Workshop: UME and GME education in partnership with tribal health systems in the Great Plains

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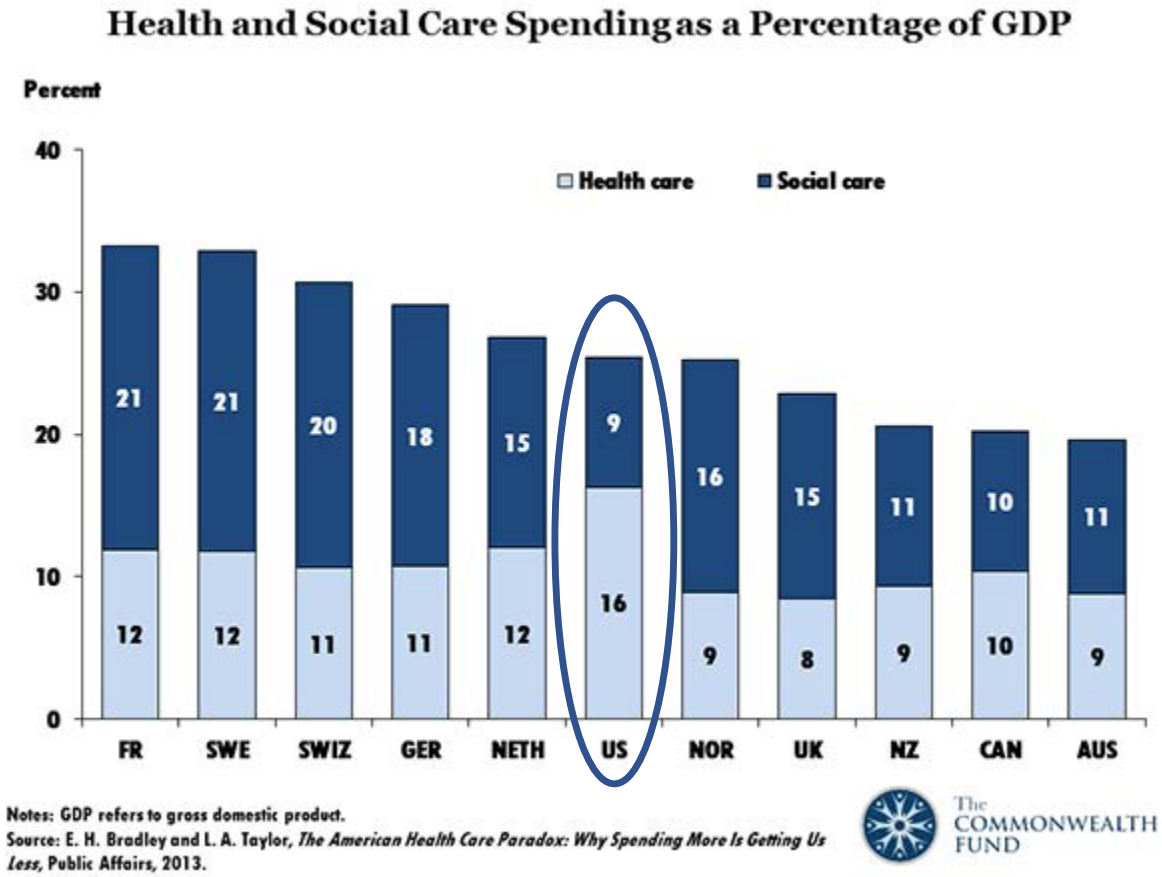
Preface

- Native communities exchanged land and resources for guarantees of health care and other services from the U.S. government during periods of genocide, stress and forced assimilation
- Outside partner organizations, including ours, conduct collaborative work that honors frameworks of tribal sovereignty and our nation's trust responsibility to tribes
- Given baseline resource imbalances, academic partners need to constantly introspect about how well-meaning collaborative activities (grant-writing, publications, program development, promotion) can lead to outsize benefit for an academic partner

