NIPDD Fellow Outstanding Academic Project Showcase

Moderated by Clark Denniston, MD

A Community Based Pipeline Program for Rural and Underrepresented Georgia Premedical Undergraduate Students.

Cliff Dunn, MD
Criteria to Apply to the Program

- 1. College sophomore working on pre-med curriculum.
- 2. Minimum 3.0 GPA overall and 3.0 math/science GPA.
- 3. Legal Georgia Resident and U.S. Citizen in a Georgia college.
- 4. Have reliable transportation during the program.
- 5. A 500-word essay entitled, “Why I’m interested in serving rural populations as a Primary Care Physician.”
The “Program”

- Seminars
- Shadowing
- Research

50% of the 4-week program is dedicated to shadowing primary care physicians.

% Gender/Race in the Program

- Male: 56
- Female: 44

- Caucasian: 71.8%
- African American: 17.2%
- Asian: 3.4%
- Hispanic: 2.6%
- Other: 5%
Students Progress Through Medical Training

- Graduates of the program: 117
- Applied to Med School: 76
- Accepted to Med School: 65
- In GA Med School: 60
- Rotated through our Residency: 8
- Matched with our Residency: 1
- Returned to Area: 1

Current Resident Data

- Total: 39
- Residency in GA: 12
- Primary Care: 21
- Primary Care in GA: 9
Current Career Data

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
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</thead>
<tbody>
<tr>
<td>Total</td>
<td>16</td>
</tr>
<tr>
<td>Practicing in GA</td>
<td>8</td>
</tr>
<tr>
<td>Primary Care in GA</td>
<td>7</td>
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</table>

Medical School Acceptance Rate

- **Total**: 85.8%
- **Female**: 80%
- **African American**: 72%
- **Rural**: 85.7%

Acceptance rate in percent.
Limitations

- Duration of training
- Exposure during training
- Selection bias
- other

Conclusion

- Community based pipeline programs can be created and are beneficial
- They may be too early to influence career choices
References

• McKendall S, Kasten K, Hanks S, Chester, A. The Health Sciences and Technology Academy: An educational pipeline to address health care disparities in West Virginia. Acad Med. 2014 Jan;89(1):37-42


• Table A-1 through A-11: U.S. Medical School Applications and Matriculants by School, State of Legal Residence, and Sex, 2016-2017. AAMC.org

• Diversity in Medical Education. http://www.aamcdiversityfactsandfigures2016.org/ Accessed December 2017

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Family Physician Burnout in Rural vs. Metropolitan Areas

Amy Hogue, MD
Sioux Falls Family Medicine Residency Program
Family Physician Burnout

• It’s real…
• But is it worse in rural areas?
  – Isolation
  – Less resources
  – Increased hours?
  – Patients are your neighbors.

The Study

• Online surveys sent to 304 graduates of Sioux Falls Family Medicine Residency Program
• Demographic info collected: age, sex, time since residency graduation, and practice spectrum
The Burnout Question

a) I enjoy my work. I have no symptoms of burnout.

b) I am under stress, and don’t always have as much energy as I did, but I don’t feel burned out.

c) I am definitely burning out and have one or more symptoms of burnout.

d) The symptoms of burnout that I am experiencing won’t go away. I think about work frustrations a lot.

e) I feel completely burned out. I am at the point where I may need to seek help.
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Results

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<tr>
<th></th>
<th>Female</th>
<th>Male</th>
<th>Age ≤45</th>
<th>Age &gt;45</th>
<th>OB with deliveries</th>
<th>No OB deliveries</th>
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Results

Why?
– Autonomy?
– Patient relationships?
– Rural lifestyle?
Implications

- Rural Recruitment—Green Acres is the place to be??
- Burnout Rate of 25% is not insignificant.
  - Wellness programs/ mental health resources
  - Telemedicine
  - Continued support of physician autonomy.

Female vs Male Milestone Scores

Ildi Martonffy, MD
U of Wisconsin-Madison

Thanks to Jennifer Birstler, MS and Justin Sena, MA
Background

• Prompted by emergency medicine residency program study
  – Male and female residents start with comparable milestone scores
  – Male residents finish with higher ending milestone scores
  – True regardless of faculty rater-resident gender concordance or discordance

(Dayal, 2017)

Different for family medicine?

