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Y. Stories to Save Lives

Interview Y-0032

Lori Hinga

26 June 2018

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ABSTRACT – Lori Hinga

Interviewee: Lori Hinga

Interviewer: Maddy Kameny

Interview date: June 26, 2018

Location: Dunn/Newton Grove, NC

Length: 1 hour, 42 minutes

Lori Hinga was born in Ishpeming, Michigan and grew up in the upper peninsula of the state. She describes playing in swimming holes over the summer, spending summers with her grandparents as a child, and caring for her grandmother who had diabetes and a stroke. Lori lived 5 miles away from an air force base and went to school with children who were bussed in from there. Lori is the youngest of four. Her father was a barber, and her mother stayed home with the children and later became a bookkeeper for an oil company. Her paternal grandmother left school at a young age to work at a boarding house for miners. She explains her mother cutting up old flannels and putting Vick's VapoRub on them when the children were sick, and using a vaporizer. She doesn't have many memories of visiting the doctor as a child. Lori's father was the youngest of 6 children, and had three brothers die of alcohol-related reasons, so he did not drink. Though he did not access healthcare much as a child, he grew to appreciate the healthcare coverage he had in his older age. Lori was very close with her mom, who passed away from ovarian cancer at age 63, when she found the mother-daughter roles reversed as she became her caregiver at age 34 with three children. Around this time, home health was privatized. Lori discusses her brother's experience with alcohol and drug dependence, and being his caregiver as he struggled with open heart surgeries (endocarditis) and homelessness in San Diego. Lori speaks highly of the healthcare received by the loved ones in her life, and of the assistance provided through Medicaid. She also discusses being a single parent who was very organized with high expectations, and involved in her children's activities. Lori moved to Hope Mills, NC in 2014 because her son was stationed at Fort Bragg. She describes rural NC as being more isolated than rural MI. Lori currently works as a project manager at CommWell Health, and describes a typical day in her work. She started studying nursing at Butterworth Hospital School of Nursing in Grand Rapids, MI and finished at Northern Michigan University. She worked for eight years at an organization providing care to the uninsured, and also for the Louisiana Public Health Institute. She describes her expertise as process and performance improvement. Lori describes various opinions of quality improvement for healthcare in the U.S.: patient-provider relationships, lack of time, access, cost, pay-for-performance, health literacy and complexity for lay people, health records, efficiency, and primary care shortage. She describes an experience following thyroid cancer when the provider made a mistake but it was not solved efficiently. This interview is part of the Southern Oral History Program's pilot project to document health and healthcare in the rural South.

TRANSCRIPT: Lori Hinga

Interviewee: **LH Lori Hinga**
Interviewer: MK Maddy Kameny
Interview Date: June 26, 2018
Location: Dunn, North Carolina
Length: 1 hour and 43 minutes

START OF INTERVIEW

Maddy Kameny: So what I have to do is basically make sure that this recording—that everything sounds good with your voice, so if you could just tell me what you had for lunch, and I'll make sure that the volume is okay.

[0:00:13.0]

Lori Hinga: I didn't eat lunch. [laughs]

[0:00:16.1]

MK: You're the second person today who said that. You nurses are too busy.

[0:00:19.0]

LH: Yeah, well, usually I eat lunch, but I didn't today. I had to run to the post office. [laughs]

[0:00:25.5]

MK: If you get hungry in the interview, we can pause.

[0:00:29.1]

LH: No.

[0:00:29.1]

MK: I don't want you to—

[0:00:30.3]

LH: No, I'm good. No, I'm fine, really. [laughs]

[0:00:32.2]

MK: Just let me—all right. Everything looks good with this. I'm gonna be trying not to vocalize anything and say "Mm-hmm" when you're talking, just because it'll interrupt what you're saying, so I'll just be nodding instead.

[0:00:45.9]

LH: [laughs] Okay.

[0:00:45.4]

MK: Just as a heads-up. [laughs] All right we can get started. This is Maddy Kameny. It is June 26, 2018. I'm at CommWell Health in Dunn, North Carolina, and I'm here with—

[0:01:01.1]

LH: Lori Hinga.

[0:01:02.4]

MK: Great. So we can get started.

[0:01:05.6]

LH: Okay.

[0:01:06.2]

MK: So I'm interested in hearing about how you got into nursing.

[0:01:12.1]

LH: Well, I always wanted to be a nurse. That was my dream from a little girl. As a matter of fact, in the high school superlatives, they said that I would be a future nurse, and I was. But I started out in an RN program and it was at Butterworth School of Nursing, which was a hospital program, and it used to be like a three-year diploma program.

[0:01:43.2]

MK: You say Butter—

[0:01:43.8]

LH: Butterworth Hospital School of Nursing in Grand Rapids, Michigan. I started there, but I couldn't be away from home. [laughs] And so I went back up to Northern Michigan University and just did a two-year program there. So.

But nursing, as a young girl, I always helped take care of my grandmother, who was sick from an early age, and so I think that kind of prompted that career choice.

[0:02:20.4]

MK: Can you talk more about what that experience was like?

[0:02:22.1]

LH: Taking care of my grandmother? [pauses] Well, sure. My mom was an only child, and so the responsibility to take care of her parents was all on her, but we had a great relationship. We were their only grandchildren, obviously. My grandfather was a wonderful caretaker of my grandmother, who had diabetes and heart disease, and very early on had a stroke. And so my grandfather—of course, she was young and he still worked, and so while he worked, my mom, you know, was a caretaker of my grandmother.

But after she had a stroke, they had a family cabin on a lake in Upper Michigan [laughs] and they always had us kids spend the summer with them, and so I was very young, probably eight, nine, ten, I would spend the summer with my Grandmom and just keep an eye on her. And, actually, after her stroke, she, you know, couldn't speak, and then she started to speak, but would slur her words or they weren't comprehend-able [sic]. And that summer, I remember saying to her, "No, Grandma, it's cereal," as if I was teaching her how to talk again, and so I remember that. And then would just spend as much time with her, and she did gain her speech back. So that's how that all came about, our summers at the camp. [laughs]

[0:04:25.6]

MK: So was that far away from where your parents were?

[0:04:27.7]

LH: No. Actually, it was only about seven miles. I grew up in a very small little town in the Upper Peninsula of Michigan, and there are a lot of small inland lakes there, wonderful for summertime. You can't really access them in the winter. We would just go and stay with them.

[0:04:57.8]

MK: Can you talk more about what it was like growing up?

[0:05:00.7]

LH: Growing up? [laughs]

[0:05:01.8]

MK: Or talk more about your parents?

[0:05:02.8]

LH: Yeah, sure. Growing up in a small town, the advantage that we had, though, was that there was an Air Force base five miles away, and so going to school and so on, we had kind of a large school for a small town because of the Air Force base. All the kids were bussed there. But growing up, it was small-town America, and very much different than today. I had a close-knit group of friends who were just the kids in the neighborhood, and we hung out and we were always expected home for dinner at a certain time, and if we weren't home, there wasn't cell phones, you know. Mom would holler out the door, "It's time to come home for dinner!" whatever. [laughs] But we were very tight, the kids in the neighborhood.