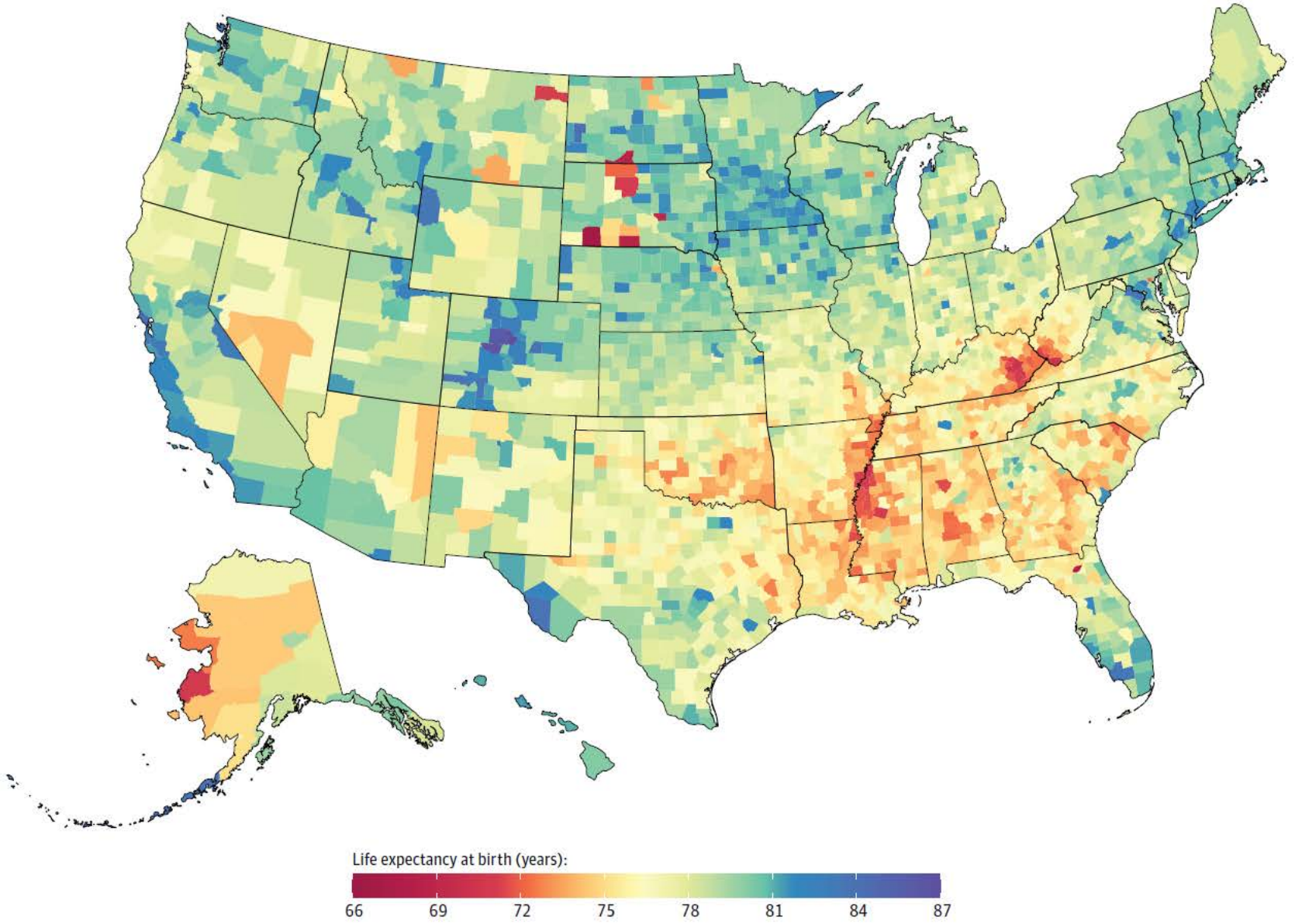
Learning Objectives

1. Briefly describe disparities in health outcomes and resources in rural and American Indian communities;
2. Describe how a tribally-centered partnership between a tribe and a teaching hospital has the potential to support a tribal community in a culturally-aligned way, as well as to support the next generation of health professionals' in developing knowledge of Native issues;
3. Identify lessons learned to date from an academic partnership and discuss ways to develop or strengthen educational collaborations with American Indian rural and tribal communities.

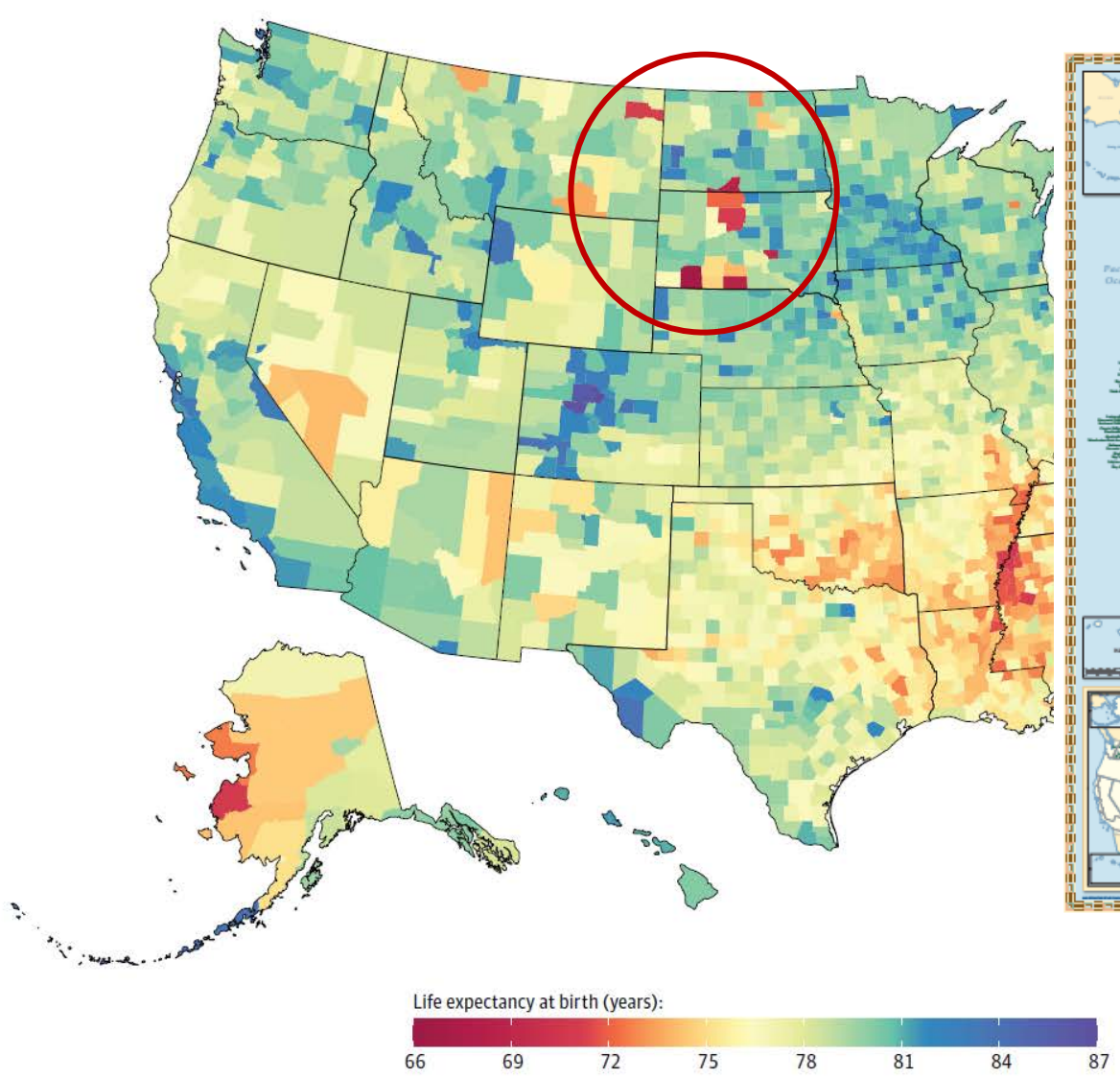
The US under-invests in health compared to other industrialized nations, especially when it comes to 'social care'

