primary care is the most appropriate setting for management of chronic diseases and coordination of care. The primary care setting is typically where patients receive health screening and checks and patient education on nutrition, exercise, and smoking. There is an obvious need for access to primary care in Jackson due to the high prevalence and mortality of chronic illnesses like heart disease, cancer, and stroke. Primary care could also address areas in which education and primary prevention could decrease other chronic illness, for example adults in MS smoke more than the national average at 22.9 % compared to 17.2%. In MS there is a problem with obesity which is high at 68.8% compared to 63.8% for the adult average in US. However, the obesity problem is even higher in children of MS at 44.4% compared to the national average at 31.6%.¹⁴

Background

The citizens of Jackson clearly have higher risks and poorer health status than most places in the US. This is in part due to poverty, unemployment, lack of insurance, and historic and current disparities in access to care. This problem is currently being addressed by federal initiatives of Bureau of Primary Health Care, the Centers for Medicare and Medicaid Services, and US Department of Health and Human Services. These agencies are provided funding to community health centers serve federally designated medically underserved areas like Jackson, or that serve homeless or individuals in public housing, or culturally competent health care to migrant or seasonal workers. In addition to funding the programs, several standards of care must be met and documented to insure quality care for all regardless of socioeconomic status. Jackson, Mississippi currently has two federally qualified health centers; Central Mississippi Health Services and Jackson-Hinds Comprehensive Health Center, which both have multiple

campuses in the community. This summer I was given the wonderful opportunity to participate in the GE-NMF Primary Care Leadership Program (PCLP) which gave me an invaluable opportunity to work alongside the health care providers at Central Mississippi Health Services to learn about more about the services provided, the populations served, and the future of primary care in the US.

Central Mississippi Health Services is also named the Robert Smith Sr. MD Family Health Center after the founder and long standing CEO. Dr. Robert Smith Sr. was one of the founding members of Medical Committee for Human Rights that formed in 1964 following the death of NAACP leader and Jackson-native Medgar Evers.¹⁶ The Medical Committee for Human Rights (MCHR) grew out of sparsity of black doctors in Mississippi, when it was founded there were only about twenty-five to thirty-five practicing physicians in the state. The MCHR became the “medical arm” of the Civil Rights Movement. The group picketed the American Medical Association (AMA) to bring attention to issues regarding disparities of morbidity among Blacks and Whites in the south.¹⁶ They also fought for the end of segregation in hospitals. However, the number one mandate of the MCHR according to Dr. Smith was “to take care of civil rights workers and local community people who could not receive appropriate and adequate medical care; to assess medical conditions in the community; to challenge segregated waiting rooms and doctors’ offices and in physicians’ offices to try to provide support to local cooperative physicians, be they black or white. Dr. Smith met with Dr. Jack Geiger and learned of the health center model used in South Africa.¹⁶ Dr. Smith’s experience and understanding of the needs of the underserved and oppressed community in Mississippi combined with the success of the health center model in South Africa birthed the neighborhood-centered comprehensive health center concept. One year after the inception of the MCHR, they received federal monies to open clinic in Mound Bayou, MS where health, economic, social, and legal help was provided. Mound Bayou was chose first primarily because it was an all-black community with an available building to use as the clinic at Campbell College that was forced to relocate there from Jackson. The community healthcare center (CHC) model was first

employed in the US in Mississippi and Boston, MA, but soon would be model for thousands CHC that were implemented in needy areas throughout the country, especially in the South.¹⁶

Central Mississippi Health Services Inc. (CMHS) is the CHC, Dr. Smith has been involved with the longest. CMHS has a wonderful and hardworking medical team with physicians and nurse practitioners participating as health care providers. The physicians at CMHS are medical staff and have rights at Jackson three major hospitals, which are Baptist, St. Dominic, and Central MS Center. CMHS also has several sites that provide comprehensive health care services not offered at other family health centers. CMHS main clinic has an onsite laboratory and imaging center. They offer women's health including obstetrics and gynecology at a separate location. CMHS collaborates with student health services at Jackson State University and Tougaloo colleges. The Tougaloo site also offers dental services. They also have a partnership with Hinds Behavioral center to provide family and individual psychotherapy services.