Most of my summers I would spend out at our cottage with my grandma and grandpa, but also we had a river that circled our town, and there were swimming holes, and so in the summer we would do that. We all walked to school. Sometimes it was pretty far. But I'm really grateful for growing up in a small town. I still have, you know, childhood friends there. Went to school from kindergarten through twelfth grade with the same group of friends.

[0:07:06.7]

MK: What did you and your neighborhood friends do for fun?

[0:07:08.2]

LH: Oh [laughs], well, it seemed we were always on our—you know, in the summers when we could spend a bunch of time together, otherwise it was school and school activities—but we were always on our bikes. There was a park in town where we would go and play. Boy, I don't know. We did everything from Kool-Aid stands to, I

don't know. [laughs] I remember mostly one of the highlights was in the eveningtime we would play Hide and Go Seek and Kick the Can.

[0:07:50.2]

MK: What's Kick the Can?

[0:07:50.2]

LH: [laughs] It's like Hide and Go Seek, except the safe zone is to come in and kick the can, and then they have to be "it" again, you know. It was just some crazy game we played.

[0:08:10.4]

MK: Do you have any siblings?

[0:08:10.4]

LH: I do. I'm the youngest of four, so I was the baby. [laughs] And then I had a brother four years older than I, and we were actually born on the same day four years apart, which was kind of cool. He never cared for me much because my mom had to go to the hospital during his fourth birthday party, and he never forgot that. And then I had a brother who was eighteen months older than my first brother, and then my sister was the oldest, and she was eight years older than me, so she was kind of bossy. She was kind of the leader of the pack. But, yeah, there were all four of us.

[0:09:02.8]

MK: What did your parents do?

[0:09:04.8]

LH: Well, my father was a barber by trade, but in the seventies when long hair came in and haircuts went out, life got really kind of tough for us financially, and so he

pursued another job working for the school system, driving the school bus. So he kept his barbershop and it was unusual at the time, but he would set appointments for haircuts because everybody in town went to him for haircuts, so he would drive school bus and then in between, when the kids were in school, he would work at the barbershop. My dad was an excellent provider and he worked twelve-, sixteen-hour days most days.

My mom stayed at home when we were young, and then she went to work as a bookkeeper for an oil company, and, you know, just to help make ends meet. But I mostly remember my mom being home. I mean, she worked when I was in junior high and high school, but for the most part, I remember her being home.

[0:10:32.0]

MK: So you talked about the one set of grandparents that lived seven miles away. What about the other set of grandparents?

[0:10:40.9]

LH: Yes, that was my father's mother. She was [laughs]—she was a very crabby old lady. [laughs] That's how I remember her. She'd had a really hard life. She'd only gone to school to the third grade, and she had to leave school to work in a boarding house, cleaning rooms and packing lunches for the miners, because where I'm from, there's—well, there's still iron ore, open-pit iron ore mines, but there were also underground coal mines. And so her parents owned a boarding house, and so she had to quit school to work. And then she had three husbands, and they all passed away. So she was just kind of a bitter old lady. [laughs]

We would—I remember going to visit her, and she was an awesome cook, but she was a perfectionist, so kids in her house wasn't really [laughs] what she preferred. That's

what I remember about her. So we didn't have a very close relationship with her, but she did live to be ninety-seven years old.

And my dad was the youngest also of—let's see. One, two, three, four, five, six children. He had three brothers and they all died, alcohol-related deaths. One was killed in a car accident, one died of DTs in jail. So it was just a really hard life, living through all of that, and he had two sisters who lived in the same small town, but they were a whole lot older than him, so there wasn't that real family connection there. So, I mean, we had cousins and they would come in from out of town and we would go to visit, but it wasn't a real connection or anything.

[0:13:18.2]

MK: Do you think that witnessing that with his brothers gave your dad—like, changed his perception of health? Or how was his perception of that, kind of witnessed all that?

[0:13:32.0]

LH: Yeah. That's an interesting question. [laughs] He was very young when a lot of that happened, but I do think what it did with my dad, my dad did not drink alcohol, but I think it caused a little bit of maybe skepticism of the community and law enforcement, you know, because it was hard for him to understand how that happened, especially his brother who was actually jailed and, you know, and died. So as far as health goes, I think he kind of took it to an extreme. He didn't drink at all, which may have been a very good thing, although he had, I always said, dry alcohol tendencies. He still had some of the same personality traits of his brothers, looking back now, being the age I am now, looking back on that.

[0:14:55.1]

MK: Do you have a sense of how your parents were raised in terms of healthcare and perceptions of health from their childhood?

[0:15:03.5]

LH: Yeah. I think my mom probably had better experiences as far as healthcare goes. I'm not sure about how insurance necessarily worked back then, but I know that my grandfather always had access to healthcare because of the work that he did, and he made adequate income at that time, an adequate income to pay for healthcare. So on the other hand, I think my dad didn't really experience healthcare. You did what you had to do to kind of get by. I think that was two totally different ends of the spectrum for my parents, maybe, but my dad did see healthcare as important.

Even to this day, he'll say, "Oh, I'm so glad—." Because he ended up retiring from the school system, and when he retired, he got to leave with a retirement package where he had healthcare for the rest of his life, he had insurance, and even supplemented his Medicare now. And he'll say, "Oh, I'm so thankful for that job. I don't know what I'd do if I didn't have coverage. What do people do who don't have any healthcare?" So at some point, it became very important. I think that was one of the things—also, he was self-employed without insurance, and he had children and a wife, and like I said, he was a good provider, and so I think part of the reason that he chose to go to the school and drive school bus is for those benefits, so that he would have access.

[0:17:49.7]

MK: So you think he has a different view of healthcare now than he did when you were growing up?

[0:17:53.6]

LH: I know as a child and growing up, he didn't have access, but I think it became important to him. I don't know what that turning point was for him, because I remember even when he took that job at the school. It was because there were benefits. He wanted to be sure that he could—that us kids would have access to healthcare, so at some point it became very important, but even to this day, he sees that as, you know, important.

[0:18:43.3]

MK: And what about for your mom?

[0:18:45.8]

LH: Well, my mom passed away very young at sixty-three of ovarian cancer, and that was typically a short-lived situation, because when they found it, it had already metastasized. But she—I mean, they were so grateful that my dad could provide or had worked to provide the care she needed, and she received the best of care, as much as you can do for that.

[0:19:33.4]

MK: Yeah. What was that experience of—when she was going through that?

[0:19:36.6]

LH: Well, it was really quite devastating, because my dad retired quite young. I think my dad was fifty-five or so when he retired. They were going to—the cottage that I speak of was a small cottage. It had one bedroom and it was an old log cabin, is what it was. And the plan was when Dad retired, they were going to sell our family home, which was a very large old Victorian home, and they were going to sell that and they were going

to invest that money into the cottage and make the cottage a home, and they would stay at the lake in the summertime and then go to Florida in the wintertime. That was the plan.

Well, my mom's diagnosis came as they were starting to plan the sale of their home, so it threw their plans kind of sideways, you know. And so I think just that change was hard for everybody, because we were excited for them. You know, my dad had retired and they were gonna go and enjoy Florida and do their own thing and live at the lake in the summer, and that wasn't to be. But they ended up—they did sell their home, they did reconstruct the cottage at the lake and made it like a small two-bedroom home with modern amenities, you know. [laughs] But my mom was sick through all that. And they did go to Florida for two—I think it was two winters. And she, of course, received care there, which was nice because she could receive care wherever she was. But it wasn't what was planned.