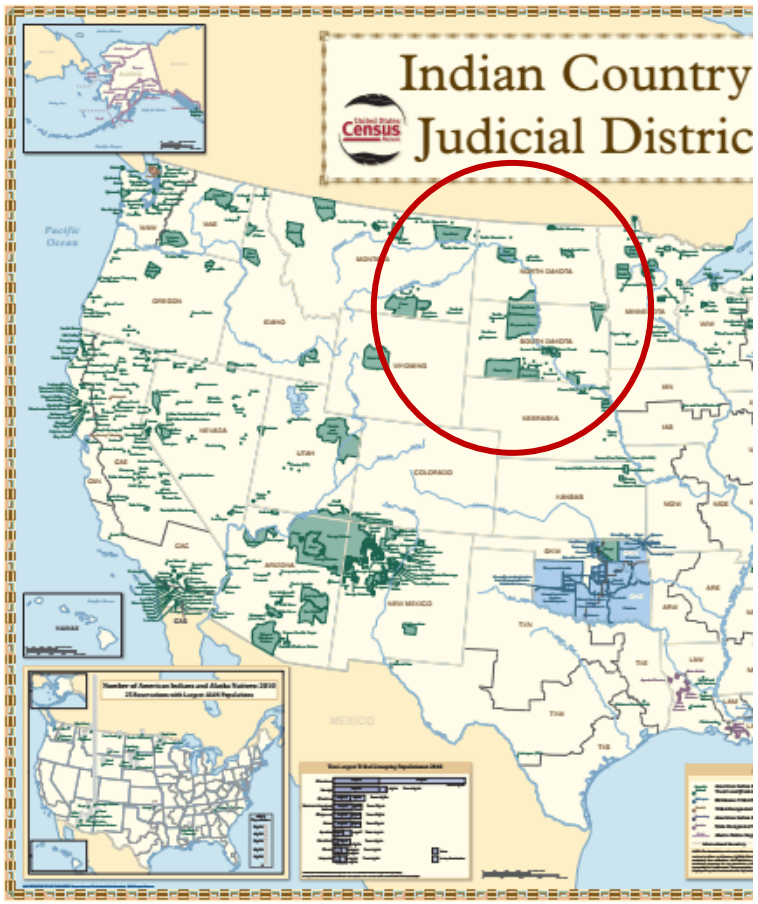


Under-investment in healthcare and social care results in stark health disparities across the US

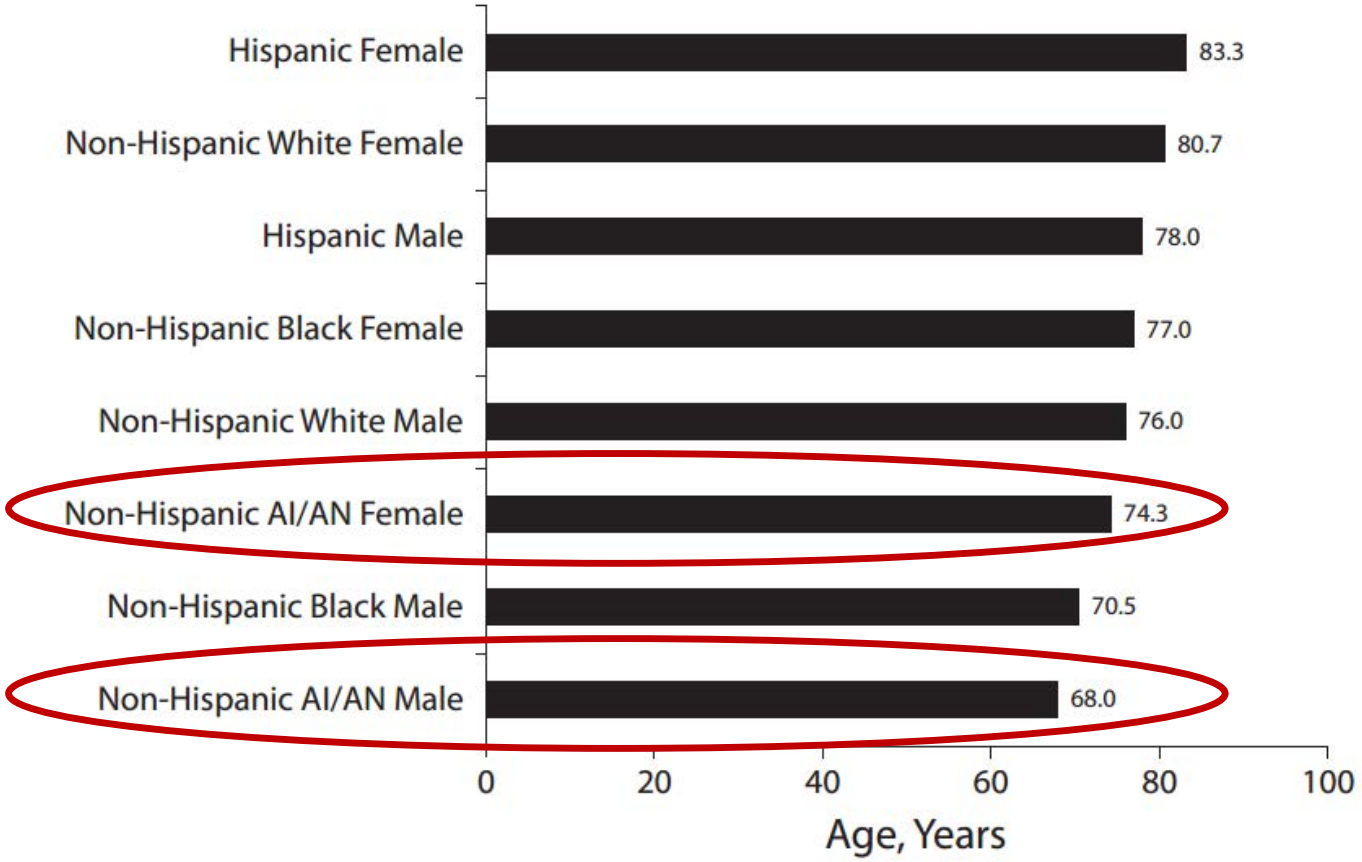


West of the Mississippi, the highest-disparity counties are American Indian/Alaska Native (AI/AN) communities, especially in the Great Plains





