WEBVTT

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00:00:14.420 --> 00:00:18.230
Dean's Lecture Series: Morning. Everyone just gonna hang on a moment while folks are trickling in.

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00:00:29.380 --> 00:00:48.570
Dean's Lecture Series: Good morning. Everyone welcome to another installment of the Dean's lecture series. I'm Matt Ammonson. I'm a learning development manager for the office of diversity, equity, and inclusion. This session is being recorded. We will share it out within 2 days to all who registered for the event. Otherwise the recording can be found under the education and training tab of the Odei website.

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00:00:48.640 --> 00:01:06.440
Dean's Lecture Series: and we invite you to take care of yourself as necessary during today's session as we will not be taking a break. Live transcription is enabled. But please note that the live transcript is not perfect. As this is an auto transcript, and any feedback or issues with accessibility, please feel free to email us at Dls dash Odei at Umnedu.

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00:01:06.820 --> 00:01:23.420
Dean's Lecture Series: So we ask that participants please use the Q&A zoom function instead of the chat. In order to ask questions of our presenter, we will do our best to respond. But please understand that we are working within a set window of time, so should we not get to your question, we'll work with the presenter to get unanswered questions posted on our Dean's lecture series, Webpage.

5
00:01:23.530 --> 00:01:35.860
Dean's Lecture Series: and then paste in the chat. You'll find a few links. You'll find the Dean's Lecture Series website, the slides to our presenters lecture and the Dean's Lecture Series email address. And I'll now turn it over to Dr. Nunez to kick off today's lecture.

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00:01:36.930 --> 00:01:37.870
Ana Nunez MD: Thanks, Matt.

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00:01:38.360 --> 00:01:55.960
Ana Nunez MD: Good morning, everybody. We have sort of our wonderful sort of struggle between trying to move towards spring with temperatures in the twenties, but the days are longer and the birds are noisier, so the wind will sort of happen in terms of moving in that trajectory.

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00:01:55.960 --> 00:02:23.579
Ana Nunez MD: We have sort of within us, sort of a tumult of happening outside in the world, of sort, of how we move forward and focus on doing what's priority in terms of taking care of people that we care of all of our communities. And today we have the opportunity to hear a wonderful example from Dr. Moreesca joining us. I have Dr. Mary Owen, who is going to give all the formal introductions to tell us about what's happening in terms of

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00:02:23.580 --> 00:02:29.600
Ana Nunez MD: the story from the Seattle experience in terms of the Indian Health Board of Family Medicine. Dr. Owen.

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00:02:30.550 --> 00:02:32.759
Dr. Mary Owen: Thanks, Dr. Nunez. Can you hear me?

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00:02:32.990 --> 00:02:33.510
Ana Nunez MD: Yep.

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00:02:33.960 --> 00:02:42.289
Dr. Mary Owen: I'm missing my controls, of course, for this meeting, so I'll ask you to help with the questions as well, because I'm not seeing any anything that comes up.

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00:02:42.400 --> 00:03:05.869
Dr. Mary Owen: Thank you, everybody for being here. I'm thrilled to be able to introduce and thank you, Dr. Nunez, for allowing me to introduce our speaker today, Dr. Terry, I actually asked for Dr. Moreesca to give this talk because we've been trying to get a residency going in this area for a long time. It's really important that we have representation. If we're going to continue this longitudinal raising of physicians and helping our workforce here in this region.

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00:03:05.960 --> 00:03:22.719
Dr. Mary Owen: Dr. Moreesca is a long time mentor for many of us in Indian health. So, as I told the other people, you are among royalty today so thrilled to be able to introduce Dr. Moreesca. Terry Maresca is a board certified family physician and clinical professor at University of Washington.

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00:03:22.980 --> 00:03:24.290
Dr. Mary Owen: School of Medicine

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00:03:24.650 --> 00:03:38.160
Dr. Mary Owen: Department of Family medicine. She's a former director of the Seattle Indian Health Board's Family Medicine Residency program and remains on their core faculty and also teaches at the Puyallup Tribal health authorities, family Medicine Residency program. In Tacoma, Washington.

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00:03:38.160 --> 00:03:58.310
Dr. Mary Owen: Dr. Maresca, has spent 37 years working in reservation, tribal and urban American Indian communities. A former President of the Association of American Indian Physicians, or Aaip. Dr. Maresca is on several medical school advisory committees working to increase the workforce of native people serving American, Indian and Alaska native communities. With that. Thank you for being here, Dr. Maresca.

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00:03:58.420 --> 00:03:59.089

Dr. Mary Owen: Take it away.