And so I think she still got to do what she wanted, but the hard part was that she was so young. And I was quite young at that time, and I had not only a mother-daughter relationship with my mom, but we were best friends. I talked to her every day. I really leaned on her, and kind of the roles reversed when she got sick. But some diagnoses or some diseases, there's just, you know, it is what it is. So she ended up with, like, three years.

But the one thing I remember about that whole situation is I became her caregiver, and as things work out the way they're supposed to, I was working for a home health agency at that time, and it was for the county, had a home health, and they pulled home health out of the County Health Department. It was connected with the Health Department, and they privatized home health. And when that happened, I got laid off, the

only time in my whole entire career as a nurse being laid off. [laughs] Was unheard of, but that's what happened. I got laid off in April, and my mom became increasingly sick, so what that did was it allowed me to take care of her. So I was her daily caregiver. My dad had retired, but he was working for my brother, who owned a business, and my dad was not a very good caregiver, so he went to work and I took care of my mom, and my youngest daughter was five then, so she was old enough to go with me. I would take care of her, you know, which is really hard when you're a nurse and it's your parent. That was in April I got laid off, and my mom died July 6th of that year.

And, of course, hospice came in. At one point, I just told the hospice nurse, "You know what? I can't do it anymore. I can't be her nurse." I didn't want to give her her morphine because I was afraid it'd be the last dose, and I would think that I killed my mom or something, you know. [laughs] It's like I had to separate. I wanted to be her daughter. Now I didn't want to be her nurse anymore, and so it was tough. It was tough. I was thirty-four, thirty-five at the time, and I had three children, and it was tough, but I did get laid off and I did collect unemployment for that short period of time, which was really a gift, you know.

[0:25:31.8]

MK: How did you get through that time?

[0:25:33.0]

LH: I don't know. I look back. I think even though the cottage had changed, it was now a home, not a camp, so to speak, but my childhood memories were so fond of being there with my grandmother and grandfather, and I don't know what I would've done without them, and that's where they were staying then when I was my mom's

caregiver. So I think that helped me a lot, but it was hard. I mean, I had a family of my own, a husband and three children, and it was really hard to balance that. I have a real heart for folks that have to try to take care of parents, or have parents living with them and still raising small kids. I mean, my two other children were nine and ten years older than Emily, so they were fourteen and fifteen. They could pretty much be on their own. But it was tough, and it was tough because my dad wasn't a caregiver, and so I felt that burden. You know, it was just the balance. But I think that it was really good that I didn't have to maintain that full-time position of working. I don't know. I just look at that as a gift. [laughs] Because I don't know how I would have done it.

[0:27:15.0]

MK: Do you think that taking care of your grandma and then your mom kind of impacted the way that you go about your job?

[0:27:23.0]

LH: Absolutely. Oh, yeah, absolutely. One of my [laughs]—one of my frustrations is that sometimes I think we forget about the patient, and I think that my career as a nurse and being a caregiver for my family members, I think that that is always at my forefront. Don't forget about—we talk about lots of things that are excellent in healthcare, population health management, which we have to navigate that way, but the point is that don't lose sight of each individual person who falls into one of those health categories. So I think sometimes I may frustrate people because I always want to bring it around to the patient, but I'm a caregiver. That was my goal, was to be a nurse. I didn't know that I would take care of grandparents and parents and a brother, too, his whole life, but it impacted me in a profound way, yes.

[0:28:48.5]

MK: Where were you taking care of your brother?

[0:28:49.8]

LH: My brother [laughs], he was six years older than me. He was an alcoholic and addict and as bright as could be—intelligent, just misdirected issues—but anyway, I was his go-to, and we were very close. At twenty-seven, he got endocarditis, which is an infection in your heart valve, and that was from dirty needles, shooting heroin. And so he was very sick for a very long time and was in the hospital for *months*, because they couldn't identify his infection.

Well, anyway, after that, he ended up having five open-heart surgeries because the infection was so bad by the time they got it, that they had to remove the valve completely, which had never been done before, and it was done at the University of Michigan. So I guess, talking to you, it's like I took care of him, too, and everywhere that—I moved around a bit, and everywhere I went, he appeared. So I probably enabled him at times, but I understood, I tried to understand addiction, didn't condone it by any stretch of the imagination, but so—and with all of those surgeries and his health issues and medication, I pretty much took care of him.

He died at fifty-three, which actually was a longer life than we thought he might have at twenty-seven, you know. But he was homeless in San Diego. He had a lifelong dream, and I think he knew that life was getting short for him. He was living with me and my family, and he wanted—his dream was to hitchhike from the Upper Peninsula of Michigan to California. That was in—probably around 2006-'07 time, which, you know, hitchhiking was not any longer something people did. It just wasn't safe. And so I helped

him prepare for that trip. He was sober at the time when he left, and one of the hardest things I ever did was drop him off on the side of the road, and that's how he wanted it. He wanted to go. And that was his dream.

Anyway, he made it to Wisconsin [laughs] and he got drunk, and apparently lost the cell phone that he had, and we lost contact. It was an interesting while, but he did eventually make it. He stayed at Yellowstone for a long time, and then finally made his way out to California. He did receive disability, and so he had a little bit of an income, and so he did have access to money, but when he got to California, I think his addiction was just too strong, and so he ended up living on the streets and probably buying drugs with his money. I don't know for sure, but I'm pretty sure that's how it went.

And then that's a very interesting story. I was working for the Medical Care Access Coalition, which was an organization where we provided healthcare to the uninsured through volunteerism. All our nurses, doctors, receptionists, everybody volunteered their time in our clinic, which was a fabulous experience for me. I spent eight years there.

[0:33:41.3]

MK: All in Michigan?

[0:33:41.8]

LH: Uh-huh, northern Michigan, yeah. But anyway, I got a call when I was working there, and it was the social worker at a hospital in California. She said, "Do you know," my brother.

And I said, "Yes, that's my brother."

Well, the social worker—he came in, he was indigent. They obviously—they knew this, and I say he chose to be homeless, because our homes were all open to him and he knew that, but his addiction was just so far gone at that point. But anyway, what had happened was he came in—he must have not been conscious, and he came in—but he had a backpack. They grabbed his backpack and she said she'd gone through his backpack three times and was looking for some contact information, you know, didn't know his name, didn't know who he was, didn't know his family. She said the third time she went through the backpack, there appeared this piece of paper with my name on it, no phone number, address, nothing, so she Googled my name and she found me at MCAC, and called me and said that he was intubated and they couldn't get him extubated, and that they needed family to come there, make decisions for him.

So my brother and I flew out there, and they did finally get him to come around and everything. We begged him to come back with us, back to Michigan, and he said no. So we set him up in a—I don't want to call it a hotel, but it was a room downtown San Diego, where he had a bed and a commode and a sink and everything in a little tiny room, and we got him bedding, everything he needed, because he didn't have a thing. All he had when he went to the hospital was that backpack. And we got him all set up in there, and we paid several months of rent, so to speak, for him, because he wouldn't come back with us. And that's where he died.