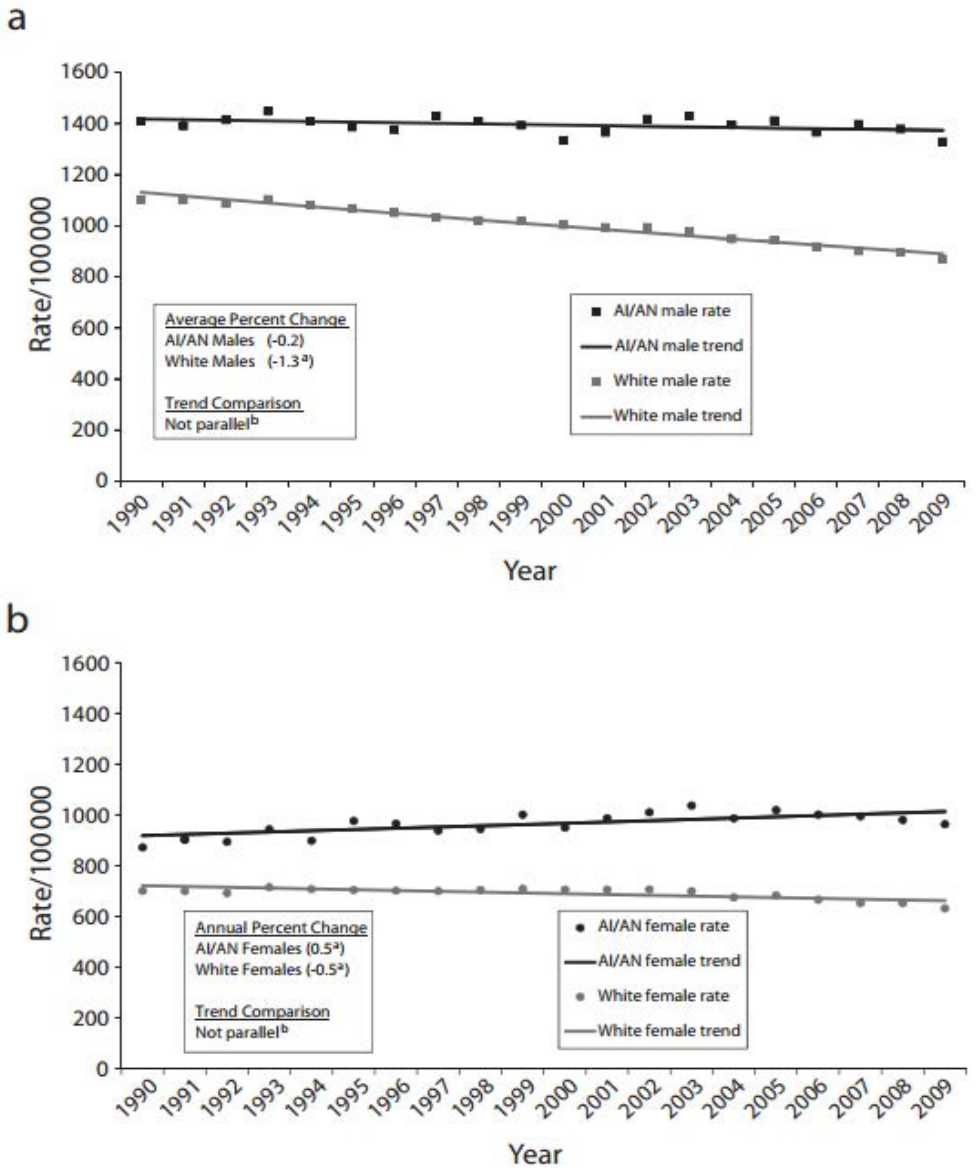
AI/ANs life expectancy is shorter when compared to other American ethnic groups



Note. AI/AN = American Indian/Alaska Native.

FIGURE 1—Life expectancy at birth by sex for the non-Hispanic American Indian and Alaska Native population in Contract Health Service Delivery Area counties, 2007–2009, and for the Hispanic, non-Hispanic White, and non-Hispanic Black populations in the United States, 2008.

…And these health outcomes are stark in the Great Plains, where AI/ANs experience a higher mortality rate than White Americans



IHS Region and Sex	AI/AN Count	AI/AN Rate
Northern Plains		
Total	23 331	1461.8
Male	12 709	1748.8
Female	10 622	1243.4

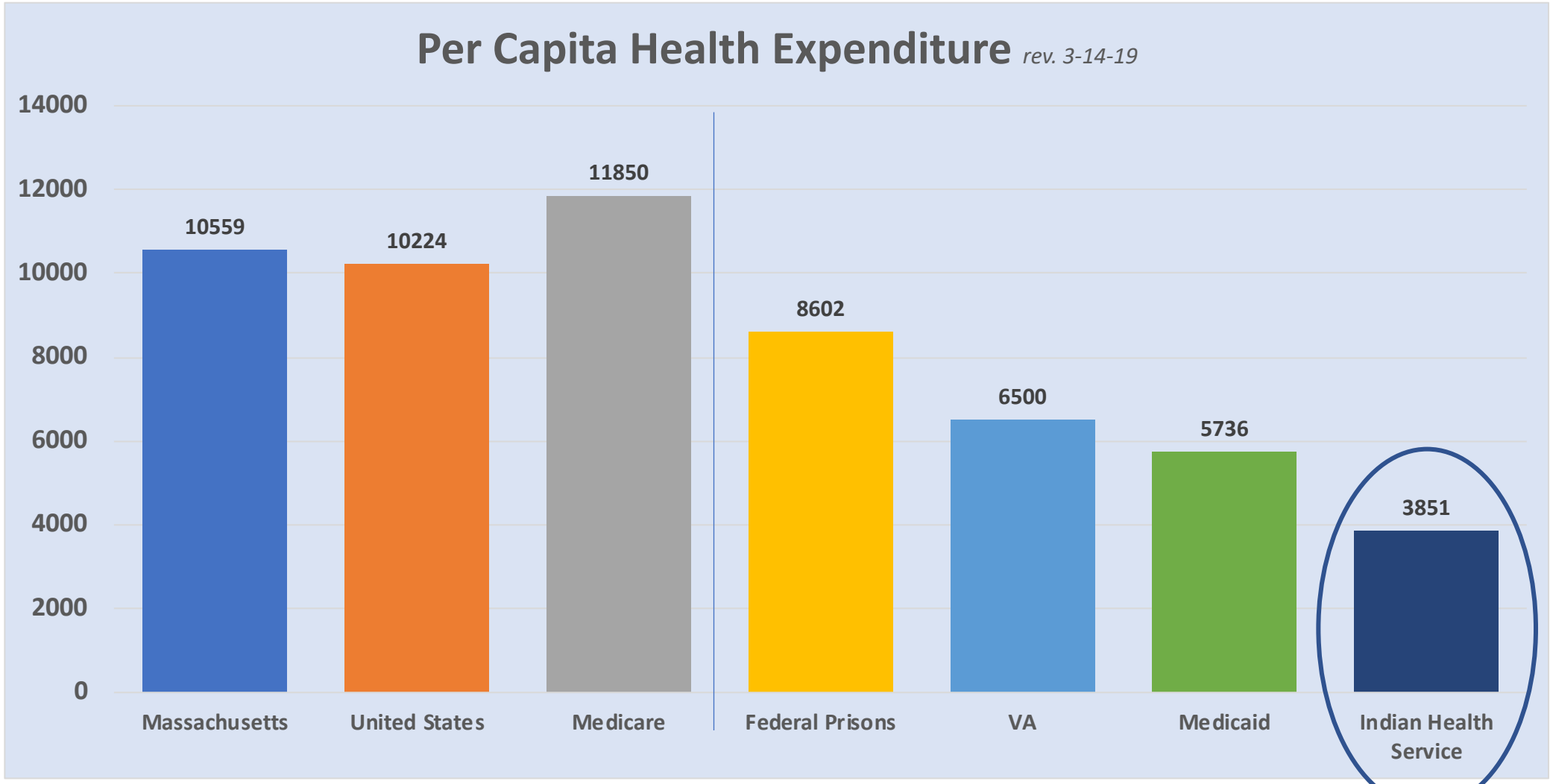
FIGURE 1—Annual age-adjusted all-cause death rates and Joinpoint trend lines for AI/AN and White (a) males and (b) females: Contract Health Service Delivery Area counties, United States, 1990–2009.