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00:03:59.090 --> 00:04:12.370
Dr. Terry Maresca: And thank you, Dr. Owen, Dr. Nunez, and the team at University of Minnesota, for inviting me and allowing us to share some information related to our experience with creating a Residency program in the Seattle area.

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00:04:12.680 --> 00:04:30.459
Dr. Terry Maresca: I also want to say my thank yous to the people of Snoqualmie, which is where I currently live, which is east of Seattle, Washington, and my appreciation to all of you for the work that you're doing for the people in your state and everyone that you serve.

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00:04:32.710 --> 00:04:44.279
Dr. Terry Maresca: I thought before we get started, just I do a tiny snapshot of primary care training specifically for family medicine, and how this relates to indigenous health. We know that the American

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00:04:44.350 --> 00:05:04.370
Dr. Terry Maresca: Association of American Medical Colleges is predicting a primary care shortage in the next 10 years or so that's been happening for some time, and we also know that at least the special. You know, the primary care specialties are essential in today's health systems. Family medicine is often some of the cornerstones for these systems.

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00:05:04.530 --> 00:05:11.590
Dr. Terry Maresca: We know that residents like to stay near where they trained, and this has been true also for some time

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00:05:11.690 --> 00:05:30.979
Dr. Terry Maresca: the system of Indian health, and by that I mean both tribally run organizations. The Federal program of Indian Health Service and urban Indian care has had high vacancy rates for a long time, and by high I mean 25% and upwards, and that can be variable by region.

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00:05:31.100 --> 00:05:57.699
Dr. Terry Maresca: We also know that the Indian Health Service system nationally doesn't have a formal graduate medical education or Gme structure. This would be in contrast to something like the Va system which has long been training residents in a variety of specialties, and as I'm certain that you are familiar with in your State, that the enrollment of American, Indian Alaskan native students has been really stagnant for decades.

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00:05:59.190 --> 00:06:11.390
Dr. Terry Maresca: My focus today will be on Seattle Indian Health Board, which is the only one of 6 programs. Nationally that is embedded, that is embedded in a tribal community or a native health setting.

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00:06:11.410 --> 00:06:32.450
Dr. Terry Maresca: Excuse me, there are 4 others that are run by tribes, and I do have an affiliation with one of them, which is the Puyallup tribal Health authority just south of us. The others are based in Oklahoma, and these were born of the funding that came through the Obama administration back after 2,008 related to teaching health centers.

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00:06:32.750 --> 00:06:42.359
Dr. Terry Maresca: There is one that is federally administered with cooperation, with Indian Health Service, and that one is on Navajo nation in partnership with the University of New Mexico.

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00:06:43.060 --> 00:07:07.750
Dr. Terry Maresca: just going back to the Va. Issue for just a moment, just as a tiny look at just the graduate medical education slots that each of these organizations have. And, as you can see, there's a big difference between 72 slots and 11,000 slots, and with the group that has a structure such as the Va. Compared to what we're addressing within the Native health system

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00:07:09.310 --> 00:07:22.519
Dr. Terry Maresca: specifically for Seattle Indian Health Board. That's what we call our clinic. It is an outpatient setting. We're triple ahc accredited and have been functioning as a nonprofit since 1970. The clinic did

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00:07:22.520 --> 00:07:42.870
Dr. Terry Maresca: acquire federally qualified Health Center status, which means that we're a safety net clinic for all comers. So we don't just serve native people, although that's the majority of our population. About 70% are either Canadian 1st nations or are American, Indian, Alaska native people that represent over 200 different tribes.

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00:07:44.140 --> 00:07:44.900
Dr. Terry Maresca: I

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00:07:45.230 --> 00:08:09.490
Dr. Terry Maresca: apologize that I on my slide. I have talking about some of the demographics of our population with our figures for below poverty level are actually 61% below 100% below poverty level. And about 1112% that are 200% or below. So we're still majority under resourced people that we're serving.

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00:08:09.830 --> 00:08:23.629
Dr. Terry Maresca: The array of services that we offer would be familiar to many of you in a larger outpatient setting, medical dental pharmacy on site, nutrition services, a large mental health

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00:08:23.970 --> 00:08:51.560
Dr. Terry Maresca: behavioral health team, including substance, use, disorder, management and a fair amount of outreach. We are governed by a community board that represents both native and non-native people, both in health care and not in healthcare. And we're funded essentially through

our patient billables as well as contracts that we have with private entities and some public grant funding as well.

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00:08:52.730 --> 00:09:03.849
Dr. Terry Maresca: I guess the real question is why the clinics decided to even approach Residency training to begin with, and this was really before my time, because this essentially was a dream that

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00:09:04.020 --> 00:09:27.129
Dr. Terry Maresca: was originated with the founders of the clinic who were real activists coming out of the era of the sixties civil rights activism. And they were pretty determined to have a workforce that looked like themselves. They wanted to grow their own. They saw the disparities already in terms of who was providing health care services, and thought that we could. We could do that, and we would need some resources to do so.