I thought when he died, you know, that his heart had given out or something, you know, because he was sick for so long and he was really sick when we got there, and he was really skinny, and it was quite sad. But, nevertheless, he had died in his room there and nobody knew. I could call him there through a switchboard, and I'd been calling. For

two days I couldn't reach him, and I thought, "Ah, darn it, he's out doing his thing again," you know. But they found him, and he'd been dead. Well, then the autopsy came back and it was amphetamine toxicity. So, accidental overdose. And so that was really sad and that was really hard for me because even though he was there and I was here, we were connected at the heart. Yeah, fifty-three, he died.

So it was tough, but he also had the best of healthcare. He really did. I mean, he had Medicaid through the state of Michigan, obviously, because he had disability. And he had, you know, he had great care too, so—

[0:37:50.3]

MK: Did you have—what were your experiences like with the healthcare providers when you went out to California, when he had been taken in?

[0:37:59.1]

LH: Well, you know, it's really—I think it was probably really difficult for them to care for him, because in the state he was in when he came in, they didn't know his history. I mean, you could look at his chest and see that, you know, by the scars, that he had had several, several surgeries or whatever, but, you know, without a history, and they—I mean, they provided the care for him, but at some point, you know, you can't keep 'em in intensive care because they couldn't get him out of that, you know, that coma state, so to speak, which was medication-induced. But then they couldn't get him out, and there is a certain medication which I knew and was well aware of that they needed to use to wake him up, because, otherwise, when he would come out, he would be so combative, ten people couldn't hold him down, you know, so they put him back to sleep, so to speak. But I think that he—for the state he was in and for the information they had, I mean, they

kept him alive and made sure he had all his medications. When we were still there, when he was discharged from the hospital and send him home with follow-up appointments and so on. So I think they did a great job, actually.

[0:39:47.8]

MK: Do you have any other negative or positives experiences with healthcare providers that you can remember?

[0:39:54.5]

LH: Um, hmm. [pauses] No. I think it's really hard not to be critical sometimes of your profession, maybe. It's sort of like if you're a waiter, you know, you might be more critical in a restaurant situation. [laughs] Sort of that way with healthcare, too, but, honestly, I think the three loved ones in my life, and being the caretaker for them, I feel like they got excellent care. Now, saying that, they were all insured, which I wholeheartedly believe makes a difference. My experience has been that it makes a huge difference in the care that you receive, not maybe through individual providers. I don't know that it's a provider thing. I don't know what providers pay all that much attention to whether you're insured or not. They're gonna take care of you because they're caretakers, too, but when it comes to hospitalizations and medications and that kind of thing.

I learned so much about the struggles of the uninsured when I worked with the uninsured population and, you know, the folks we worked with had to be denied by Medicaid. They were all really working at least a part-time job, trying to make ends meet, but certainly couldn't, didn't have access to a group health plan or couldn't afford an individual premium, and so we really fought. I mean, our patients could get the ten most commonly ordered labs. The hospital would donate those. And they could get basic x-

rays and ultrasound through our program. I mean, I think we secured probably \$3 million in patient assistance program pharmaceuticals, so our patients could get their medications, but without that program and before the Accountable [*sic*] Care Act, there was no access. There was no care for them at all.

So I think I've seen really both ends of the spectrum, but I'm—you know, my expertise really is process and performance improvement, and so I think there's always room for improvement. No matter what it is, there's room for improvement. And in 2018, there's a need for improvement in certain areas in order to stay alive financially, you know. But in saying that, I do think I guess I've seen the best and the worst, as far as access to care. Now, the care itself, yeah, there's always room for improvement.

[0:44:02.2]

MK: What made you come down from Michigan? Did you come directly here from—

[0:44:07.7]

LH: Well, yeah—

[0:44:06.6]

MK: Directly work at CommWell?

[0:44:10.0]

LH: No. [laughs] Well, yes and no. I moved here in 2014. My son is in the military, and he was stationed at Fort Bragg. I was—still am—consulting, and so I was working from home completely, and so I could live anywhere I wanted, and I wanted to be by my grandchildren. They have three children. So I thought, “Yeah, I'm gonna go. I have the opportunity.”

So I moved down to Hope Mills to be by my grandchildren, but then a year after I got here, my son got transferred, and I decided to stay. I had several contracts when I was consulting, but one of the issues for me was that being self-employed, my healthcare premium was astronomical, partially—well, I mean, it tripled in three years. It was horrible, and I just thought, “You know what? I can’t really do that. I can’t do that. I’m gonna have to go back to work.” So that’s when I started exploring the option of being employed for access to healthcare, so that’s why. But I did move over this way, which is, you know—because I work here, and that was, you know, that was quite a drive.

[0:46:11.4]

MK: Where do you live now? Is it a commute?

[0:46:12.9]

LH: No, I live just outside of Dunn. It’s only twelve minutes for me to come to work, but I was driving an hour.

[0:46:24.1]

MK: How has that been, that transition to such a different place? You said, before we started, said you’d been here four years, right?

[0:46:30.9]

LH: Four years, but three in Hope Mills, and now here. This was hard for me. I’m from rural America, and, I mean, there is absolutely—my heart is in rural America, but it’s very isolating here. It’s very isolating. You know, things that you don’t think about, like I used to be able to run an errand on my lunch hour, but you can’t here. It’s just too far. And living in the country is really lonely for me, because I’m alone, and it’s hard. It’s

hard, you know. There's a lot of really great things about CommWell Health, and I did a lot of research before I jumped ship, so to speak, but—

[0:47:24.6]

MK: Can you describe a typical day at your job?

[0:47:27.1]

LH: At my job?

[0:47:27.9]

MK: Mm-hmm.

[0:47:29.1]

LH: Well, I'm a project manager, so I'm like a moving target. [laughs] So a typical day at my job is multitasking, trying to—I take a large project, of course, and then try to get the disciplines who are responsible to make certain things happen, to make them happen. And so I do a lot of that. But also, some of my skills are performance improvement, and so I've been working a lot with collecting data, evaluating or analyzing that, and trying to come up with a plan for improvement where it's needed, and kind of helping to direct a little bit of quality improvement here. But I attend meetings. In a typical day, I'm usually at my computer returning emails, talking on the phone, attending meetings, sending reminders. It's a little bit of everything.

[0:48:51.2]

MK: Yeah. What do you do to unwind and just kind of care for yourself after the stress of ()?

[0:48:59.0]

LH: That's just it, you know. That's just it, and that's a hard balance to reach. I think the older I get, the more I realize it. So I go home, I like to be busy. I have to always be busy, but I like to do crafts. I love to sew. I do those kind of things. I love to work in the yard. To me, there's nothing more relaxing—or garden. Where I live, I don't have a garden, but I do container garden. So I go home and visit my plants [laughs], talk to my vegetables.

[0:49:48.0]

MK: Plants are great. [laughs]

[0:49:49.0]

LH: They are. Honestly, I think gardening is one of the most relaxing activities on Earth. Now, I also go to the gym, but I've been limited because I've had a couple injuries. I think I get older and I think I can still do what I did when I was thirty-five, and not so much. But I also go to the gym, and I like to shop once in a while, but I don't like to shop like I used to.