Substance use, accidents, suicide, and preventable chronic diseases contribute to high rates of mortality in the counties that overlay AI/AN reservation land in the Great Plains

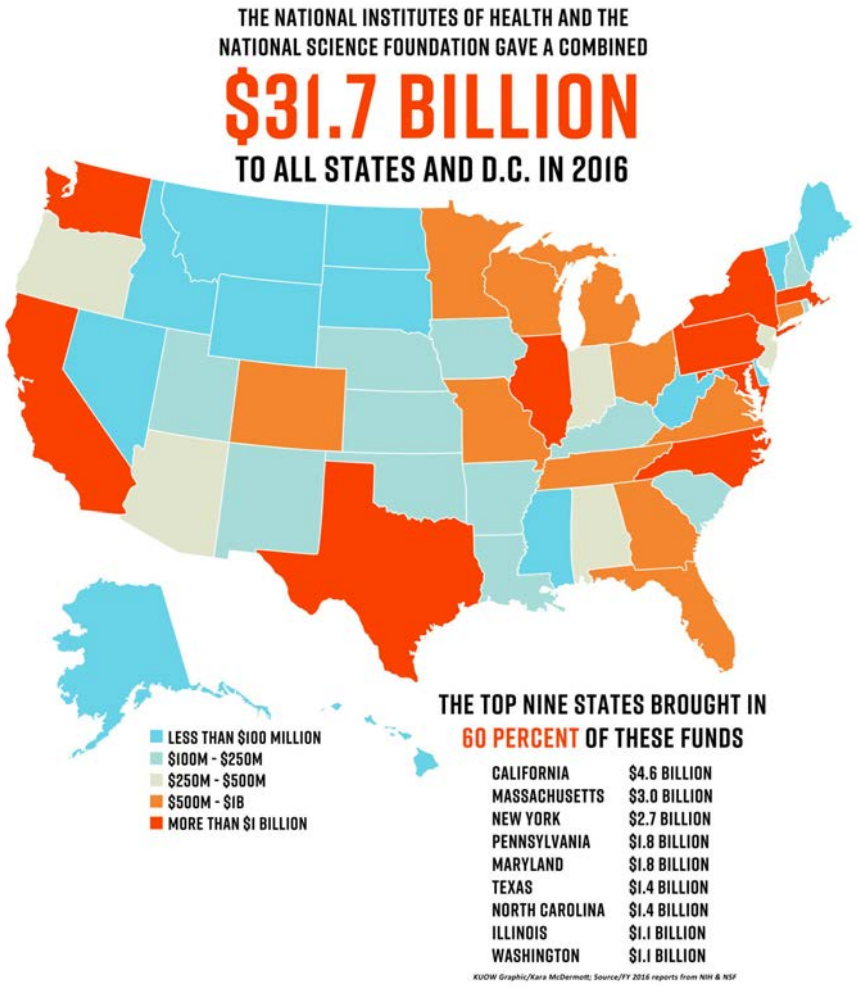
National highest-mortality counties, 2014 (age-adjusted)

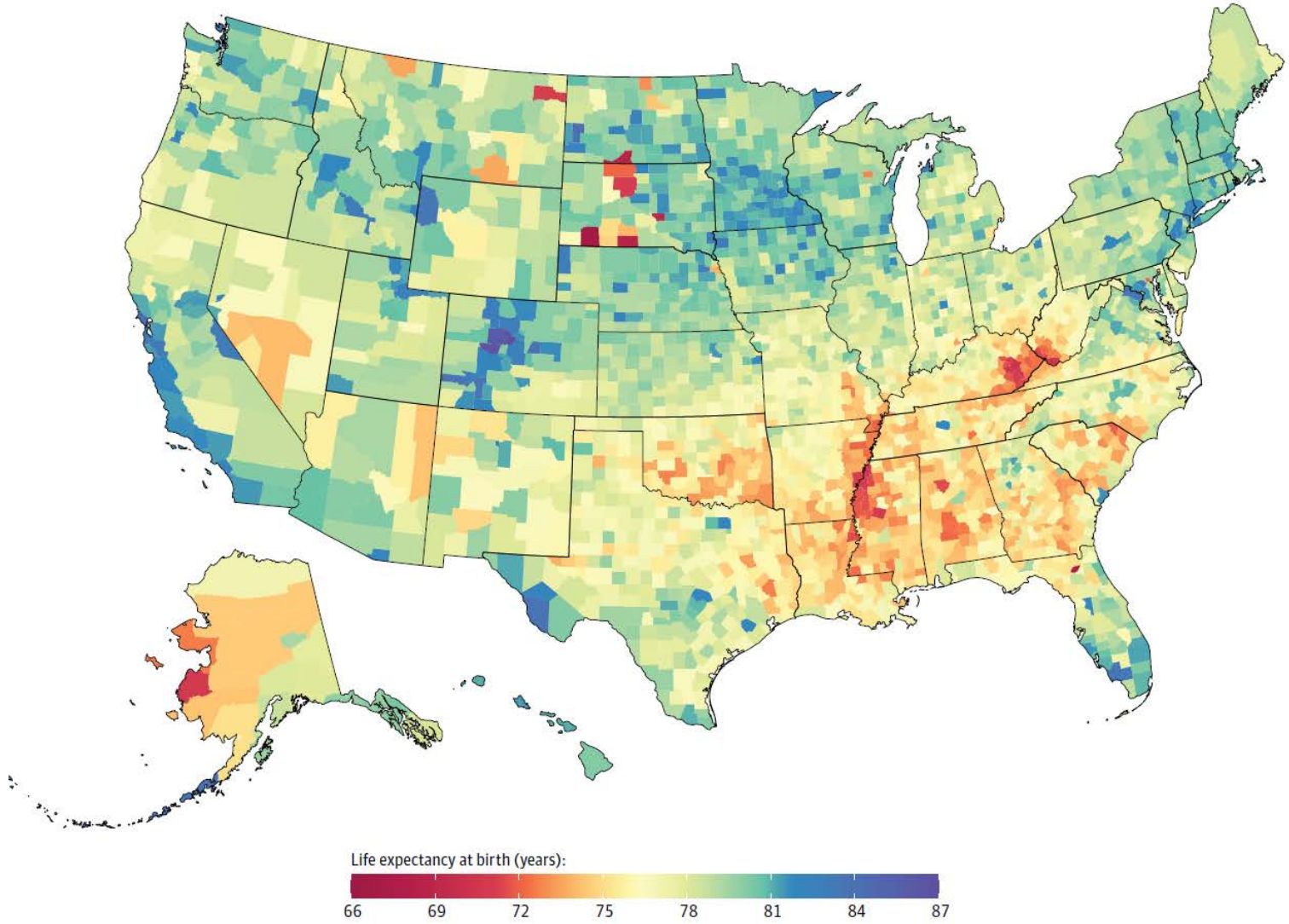
All causes		Alcohol		Diabetes		Injuries		Suicide	
1	*Union FL (prison)*	**1**	**Todd SD**	**1**	**Oglala SD**	**1**	**Todd SD**	**3**	**Sioux ND**
2	**Oglala SD**	**2**	**Sioux ND**	**2**	**Sioux ND**	**2**	**Oglala SD**	**4**	**Buffalo SD**
3	**Sioux ND**	**3**	**Buffalo SD**	**3**	**Buffalo SD**	**3**	**Sioux ND**	**5**	**Todd SD**
4	*Owsley KY*	**7**	**Oglala SD**	**6**	**Todd SD**	**5**	**Buffalo SD**	**8**	**Corson SD**
5	**Buffalo SD**					**6**	**Dewey SD**	**9**	**Dewey SD**
6	**Todd SD**							**10**	**Oglala SD**