The mission of Central MS Health Services, Inc. is "to provide quality primary health care through its community-based organization to populations facing significant access barriers to the health care system. All services will be provided within an environment that preserves human dignity and is culturally sensitive to its user population." The vision statement set forth is that "CMHS will have significant impact on the health and well-being of the people within the community it serves. The organization will advocate and work with others in the community to coordinate services and develop creative liaisons that offer a broad range of health care and assistance in meeting user-population needs.

CMHS serves about 7,119 patients, approximately 60% women and 40% men. Ninety-six percent of the patients are black and 98% of patients a recognized minority group.¹⁷ CMHS serves a highly impoverished population with approximately 1/3 of the patients living below the poverty level

which is currently \$15,130 for two-person family or \$23,050 for a 4-person family.¹⁸ Fourteen percent of CMHS patients are uninsured with greater than 40% having Medicaid or Medicare as primary insurance.¹⁷ CMHS generates revenue for clinic operations and payroll through a variety of methods including federal funding and grants in addition to third party insurance payments. The overall break down consists of 17% from US Department of Health and Human Services via the Health Resources and Service Administration. An additional 20-30% comes from per diem payment for services from Medicare and Medicaid. The remainder is comprised of federal grants, patients with private insurance, and payments from patients based on sliding scale according to income. In accordance to the mission and vision statements of CMHS one of the top priorities of the clinic is to become recognized as a National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH). The NCQA PCMH program began in 2011 to improve primary care, through the establishment of a set of standards that describe clear and specific criteria, in addition to, providing information to clinics on how to organize care around patients, work in teams and coordinate care over time.¹⁹ According to NCQA the PCMH should be, “ health care setting that facilitates partnership between individual patients, and their personal physicians, and when appropriate the patient’s family. Care is facilitated by registries, information technology, health information exchange, and other means to assure that the patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.”¹⁹ CMHS’ goal to obtain PCMH status will positively improve mechanisms to provide patient-centered care and improve the overall quality and access to care to the community. The PCMH status will also bring additional federal funds to the clinic necessary to maintain a clinic that provides a majority of its services to those who are impoverished and underserved. PCMH recognition is based on meeting elements of six standard categories. The first standard is to: Enhance Access and Continuity by provided access to care and advice after hours. The second is to: Identify and Manage Patient Population by collection and using data for population management. The third is to: Plan and Manage

Care by using evidence-based medicine guidelines for acute and chronic illnesses including medication management. The fourth is to: Provide Self-Care Support and Community Resources through information, tools and resources. The fifth is to: Track and Coordinate Care including tests, referrals, and transitions of care. The sixth and final standard is to: Measure and improve performance through patient experience data for continuous quality improvement.¹⁹

Methodology

This opportunity to work alongside the health care team at CMHS, not only provided me with powerful historical insight to the socioeconomic and health status of the community; I was also charged with creating a resource or tool that would bolster the already high level of care provided at the clinic. During the brainstorming process, I was certain that I wanted my project to be focused on the patient-physician relationship and something that would get the patient actively involved in their care at each visit. Data from several clinical trials indicated that for chronically ill patients, better health outcomes both subjectively and objectively were consistently related to specific aspects of the patient-physician relationship including the patient being actively involved in medical decisions.²⁰ CMHS has over 5,000 diagnosis of chronic disease, including hypertension, diabetes mellitus, heart disease, and COPD.¹⁷ Since more than fifty percent of the patients at CMHS have chronic disease as their primary diagnosis it is obviously important to maximize health outcomes via the patient-physician interactions.¹⁷ My first proposed idea was to create a patient tool that could be filled out prior to seeing the provider that included specific questions to ascertain the current state of the patient and the reason for their visit, as well as, any specific questions they wanted to ask. This tool would allow the patient to feel more involved and expressive during the visit and allow them time to think of questions that they could feel would surely be addressed. After discussing my idea with my faculty advisor Dr. David Norris, we agreed that allowing patients to fill out the patient tool while in the exam room would decrease