• Procedure based vs relational specialty
• Make up of residency and practice cohorts

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<thead>
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<th>Female</th>
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<tbody>
<tr>
<td>Emerg Med residents</td>
<td>62%</td>
<td>38%</td>
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<tr>
<td>Fam Med residents</td>
<td>42%</td>
<td>58%</td>
</tr>
<tr>
<td>Emerg Med in practice</td>
<td>74%</td>
<td>26%</td>
</tr>
<tr>
<td>Fam Med in practice</td>
<td>62%</td>
<td>38%</td>
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</table>
Scores by 6 month evaluation period, academic year, residency year

“Advantage of being male score” calculated for each (green minus yellow)

Can examine specific cohorts and time periods

Women scored higher than men here
Data analysis

Excel sheet was interesting to look at, but what does it mean?

Is there a significant difference in scores?

$\beta_2$
Do males have higher scores than females?

$\beta_3$
Do males improve their scores at a faster rate?

Figure 2: Results of difference in intercept and slope between genders. No significant differences were found.
P values for aggregate mean milestone score values across semesters compared by gender

No significant differences found

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Good news, but …

- Scores given by CCC rather than individual faculty
  - Harder to effect change?

- Predominantly female faculty and CCC could be a confounder

- Did not examine narrative feedback or remediation plans
Questions?

REFERENCES:

- Dayal A, O’Connor DM, Quadri U, Arora V. Comparison of Male vs Female Resident Milestone Evaluations by Faculty During Emergency Medicine Residency Training. JAMA Internal Medicine. May 2017, Vol 177, Number 5, p. 651-657.


Evaluating Community Need and Graduate Medical Education on Opioid Use Disorder in America’s Heroin Overdose Capital

Anna Murley Squibb M.D.
Associate Program Director
Soin Family Medicine Residency
Kettering Health Network

A Tale of Two Interstates

Greene County\textsuperscript{1}: 5 fold increase since 2010
Montgomery County\textsuperscript{2}: 2016: 57 per 100,000 UOD deaths

2016 SAHMSA\textsuperscript{3}:
11.8 million OUD patients
21 million Need SUD treatment
3 million Received SUD treatment
3% Family Physicians currently provide MAT

Rare in rural areas

The patient perspective

50% Physicians didn’t address the issue
40% Physicians missed diagnosis
25% Shared Decision for Treatment

STFM 2015

26% Curriculum addressing SUD
8% Programs had ONE graduate treating SUD

Wakeman et al, Harvard

55% Addiction Training “fair to poor”
72% Insufficient ambulatory training
56% Insufficient hospital based training
Knowledge poor: MAT and Naltrexone
“Cross Sectional Descriptive Design”

Goals:
- Current self reported competence
- Culture of our health system
- Resident MAT
- Resident Education Opportunities
- Faculty Development Opportunities

41 Participants:
- 20 Faculty & 21 Residents
- Representation from: FM, IM, EM, Gen Surg, OB, TY, Radiology

Self-Identified Competence

- Screening for Substance Use Disorder
- Diagnosing a Substance Use Disorder
- Providing Brief Intervention
- Referring for Treatment
- Discussing Behavioral Therapy
- Discussing Medication Assist Therapy
- Discussing Overdose Prevention and Naloxone
- Discussing Harm Reduction

Very / Somewhat Prepared
Very / Somewhat Unprepared
Faculty - Teaching

I intend to prescribe medication assisted therapy in my future practice

70%
Focused Education & Faculty Development

Clinical Site Champions\textsuperscript{8}

Early Training & Standard Care\textsuperscript{9}

OSCE\textsuperscript{9,10,11}

“Better is possible. It does not take genius. It takes diligence. It takes moral clarity. It takes ingenuity. And above all, it takes a willingness to try” \textsuperscript{12}

Atul Gawande
References- Directly Referenced


References- General

Please complete the session evaluation.

Thank you.