Moreover, AI/AN healthcare is underfunded compared to other health systems and providers in the US

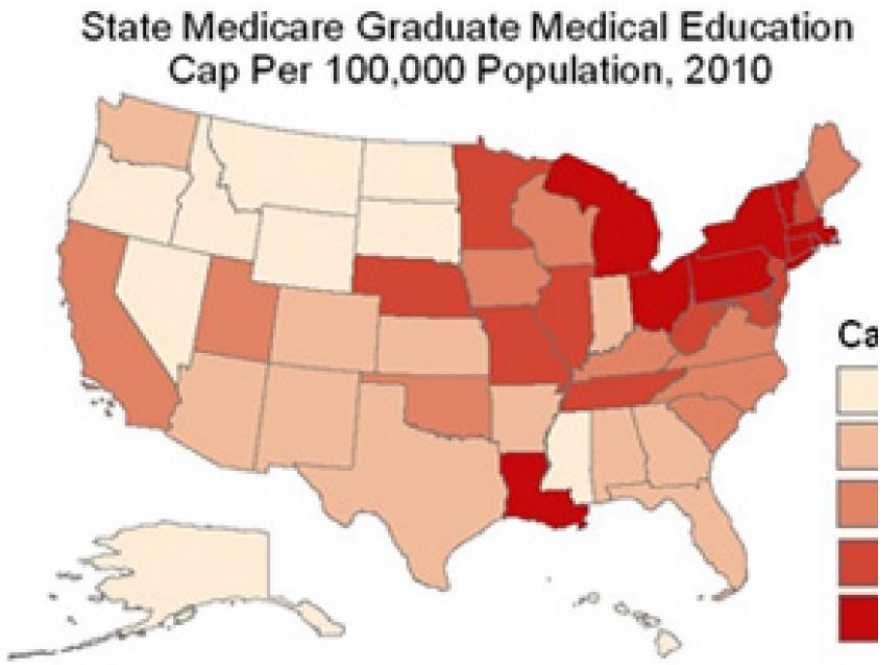


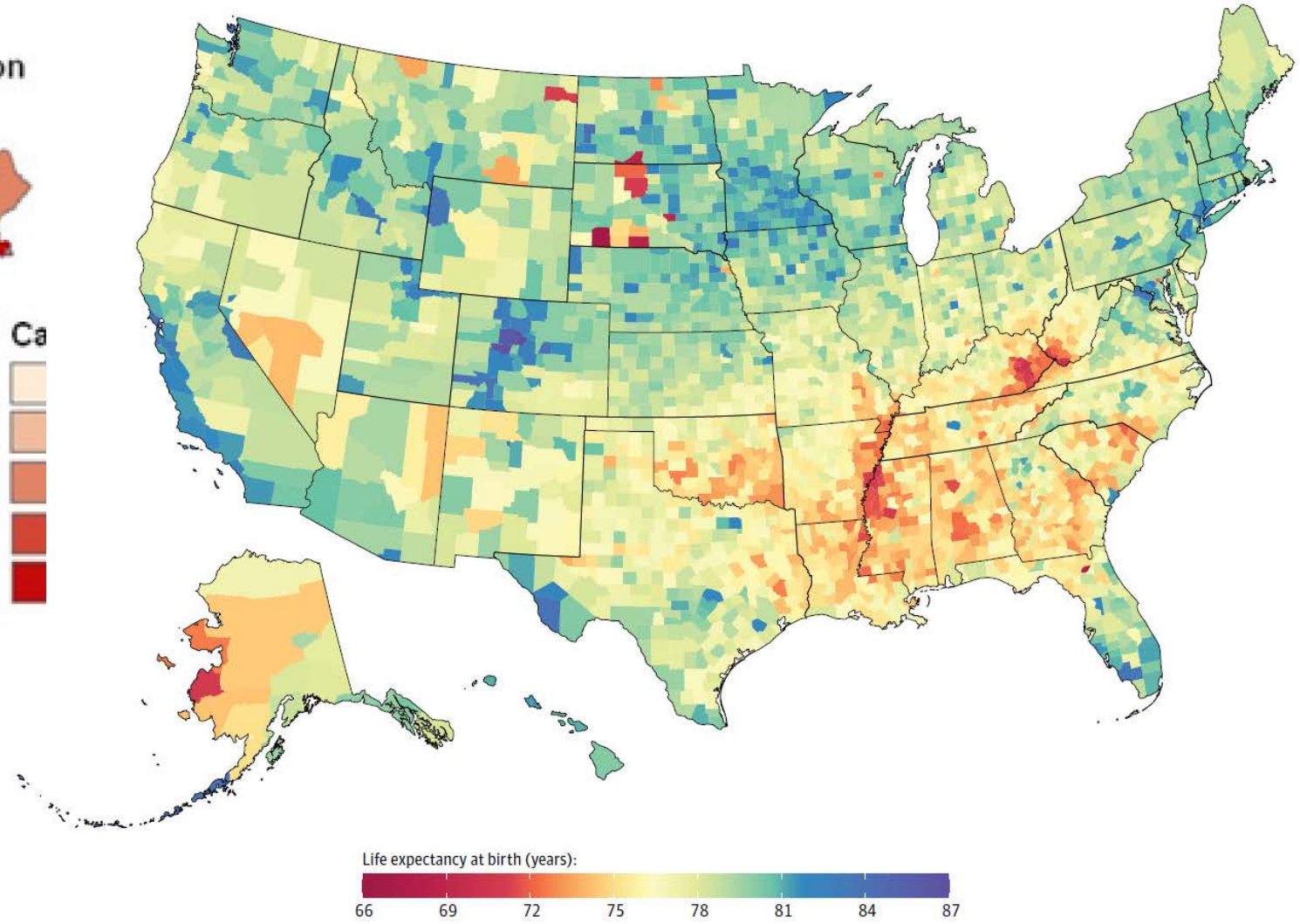
Academic research funding is maldistributed to address these AI/AN and rural health disparities