[0:50:23.3]

MK: Can you talk a little bit about your experience parenting?

[0:50:27.6]

LH: Parenting?

[0:50:28.8]

MK: Yeah.

[0:50:28.9]

LH: Yes. No, I honestly—the difficulty in parenting, for me, was that—let me just say I was a single parent most of my children's life, just the situation. So the difficulty for

me was the balance of working and having a career, which was not optional. I mean, you had to support your children. So I think that was difficult. And, honestly, I'm sure I'm very biased about my children, but being a single parent, I'm really blessed to know my kids never really gave me a run for the money, and they sure could've because there was times when they had to be alone. I mean, there's only one of me.

The biggest joys in parenting, though, I think, was I never missed a school program, a school conference, football game. I never did. And a lot of that was while I was working at MCAC, and there, family was really encouraged and important, so we were allowed to leave for our kids' activities and so on and so forth, and I'm so grateful for that. My kids, I encouraged them to stay really busy in school, because I believed, since they were little, busy hands were happy hands and they didn't have time to get into stuff—but I wasn't always there. But I loved being a parent.

I have a super relationship with my kids to this day. Two of my girls are still up in Michigan. My son is in Virginia. He has had an exceptional military career. I love my son-in-laws. [laughs] I love my daughter-in-law. I mean, it's just—I really feel blessed. I have two grandchildren now up in Michigan, though, that I didn't have when I moved to North Carolina, and that's a little—that's a little hard, because they're little and I want to be there. But with FaceTime and technology, you know, we connect.

But being a parent was a joy and it was hard. It was tough sometimes, but, you know, I wasn't really a pushover either. My kids knew that. They make fun of me now, but they're doing the same thing with their kids. I just—I'm a firm believer in accountability, and so that was one of the things.

[0:53:53.4]

MK: Yeah. What do you feel like you kind of took from your parents and applied either the same or differently to your own kids when you were raising them?

[0:54:05.0]

LH: Well, let me throw this out. [laughs]

[0:54:06.5]

MK: Okay.

[0:54:06.8]

LH: I was raised by two perfectionist parents, okay? [laughs] So! And am I kinda Type A? Not as much as I used to be, and, seriously, I'm not as much as I used to be. But in saying that, I think I took the organization and that's really important in raising kids, although it's hard to balance because it was hard to—I mean, if my priorities were that the house had to be clean before we could go and do something fun, that wasn't okay, and looking back, I wouldn't do that again.

But from my parents, I think accountability was really important. I think expectations—raising my kids and managing people, I always felt like if you set the expectation, they'll rise to it. If they don't know what your expectation is, they'll flounder. And I think I learned that from my parents too. I probably put it into practice a little different. But it was kind of tough, because I was the baby, so they had relaxed by the time they were raising me [laughs], and all of a sudden, I had these kids. And I mean, I think I was a decent mother, but I didn't probably have all the tools I should have had to—I was a young mom, well, twenty-one, but, you know, young. But I do believe that no matter what, I'll think, "Man, I just said what my mother said," and I catch my girls doing the same thing now. So I think there's an influence.

[0:56:25.5]

MK: Yeah. It's a cool life. [laughs]

[0:56:26.9]

LH: You say you're not gonna be like them, and then you are. It's the way it is. Some of the stuff is just ingrained in you. And so as much as you don't want it to be that way—I was a much more liberal parent, I'm sure, than my folks. You know, my folks, here's one thing I can tell you. My folks always were worried about what everybody thought, you know. It was like, "Shh! We don't want the neighbors to hear." You know, not even necessarily from a private standpoint, but more of a, "Well, we don't want anybody to think we have any flaws," because, after all, they were perfectionists. My mother sorted her buttons by size and color in baby-food jars, and I'm not lying to you. And my dad's tools were hung up, and if you didn't hang it up in the same spot after you used it, you were in trouble. And, I mean, I had that comin' both ways, right? But anyway, no matter what, you could fight it all you want, but—

[0:57:41.3]

MK: Yeah. What about when your kids got sick? What kinds of things did you do?

[0:57:45.1]

LH: You know [chuckles], when my kids got sick, I was useless because, honestly, when I had to bring the kids for shots, my mom went with me because I couldn't stand to see my children get shots. Now, did I *give* children shots? Yes. Am I a nurse? Yes. But when it was *my* kids, it was different, and it was horrible for me when my kids were sick. It was like when my mom was sick. I couldn't be a nurse then; I had

to be a mom, and it would just break my heart. They would cry and I just would want to cry right along with 'em. It was horrible.

And I realize that my little granddaughter has some medical challenges right now. She's two. And I was recently up north to attend some doctors' appointments with my daughter. This is my youngest daughter's daughter. She just needed some support and really somebody to try to interpret what the specialists are saying, because if you're a layperson, that can be really intimidating and really hard. That is one thing I will say. But anyway, I went. She had to have more blood drawn. No, nuh-uh. I wanted to be there to support my daughter, and I left the lab crying and left here there with Willow. [laughs] So, it's that tender heart and that's—I come off probably more hard or strong, but I'm just a caretaker, and to hear her cry was just too much for me. I couldn't do it.

[1:00:00.0]

MK: Do you remember when you were younger and you were sick or your siblings were sick, what your parents would do?

[1:00:06.2]

LH: Yeah. [laughs] So I do remember—and, here's the thing, is we had a doctor in our little town, and for as long as I could remember, it was the same old, very old doctor, okay? [laughs] You know what I mean? But we didn't go to the doctor when we were sick. We didn't go, really, for certain things. But when we were sick, especially like it was like the flu or a cold or something, my mom would cut up old flannel nightgowns and she would put Vicks VapoRub on our neck and she'd put the flannel around it and she'd pin it with a safety pin. [laughs] And we weren't allowed to be on the couch and watching TV. If you were sick, you were in bed, you know? And we would stay in bed

and she would bring us soup and bring us popsicles or whatever it was that we needed. But I don't remember my mom taking my temperature or things that we do now. The first thing, if you call [a doctor], is "What is their temperature," or "Have you tried Tylenol?" or all those things. But I don't remember that. I mean, it was more like a homeopathic, kind of—my mom gave us fluids, I guess, but didn't really call it that.

[1:01:52.9]

MK: Do you remember any other home remedies that she would use?

[1:01:54.8]

LH: The Vicks was just—that was just always the highlight. Oh, and we would have a vaporizer, a hot-air vaporizer, which was probably just throwing out more bacteria than we care to think about. [laughs] But you'd get the vaporizer, no matter what your ailment was. It was like you'd get the vaporizer.

[1:02:20.1]

MK: Was it like an electronic—

[1:02:21.7]

LH: Yeah, it was electric, but it heated the water and then it vaporized it, not like the cool-air ones now, and it was just something else.

[1:02:34.6]

MK: Hmm.

[1:02:34.8]

LH: I don't know that she gave us any special drinks or anything, but you could never get away with not being sick, because it wasn't really any fun to be home sick. You

know what I mean? It wasn't fun and games like sometimes it is, because she was very [laughs] to the point.