perceived wait times. Research has indicated that reduction of perceived waiting times may lead to increased patient satisfaction and greater willingness to return to primary and specialty care outpatient settings.²¹ Which is obviously important to maintain the appropriate use of the health care system to promote prevention strategies and discourage the abuse of expensive Emergency Services the abundance of which are used by uninsured. After creating a prototype, I met with a nurse practitioner Yolanda Bennett and interviewed the medical director Dr. Obie McNair, who explained in detail CMHS current efforts to obtain PCMH recognition. CMHS already meets and exceed several of these standards including: Level III National Quality Assurance, increased access to care by providing 24 hour access to providers, with 6-7 providers accessible at any giving time, and having Saturday operating hours for a half-day. CMHS also had instituted electronic medical records in their offices which are also a requirement. There are other PCMH standards that CMHS are actively working to meet for example, creating an interactive website for patient, where they can make appointments and look at personal health information. Other PCMH standards they are working toward are instituting an extra 15 min per hour for walk in patient per provider creating communication receipts for telephone, call, and mail correspondence with patient, as well as, providing clinical summary or copy of record to patient the same day of visit.

With this goal in mind I worked actively with Mrs. Bennett who heads up the Quality Improvement Program to exceed PCMH sixth standard. We reviewed the clinical performance measures for 2012 and added questions for the patient to answer to address certain prevention, education, and health outcome deliverables. We chose to include questions concerning medications including the use of narcotics for pain. We added questions to query about pregnancy in order to coordinate care with obstetrics or provide prenatal care. We also included questions concerning preventative care for pap smears and mammograms; and questions to address smoking cessation and immunizations. The final section added to the patient visit tool, asked the patient if they were interested in educational resources

directed towards the chronic illnesses most prevalent in the population CMHS serves. The updated patient tool was provided to the other health care providers for approval before the trial on patients was begun. In order to determine the patient's perspective of the tool, I included these follow-up questions to be answered after visit. Do you feel like the doctor answered the questions you had? Did these questions help you remember everything you wanted to ask the doctor? Did you feel more involved in your visit today? Were you more satisfied with this visit than previous appointments? Did your wait time in the room seem shorter than usual? The patient visit tool trial included twenty-four patients with a variety of age and health status.

Results

Of the 24 patients 22 (91%) completed all the questions on the patient visit tool. According to the follow-up questions, 21 of the 22 participants who completed survey suggested increased overall satisfaction with the visit using the patient visit tool by answering yes to all follow-up questions. One person did not answer yes to all questions. The patient left blank the question concerning more satisfaction with the current visit over previous visits because this was the patient's first visit to CMHS. The health care providers were able to ascertain information regarding the specific clinical measures noted above on each patient visit tool because they were all filled out completely.

Discussion

There was excellent participation with the patient visit tool indicating patients did not mind filling it out. Overall, patients were more satisfied with the use of the tool and felt more involved in their own health maintenance. The questions supplied by patients to the health care providers were covered during the visit increasing the patient's satisfaction. The use of the patient visit tool in the exam room prior to the visit, allowed the patient time to remember all questions and concerns and decreased perceived wait time. The patient visit tool also allowed the provider to look over the patients concerns

prior to visit and allowed them to use time in visit more effectively. Hopefully, this improvement in the patient-physician dynamics will improve patient compliance and prevention visits in order to improve health outcomes. The patient visit tool was also deemed very helpful by all providers in the trial. They were able to obtain pertinent health information to be discussed with patient. This will assist in continuity and coordination of care, and decrease futility of care, for example not giving someone immunizations they already have or being able to supply smoking cessation advice at each visit. The pertinent health information collected on the patient visit tool was also documented in the patient's electronic medical record and can be used for documentation for NCQA six standards to help establish and maintain PCMH recognition. The patient visit tool template was supplied to Quality Manager and can be updated or revised based on the needs of CMHS.