…And GME funding is maldistributed to address AI/AN and rural health disparities, especially in the Northern Great Plains





American Indian/Alaska Natives are vibrant members of communities across the US and have been traditionally underserved, despite treaty obligations

- 5.2 million AI/AN individuals in the 2010 census
  - 71% urban-dwelling, many others living on reservation land
- 2.3 million Indian Health Service (IHS) eligible individuals
- AI/AN seek care from a variety of providers:
  - Indian Health Service clinics and hospitals
  - Tribally-run health systems and providers
  - Urban Indian health organizations/non-profits
  - Other rural and urban providers (with qualifying Medicaid/Medicare or private insurance coverage)
  - Veterans Affairs system

There are many examples of excellent health care in AI/AN communities to be learned from

- The Southcentral Foundation's Nuka System of Care, in Alaska
- The Behavioral Health Practitioner / Aide Program in Alaska
- Tribal and federal sites in the Southwest
- Project ECHO developed in part with partnerships in AI/AN health systems
- There are developing UGME and GME models in New Mexico, Oklahoma, Oregon, California, South Dakota, and elsewhere

The IHS faces unique challenges in providing high-quality care to AI/AN communities, providing an opportunity for academic collaborations

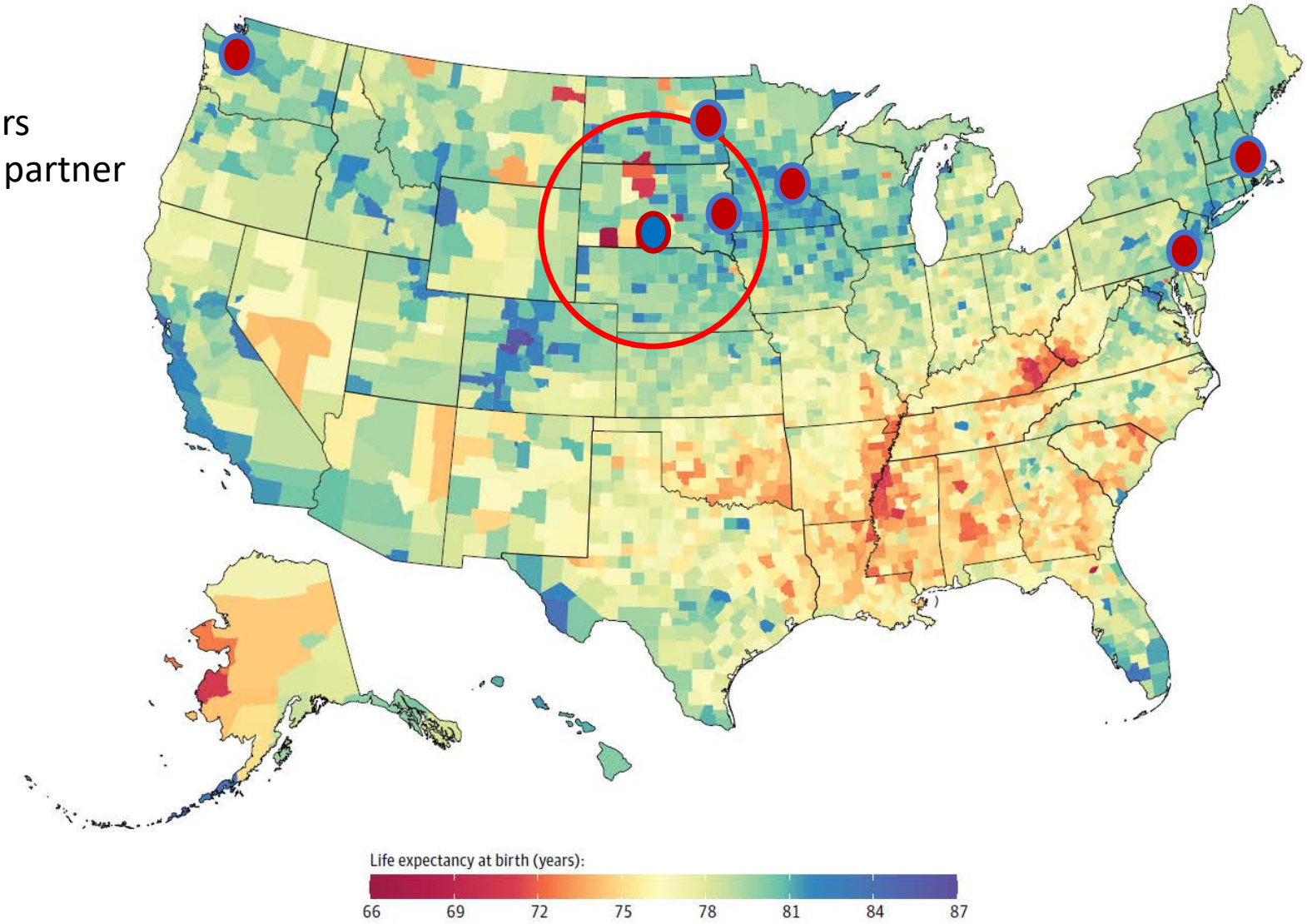
- Some of these challenges include:
  - Staffing shortages, difficulties in retaining rural providers
  - Frequent leadership turnover
  - Accreditation
    - Quality assurance and process improvement
    - Governance
  - Institutional cultures that do not promote provider and community wellness
  - Trouble leveraging what is available in acknowledgment of limited federal funding
  - Limited time/resources for staff/leadership development and continuing medical education
  - Limited time/resources for research and health policy activities
  - Strained relationships that result in limited community engagement and promotion of tribal sovereignty