[1:03:02.3]

MK: Get better as soon as possible?

[1:03:03.7]

LH: Yeah, we did, too, we sure did. You didn't fake it. My brothers might've tried because they were just like that, but, nuh-uh, no.

[1:03:17.1]

MK: What is "health" to you, Lori?

[1:03:18.6]

LH: Health to me?

[1:03:19.8]

MK: Yeah.

[1:03:20.1]

LH: Well, health, to me, is being responsible for your own physical health, having access to healthcare, maybe not necessarily top of the line, but to basic healthcare is health, to me. And I think—I guess—I mean, that's kind of loaded, too, because it's like, well, health, to me, is managing your, you know—being responsible for healthy living, but having—yeah, just having access to basic healthcare and required medications, but, you know, if you say, well, what is healthcare to you, I mean, I could list off a lot of things, but I think one of the things, for me personally, is having a relationship with a provider, maintaining that relationship, because I think that that's a two-way street, and then having the relationship and being allowed enough time to comprehend and

understand whatever is being addressed, and having access to that provider if you need them, to me. I'm pretty simple. I mean, I do try to simplify things. I don't want to complicate things, but I just think my life experiences more so in my professional life has taught me a lot, a whole bunch, and I could go on and on about that, but I think there's a lot of different—hmm—stakeholders, maybe, who maybe direct healthcare or misdirect healthcare [laughs], and I think that causes a lot of destruction in the basic, simple “What do we need to do, what do we need to provide, and how do we need to do that for patients with such diverse needs and backgrounds,” you know.

[1:07:19.0]

MK: Is there anything—I mean, I don't want to take too much of your time, but if there's anything—

[1:07:19.0]

LH: Well, I don't care.

[1:07:22.2]

MK: —else that you want to say about what your experience has taught you? I don't know, you said you had a lot, so—

[1:07:32.0]

LH: I mean, I did think about a few things because, reading this, and I love to tell my story. And we all have a story, and for the most part, I think that growing up, I grew up in a pretty healthy environment, and I got bit by a dog. That's when you went to the doctor, when you needed stitches, right? Or something like that. And there's a lot of things that have directed my path, for sure, including being a cancer survivor myself, of thyroid cancer, which most people say, “Well, if you're gonna get cancer, you know, you

should have thyroid cancer.” Really? Have you ever had cancer? I don’t think there’s any good cancer. You know what I mean? So, those kind of perceptions are a little off, and that’s okay. I’m good. I’m golden. So have I experienced healthcare myself? Yes.

But one of the things about health and healthcare is that it has been and continues to be directed in a large part by payment—and, look, we all have to make a living and we all have businesses to run and everything, but we went from fee for service, so the more services we did, the more money we made—and whether they were necessary or not, right? I mean, so [laughs] fee for service. And now we’re gradually working into pay for performance, where, well, “Show me some outcomes on certain disease conditions” and then you deserve more money.

But there’s a lot of things that impact that, too, because we have a shortage of primary care doctors, not just in North Carolina, in Michigan and in every state, probably, almost. So we’re directing healthcare by payment, but I don’t know that we have all of the things in place for any of those payment systems. In other words, if we’re gonna go to pay for performance, I’m all about that, because I’m all about data and I’m all about improvement and I’m all about that, and I’m all about diabetes and so on and so forth. The problem is, it takes a lot of time to provide the care necessary to influence those outcomes. So I feel like we’re always chasing our tail. We’re always chasing our tail. Yeah, pay for performance and value-based payment is all very important. I don’t doubt that. But how are we gonna do that? You can’t see eighteen or twenty-four patients a day and provide the care necessary to influence positive outcomes. You know what I mean? So I always sort of feel like we’re putting the cart before the horse. They’re all great ideas

and they all have to happen, and I get all that, but are you gonna give us, like, a million primary care doctors to provide this type of care? You know what I mean?

So there's some gradual changes being made in healthcare just in my time. We used to pay bonuses to providers for productivity. If you see twenty-four patients, you get this bonus, but if you only see twelve, you get nothing, right? Well, that's not—that's not really great, because didn't matter what kind of care you gave [laughs] as long as you saw those patients. Sort of like fee for service. You know what I'm saying. So that didn't work. So now we're gonna pay providers, and we're headed in this direction at CommWell, and I was—in 2010, up north, we paid our providers by quality of care, one of them being patient satisfaction and customer experience, you know. That's important. There's no question about that. I'm all about that. And so to get them thinking in that value-based payment thing, we paid them a bonus on quality. That's a good move, but in order to do that, they have to have time with the patient or you have to have other systems in place, and you gotta have a whole healthcare team that's pitching in to see that that happens with the patients, you know.

So, one of my soap boxes is, I'm all about value-based payment. I'm a quality person. I'm a process and systems thinker. [laughs] I know that. And I can put all the systems and processes in place and be the most efficient primary care clinic, but there still isn't enough time to see the percentage of patients that each provider needs to see in order to get everybody healthcare. So I think it's an uphill climb. I don't know what the answer is, necessarily, to this.

And the Accountable [sic] Care Act is great. Trust me. I mean, I worked with the uninsured for eight years, and our whole goal was to have healthcare for everybody, and

that's what we have. The part we forgot in that was *affordable* healthcare for everybody. I mean, I make decent money consulting, don't get me wrong, but I still couldn't afford the price of the premium. You see what I mean? So even though there's subsidies, people, they either have to eat or they gotta pay a healthcare premium, and they're gonna eat. You know what I mean? So we haven't solved that problem yet. So we still have a lot of people that are uninsured. And do they have access? Not so much. Here they do, at CommWell Health, because that's what a community health center does, but if they're uninsured and you try to get 'em to a specialist, see? So there's still some things that aren't—I think we're changing things and change is good and I'll all about change. I'm a project manager. I'm not here to make friends, that's for sure. [laughs]

But the point is, is we have to have—we have to think these things through before we try to implement 'em. We've got so many requirements. You got Patient Center Medical Home and you got Meaningful Use and you got Joint Commission. [laughs] And you got CMS, and you got HRSA. And in order to meet those requirements, you have to train and educate people, including providers. Providers go to medical school and they get a wonderful education as far as that goes, but all these other things, when they come out of medical school, they still have to learn that, and we can't expect them to see twenty-four patients and provide value services [laughs] if they don't even have the basic concept of what it is. So those are just some of my issues in healthcare.

And here, the other thing I just wanted to just share is, here at CommWell Health, in a big way, but I think everywhere, you heard the term “social determinants of health,” right? And being in public health—by the way, I worked with the Louisiana Public Health Institute for three years. Man, I'll tell you what. That was an experience. I was just

on their website today checking it out, see if they have anything new going on. But off the record, I'll tell you about that.

But the social determinants of health—so there are pockets where there are higher incidents of that, but we don't take any of that into consideration, and when you consider those social determinants, they influence disease and condition and literacy [laughs], addition. I mean, there's so many things. Housing. Just housing. So you have all those things and none of that's taken into consideration for payment. You know what I mean? And so these are the things that I see, and I wish I had the answer. I don't. And we have to depend on the lawmakers. I just hope that they bring the right people to the table, who can influence or who can share experience and say, "Whoa! Wait up! Back up that pony. What about this?" You know? And maybe if we did that, nothing would ever happen. I don't know. But I feel really bad, because I think that as caregivers—whether it's a provider, a nurse, anybody who works in healthcare, period, and it doesn't even matter necessarily what influenced us and our generation—but where do we get the time? How do we—you know, how do we make it happen?