Conclusions and Reflections

My experience with the GE-NMF PCLP program was extraordinary and invaluable. Half of my family is from Jackson and I have visited all my life, but I learned more about the community during this past summer than I ever knew before. My experience at CMHS prepared me for my upcoming clinical clerkships in medical school, taught me the ins and outs of running a CHC, and gave me the opportunity to actively participate in improving the quality of care provided to the community. The patient visit tool can bolster the patient/physician relationship and get the patients more involved; while collecting pertinent health information to indirectly support patients by assisting in the PCMH recognition. I have done considerable thinking about my experience and my intimate ties to Jackson. I am strongly considering returning to Jackson to practice and serve the community in with primary care.

References

1. "[History of Meridian, MS](http://www.meridianms.org/history.htm)". Official website of Meridian, MeridianMS.org. <http://www.meridianms.org/history.htm>. Retrieved June 7, 2008.
2. Bob Ferguson (2004). "[Choctaw Treaties – Dancing Rabbit Creek](http://www.choctaw.org/history/treaties.htm#1830)". Choctaw Museum of the Southern Indian. <http://www.choctaw.org/history/treaties.htm#1830>. Retrieved June 7, 2008. ^{[[dead link](#)]}
3. "[WorldWeb.com Travel Guide](http://www.jacksonmississippi.worldweb.com/JacksonMS/FeaturesReviews/TownCityReviews//8-146541.html)". Jacksonmississippi.worldweb.com. <http://www.jacksonmississippi.worldweb.com/JacksonMS/FeaturesReviews/TownCityReviews//8-146541.html>. Retrieved January 31, 2010.
4. "[Official City of Jackson, Mississippi Website – Jackson's History](http://www.jacksonms.gov/visitors/history)". Jacksonms.gov. <http://www.jacksonms.gov/visitors/history>. Retrieved January 31, 2010.
5. William C. Davis, *A Way Through the Wilderness: The Natchez Trace and Civilization of the Southern Frontier* (New York: Harper Collins, 1995), 30.
6. Knut Oyangen. "[American Agricultural History Primer: The Cotton Economy Of The Old South](http://www.history.iastate.edu/agprimer/Page28.html)". *Center for Agricultural History and Rural Studies*. Iowa State University. <http://www.history.iastate.edu/agprimer/Page28.html>. Retrieved 16 January 2011
7. George C. Rable, *But There Was No Peace: The Role of Violence in the Politics of Reconstruction*, Athens: University of Georgia Press, 1984, p. 132
8. Richard H. Pildes, "Democracy, Anti-Democracy, and the Canon", *Constitutional Commentary*, Vol.17, 2000, pp.12–13. Retrieved March 10, 2008.
9. Michael Perman, *Struggle for Mastery: Disfranchisement in the South, 1888–1908*, Chapel Hill: University of North Carolina Press, 2001
10. Dudley J. Hughes, *Oil in the Deep South: A History of the Oil Business in Mississippi, Alabama, and Florida, 1859–1945* (Jackson: University of Mississippi Press, 1993), 67–86.
11. "[Mississippi - Race and Hispanic Origin for Selected Cities and Other Places: Earliest Census to 1990](http://www.census.gov/population/www/documentation/twps0076/twps0076.html)". U.S. Census Bureau. <http://www.census.gov/population/www/documentation/twps0076/twps0076.html>. Retrieved May 1, 2012.
12. John Dittmer, *The Good Doctors: The Medical Committee for Human Rights and the Struggle for Social Justice in Health Care*. Bloomsbury Press (July 1, 2009)
13. [http:// quickfacts.census.gov/qfd/states/28000.html](http://quickfacts.census.gov/qfd/states/28000.html)
14. www.statehealthfacts.org
15. msdh.ms.gov/county/Hinds.pdf
16. www.usm.edu/crdp/html/transcripts/manuscript-smith_robert.shtml
17. Central MS Health Services, Jackson MS, UDS Report 2010
18. aspe.hhs.gov/poverty/12poverty.shtml
19. www.ncqa.org/tabid/631/default.aspx
20. www.ncbi.nlm.nih.gov > ... > *J Gen Intern Med* > v.14(S1); Jan 1999
21. www.ncmedicaljournal.com/wp-content/uploads/.../Camacho.pdf