An opportunity exists to build academic collaborations that serve rural AI/AN communities, especially those in the underserved and under-resourced Northern Great Plains

- What the communities stand to gain:
  - Improved access to evidence-based high quality healthcare
  - Provider training, retention and recruitment
  - Continuing medical education
  - Enhanced leadership support
  - More academic and clinical resources
  - Advocacy
  - Research infrastructure and products
  - Community capacity building and programming to promote wellness and tribal sovereignty
  - Increase AI/AN healthcare workforce and leadership
- What the academic partners stand to gain:
  - Reinforce social medicine and community commitments
  - Recruitment, help address provider burnout
  - Continuing medical education and learning/collaboration with community experts/leaders

Our partnership brings large national academic medical centers (AMC) together to support the Rosebud Sioux Tribe in South Dakota

AMC partners
Community partner



Through the following steps, a partnership developed between Massachusetts General Hospital (MGH) and the Rosebud Sioux Tribe

Step 1: Work to understand community priorities, communicate about the strengths/weakness of academic medicine

Step 2: Initiate a community-driven clinical program

Step 3: Following community cues, work toward program expansion and empower community involvement

Step 1: Work to understand community priorities

Step 1

2012: First visit to Rosebud, community engagement

2013: Case study written with community collaborators, and first clinical rotations by resident trainees from MGH

The following themes were raised by the community as priorities

- Strengthen IHS site
  - Promote community-centered care
  - Enhance quality/trust
  - Address erosion of services – e.g. obstetrics
- Improve overall access to care
- Prioritize health topics of concern
  - Methamphetamine and alcohol use
  - Suicide and behavioral health
  - Maternal child health
  - Pain management
  - End of life care
  - Diabetes prevention and treatment

Step 2: Initiate a community-driven clinical program

Step 1

2012: First visit

2013: Case study and first rotations

Step 2

2015: Fellowship in Rural Health Leadership development

2016: Fellowship begins, providing year-round internal medicine clinical care with rotating fellows dividing time between Boston and Rosebud

Our fellowship team is large, diverse and growing

MASSACHUSETTS GENERAL HOSPITAL
DEPARTMENT OF MEDICINE

Rural Health Leadership Fellowship








- Rural clinical presence with internal medicine physicians
  - >25% time clinical care in Rosebud, remainder in Boston
- Curriculum is ~66% ‘real-life’, ~33% classroom/didactic
- Strong mentorship and coaching programs
- Time and funding for MPH through Harvard

Many opportunities for the team to conduct collaborative work

- Manage complex patients
- Coordinate care
- Perform process improvement
  - Pain prescribing
  - Health maintenance
- Provide medication assisted recovery
- Run a weekly jail clinic
- Treat hepatitis C virus
- Coordinate 40 UGME and GME trainee rotations a year
- Facilitate volunteer faculty trips
- Bridge work between IHS and the tribe
- Build capacity at IHS and the tribe
- Offer technical support for grants
- Join regional and national task forces
- Provide continuing education
- Provide community health promotion

Our program has been strengthened by engaging with regional and national partners

Step 3: Following community cues, work toward program expansion

Step 1

2012: First visit

2013: Case study and first rotations

Step 2

2015: Fellowship development

2016: Fellowship begins

Step 3

2018: Radcliffe Workshop

2019: UND workshop

2019: HRSA award to develop a novel internal medicine rural residency training track between MGH and Rosebud

As the program scales up, we brought community stakeholders together to help identify priorities for academic partnership

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Laying the Path to Partnership: Academic Health Centers and Rural American Indian / Alaska Native Communities

Workshop at the Radcliffe Institute for Advanced Study

The Radcliffe Institute meeting helped identify a roadmap with specific aims/goals articulated by community stakeholders

Goals:

1. South Dakota's American Indian health system should rival Alaska's (Southcentral Foundation and 638-tribally run program)
2. Rosebud and Pine Ridge should serve as the nation's premier rural teaching hospitals
3. A coalition should generate opportunities and support for Lakota youth and future tribal leaders

The Radcliffe collaborative discussion suggested following approaches

Approach 1: Reinforce IHS centers and expand UME/GME programs

- With academic partnerships to support staffing, leadership
- Rural residency training track development and implementation
- Increase capacity by supporting NP/PA and other frontline medical providers
- Continuing medical education
- Leadership support

Approach 2: Build capacity for sovereign tribal health management with coalitions and engaged partnerships

- With professional pipeline development
- Aligned with economic development
- Leadership development that reinforces tribal sovereignty

Lessons learned from seven years of partnership

- Key values: listening, humility, genuineness, generosity, altruism
- Effort is needed to understand community priorities and perspectives. Those should guide all efforts, with community stakeholders always involved and empowered in the process
- Work in challenging environments challenges everyone. Sharing across cultures and settings regarding wellness, management, and leadership helps everyone.
- Tribal-AMC partnerships have the potential to become something to celebrate

Do these lessons apply to you or your partners?

- Are there opportunities to engage with tribal leadership and tribal partners to identify the appropriateness of / opportunities for an academic-tribal partnership?
- Consider how a partnership could strengthen tribal sovereignty and assure community stakeholders are involved and empowered in every step of the process
- Our pathway to tribal-AMC partnership, for reference:
  - Step 1: Work to understand community priorities, communicate about strengths/weaknesses of academic medicine. This will likely take years and be an ongoing process.
  - Step 2: Pending tribal input, develop a clinical program along tribal requests
  - Step 3: Plan for the future, always work to empower community leaders, and consider the appropriateness of UGME/GME opportunities

Thank you for your time and interest in this topic!

Many thanks to the Sicangu Oyate, the Indian Health Service, MGH, Harvard Medical School, our families, and our many colleagues and partners. We are honored to be able to do this work.

We would be privileged to learn from you. Please reach out with comments or questions.

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