Well, I impact that because I help them put efficient systems into place, as efficient as you can be. But no matter if you have the most efficient systems, you still have these other influencers that are hard to overcome, and I think when you talk about payment, you have to take some of that into consideration. That's just—it's just necessary. So, I mean, I could go on and on, because I got lots. [Kameny laughs.] I've been a nurse for thirty-four years, you know.

[1:19:46.4]

MK: Talk as much as you want. I mean—

[1:19:51.3]

LH: So I think—I saw something, and, you know, I had written down here, “more outreach.” I really think that where we’re at is something, we gotta meet our patients where they’re at, and I don’t think population health management is a bad thing at all. I think it’s a wonderful thing, and it’s not cookie-cutter. It’s just a wonderful way to manage health. But in saying that, there’s additional steps, and that is, you gotta educate people. And do you have time in a ten-minute visit to provide the education that you need? And outreach, what I mean is if we go to our folks, especially in rural USA and where you have high numbers of social determinants of health, and we go meet them where they’re at, and provide education at their literacy [laughs] and that we remember, we remember all that, regardless of payment. I know we have to survive and I get that, and we have to get paid for what we do, but—so for the most part, I’ve been involved in public health and community health centers, MCAC. I mean, that’s where my heart lies, right? But—and it doesn’t change the fact that you still have to get paid for your services, but I feel bad because I do think that all caregivers really want to provide the best that they can, but the limitations, because of the requirements [laughs], you know, and you just can’t provide what’s needed, and I don’t know. I’m not suggesting that they go away from value-based payment or pay for performance or anything. I mean, we have to—we need to do that, but then we have to have the time and resources to do it.

[1:22:24.5]

MK: How was it when you were a patient? I mean, you can talk about cancer and talk about something else if you don’t want to, but knowing so much about this system

already, like, all of that knowledge that you have, but then going through it on the other side as a patient?

[1:22:42.4]

LH: Well, it's frustrating as a patient because even as a patient and putting all that knowledge and everything else aside, I will say this, that I've had wonderful care, wonderful doctors, and all of that, but I never felt like I had the time to ask the questions or to get the answers. I always feel—and even with my primary care provider, I love him to pieces, I drive to Hope Mills to see him because he was my provider there and I don't want to switch, because I think that much of him, but everybody has their hand on the door. They gotta go. They got how many more patients to see today? And I don't think that that's even a judgmental. I just think that that's how I feel, that I never, ever get enough time, no matter where it's at. You know what I mean?

For instance, so I've had thyroid cancer, right? So you have to have an annual ultrasound of your head and neck. That's just standard. So my doc—Travis ordered—he obviously wasn't thinking, right, and so he orders a thyroid ultrasound. Well, I don't have a thyroid, right? But as a healthcare provider, you gotta think outside of that box. So I go for my ultrasound, and the ultrasound tech's like, "So we're doing a thyroid ultrasound today."

And I said, "Not so much." Right?

And she said, "What do you mean?"

And I said, "Well, I don't have a thyroid."

"Well, why are we doing a thyroid ultrasound?"

And I said, “We’re not doing a thyroid ultrasound. We’re doing my annual head and neck ultrasound.”

“Well, that’s not what he ordered. Are you having any issues?”

And I said, “Well, actually, I am. I have this one node that they’ve been watching for three years, but it’s important to get it measured, and I been feeling something under here that Travis was concerned about.”

And she goes, “Well, where are they at?”

And I said, “Well, right here and right here.”

She ultrasound [*sic*] those. She didn’t do a thyroid ultrasound, she didn’t do a head and neck ultrasound. Doesn’t do any good for you to do that, what’s already there. [aside] What’s there and not [aside] and not do what’s necessary and not be able to problem-solve that. You know what I mean?

So, first of all, it was really a waste of my time. You know what I mean? And that was frustrating, because I knew what he wanted, she knew what he wanted. All she had to do was call to say, “You know, you ordered a thyroid, but the patient’s here and—,” but wouldn’t do that. So, again, I didn’t get what I needed that time. See what I mean? [laughs] So it’s like—

[1:26:15.8]

MK: Simplification thing you were talking about.

[1:26:18.4]

LH: It’s not hard, but you know what I mean? And that was not efficient. And it started, you know, with my provider. And did he write “thyroid ultrasound” because he was in a hurry? But what that did was caused a hiccup for everybody. And so we didn’t

get back what he needed. I didn't get my annual—. [laughs] You know what I'm saying? And I'm just using that for an example. I don't think I'm being over-critical of that.

But the problem is, is I'm a nurse and I've taken RB for my healthcare and I tell him when it's time for my annual neck and—you know. [laughs] 'Cause that's my RB, I feel. But wonder if I'm a layperson? Wonder if I'm somebody who doesn't understand that and I show up and they say they're gonna do a thyroid ultrasound and I say, "Yeah," and they look at it and there's no thyroid there? You know what I mean? So I don't know why that is. I don't know if that's because everybody's in a big hurry, and I feel that. I feel that. When I see my provider, who I love, is he still in a hurry? Slow down. But you can't slow down—

[1:27:45.7]

MK: Right.

[1:27:45.7]

LH: —because you gotta see these patients. You got—and he's independent, so he probably doesn't have a quota of patients to see. But we're short on primary care providers, and so there's a lot of patients, and now a lot of patients do have insurance, so they feel like they can go to the doctor, and they should. But I don't know that we looked at all that as public health officials. You know what I mean?

[1:28:31.9]

MK: What do you think about, um, bringing—like, there's a lot of talk about bringing more PCPs to the rural areas, and incentivizing people and—like, have you seen any of that first-hand?

[1:28:44.3]

LH: Mm-hmm.

[1:28:44.3]

MK: Have any opinions about it?

[1:28:45.2]

LH: Mm-hmm, 'cause I've worked with a lot of FQHCs and, of course, they have that repayment program for providers, but, I mean—you can turn this off. [laughs] You probably don't need all this. But—

[1:29:04.0]

MK: If you're okay with it being—

[1:29:04.9]

LH: I think that—I think incentives are an excellent way to bring providers especially to rural areas. The question, though, is even if we incentivize, is there still enough—

[1:29:34.6]

MK: Yeah.

[1:29:34.6]

LH: I don't know the answer to that. I don't know what it's gonna take. I mean, we use a lot of mid-levels, and that's okay. I'm a firm believer in that. But I think one of the missing links is that we talk about care teams, but we don't really function in care teams, and I don't mean just CommWell Health. Look. I worked with a whole bunch of FQHCs up and down the Gulf coast when I was with LPHI [Louisiana Public Health Institute], and it's universal, pretty much, that we don't understand what a care team is and how it's supposed to work and how it can benefit us, because we don't have time to

stop. This is the way we've done it. This is where we're comfortable. This is how we're gonna continue to do it because we got to get it done, and we don't take that step back and try to understand it or bring people in who can help you understand it, because I think that's the only answer to the whole thing, is that every discipline is functioning at the top of their skill level, and if you can't function at the top of your skill level, then you need to get retrained. [laughs] You know? Seriously. Because there isn't time. We got people's lives we're talking about here. This isn't—you know what I mean?

And a provider cannot do it alone, whether they think they can or try to do it, it's just—you can't do it. The requirements that are set now for payment, etc., require a care team approach. It's the only way to get it done. And even then, you'll have your hand on the door, because we don't have enough care team members, but it's hard. It's really hard. I think that we have to continue to be innovative and we have to continue to think outside the box on how can we make this happen for our patients. At this point, we have to focus on our population of patients. I could go on and on.

You can go into population health. You better be looking at your provider panels, you know. You gotta be looking at those panels, because if you have one provider with 3,000 patients and one with 1,500, and the one with 3,000, a third of those are diabetic patients, now, they can't take care of that many. I mean, just the math and data tells you they can't care for them. I don't care how great a care team you have. That's impossible. But I'm not sure, especially in primary care, that we understand all that yet. I'm not sure we understand it, and we're takin' care of sicker and sicker patients and more and more patients with less and less providers. So we all have great intentions, we're all caregivers,

we all really care about patients, you know, but I don't know that we're doing the best we can.

[1:33:12.5]

MK: That's the battle.

[1:33:12.6]

LH: Huh?

[1:33:13.1]

MK: That's the battle. I'm really glad that you're here fighting it. [laughs]

[1:33:17.1]

LH: Yeah. It's hard. I mean, people don't like change. They don't like change, but we have to change, because you're not gonna get paid. The bottom line is this: you're not gonna get paid if you continue to provide care the way you always have, because it just doesn't work that way. I don't care if you're Atlas. You can't do it. It's impossible. The numbers tell you that, so you have to get creative and innovative, and got gotta be open to change.

And technology is our friend and technology has come a huge long way. I mean, I think about those paper charts. I mean, now paper makes me nuts. I can't—and some of 'em like Linux, you know. The problem is, is that that came in like a firestorm. This is life according to Lori. But EHRs [Electronic Health Records] came in like a firestorm and we didn't know what we didn't know. We didn't know what we needed. We didn't know. Nobody did. And we didn't bring in people who could help us know what we didn't know. So we all ended up with these fabulous systems, but we don't know how to work 'em, and we didn't build 'em because we didn't know we had to build 'em. I mean,

I could go on and on on that. But the point I'm making is, we've had these EHRs long enough, but what people have done is, when they didn't know what they didn't know, then they made workarounds to all of the technology, and even at my doctor's office—and I told my provider this, and he knows me, he knows what I do for a living, he knows, but he'll come in, he doesn't even have his laptop with him. I said, "Travis, where's your laptop?"

"What do you mean, where's my laptop?"

I said, "Well, don't you have an EHR?" And I know he does.

"Well, yeah, I got an EHR, but I can't haul that thing around with me."

I said, "Travis, what you're doing is really inefficient. I'm just saying."

We're not using that either. We're writing stuff down on paper, right? Then we're gonna go, then we're gonna transfer it in. Number one, the chance of error when you use electronics and paper, I mean, your error rate goes like through the ceiling, right? Not only that, but the time involved in doing that. That's what I mean. We have all these inefficient systems, Maddy, because we didn't know what we didn't know, and we didn't have time now to ask the questions or figure it out. "Maybe we didn't buy the maintenance package so they'll help us figure it out. So we just go back and do what we were doing. We grab a sheet of paper and we write the vital signs on a piece of scrap paper"? Come on. And then we wonder. We're short on providers, right? And we got all these patients to see, and we're gonna have inefficient systems on top of it. You see what I mean? I mean—

[1:36:56.9]

MK: Absolutely.

[1:36:57.3]

LH: So I've had a lot of experience. You don't even know how grateful I am to have had it and to experienced what I've experienced in my career. I think it's a battle we have to continue. I think incentives in rural areas is an exceptional idea, but I was thinking, if there was one thing that would have the biggest impact or the biggest influence on primary care—now, I can only talk to primary care, because I directed quality in a hospital and blah, blah, blah, but that wasn't my forte. My forte is right here. What would that be? What would that one thing be that would be the priority? Because I've talked about lots of things. But I think if all is said and done, what's really lacking is the training and education we need. The people, you can't just put out initiatives with how-to manuals. [laughs] Because people don't have time to sit and read it and figure it out. You know what I mean? And I think if we're gonna change a lot of things, or hold whole primary care accountable to certain initiatives, I think that's a good thing, and I'm all about change, but we gotta make sure that people—well, you can lead a horse to water, but you can't make 'em drink.

So what I'm saying is, you have to make the training and education available for them, because the Electronic Health Record, like, we incentivize that in a big way for meaningful use, I mean, but the problem with it was this. [laughs] Nobody knew what they needed and how to get there. They didn't even know the word "workflow," right? And so what are they doing now? Now what they're doing is they're replacing all their electronic health records because they couldn't figure it out and they didn't know how to build it, so they're spending millions more on a new one, and they're gonna have the same issue. You know what I mean? And that's going on all over. That was happening

down along the Gulf Coast. You know what I mean? Because—or we’re just gonna go back and make workarounds and use paper and walk in the room without the record.

I said to Travis, “Would you have come to see me without the paper chart?”

“No.” [Kameny laughs.]

“Then where’s your laptop?” You see what I mean? They do the same thing here. Drives me bananas. I don’t have any influence over there, but I’m just saying.

So, to me, in a nutshell—and I’ll finish with this—there are very simple things that could be done to help streamline primary care. Simple things. A little robust training before initiatives would be super, and maybe even [laughs] getting more folks to study medicine with a focus on primary care. You know, they all want to be specialists because there’s a lot more money and a lot less call time.

Anyway, I could go on. I’ve got a thirty-four-year career.

[1:41:11.8]

MK: You’re a wealth of knowledge. It’s been great talking to you.

[1:41:14.9]

LH: You know, but I want to tell people, you know, and I loved being at Louisiana Public Health Institute and, honestly, I thought about movin’ down there and workin’ with them. I don’t have an MPH [Master’s of Public Health], obviously, and that’s probably what you’re working for, huh? But they loved me anyway, because I was just a little different. [laughs] But they do such great work. Some of the projects we worked on were incredible. What an incredible opportunity I had. Now, at a point I thought, “Well, I could live in New Orleans, you know. I could just get one of them apartments above and enjoy this nonsense for a while.” But I don’t know if I could do it,

really, truly. I was consulting with them, so I would go down every four to six weeks, you know, and it was fabulous. It was the best of both worlds. But I don't know if I could live in New Orleans, and I know there's other Public Health Institutes, but—

[1:42:28.0]

MK: Yeah, () here.

[1:42:31.7]

LH: That's a great place. I'm just throwin' out a plug for ya. [Kameny laughs.]

Where are you from? Here?

[1:42:37.6]

MK: I'm actually from—well, we can turn this off.

[1:42:39.7]

LH: Yeah, turn it off. I always want to know.

[End of interview]

Edited by Emily Chilton, October 23, 2018