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00:09:27.400 --> 00:09:56.359
Dr. Terry Maresca: I think the Board of directors was really concerned about improving patient trust and also encouraging more continuity by having people who were well trained in indigenous ways of knowing and also Western medicine, and they wanted to actually have a group that could incorporate indigenous medicine practices along with Western science. That was a critical piece of this, as the clinic was evolving.

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00:09:57.950 --> 00:10:21.380
Dr. Terry Maresca: Although our program didn't use this particular rubric to develop the Residency program. I think that what was been published by rural gme is useful for this. We're thinking about 5 steps when someone is thinking about creating a Residency program. And those 5 domains have to do with initial exploration of the idea moving on to an actual design of what that would look like

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Dr. Terry Maresca: doing the internal development of that, including financing the actual startup of a program followed by maintenance. Once the program is really underway. And so I'm going to use that today as our guideline for talking about the work that we did.

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00:10:37.870 --> 00:11:06.850
Dr. Terry Maresca: The initial exploration, as I said, really started in the seventies. However, the early 19 nineties was an era of some change in national health care reform, and that was kind of precipitated also by Bill Clinton's election in the fall of 1992. The Health Board started to actively plan this in 1992, and took about 3 years with the 1st interns, arriving in 1994 to our program.

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Dr. Terry Maresca: The Vision and Mission was one of the key pieces. That was the driver of this and thinking about future focus and thinking about how we were going to define success. What would that look like? And the

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Dr. Terry Maresca: the definition of that for us was actually fairly simple. Part one was, could we actually, would we be successful to actually train graduates who would serve

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00:11:35.300 --> 00:11:51.859
Dr. Terry Maresca: what I call itu sites? So again, federally operated Indian Health service sites, tribal sites or urban programs? Number 2 was, would some of our graduates be able to function in rural or other underserved settings? We would consider that success as well.

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00:11:51.970 --> 00:12:06.330
Dr. Terry Maresca: That was a key piece of that. And everyone was on board. The issue of thinking about strategic partnerships was also a big question, particularly for the hospital component of this, which is required by the national curriculum.

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00:12:06.460 --> 00:12:30.560
Dr. Terry Maresca: There was some exploration, not just by our governing board, but within the community of our current employees about their support for such an effort. And the patients that we were serving, were they on board with this idea, and starting to look for some seed money to start to work on a startup program for the Residency.

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00:12:32.280 --> 00:12:34.530
Dr. Terry Maresca: We had 4 initial partnerships.

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00:12:36.030 --> 00:12:39.100
Dr. Terry Maresca: The 1st one was trying to get the hospital partner.

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00:12:39.470 --> 00:12:58.850
Dr. Terry Maresca: which is critical again for national certification, and it turned out that our choice was Providence Hospital, which was also the administrative hub of a program that was starting to branch out into satellite clinics and essentially Seattle. India Health Board became the second satellite of the Providence system.

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00:12:58.850 --> 00:13:21.890
Dr. Terry Maresca: and we chose them because the hospital mission was very clear about having an underserved population focus. And so that was very well aligned. They also happened to have an established Residency program within Washington State with a program director that had been doing it since the onset of family medicine as a specialty in the seventies. So this person was quite experienced, so were the faculty.

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00:13:21.890 --> 00:13:31.640
Dr. Terry Maresca: and they had a lot of regional and local connections, you know, for example, with State family medicine organizations. They were well connected and

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00:13:31.710 --> 00:13:56.709

Dr. Terry Maresca: and supportive of the idea. The other piece that was definitely a carrot for them was the fact that the Providence Hospital had unfunded what's called Gme slots. So basically, the funding for graduate medical education, especially funneling through Medicare, had some available Residency slots at that site because of a change within the University of Washington Medical School System.

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00:13:56.710 --> 00:14:10.080
Dr. Terry Maresca: and at that time the amount of funding for residents was very, very high, over $200,000, which is not what we see today with with current funding. So this was definitely an opportunity for the hospital as well as for us.

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00:14:10.450 --> 00:14:40.210
Dr. Terry Maresca: The second partner was another Fqhc. Who happened to be the 1st of the satellites of Providence. And so this was the Seymour clinic, which had a Latinx focus of care with primarily Spanish speaking clients, but also a community health center open to all, and they were partners with our chief executive officer. The 2 Ceos would meet together because they felt like there was a lot of similarity in terms of how

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00:14:40.940 --> 00:15:01.789
Dr. Terry Maresca: how to think about embedding an educational system within what was already a functioning primary care Center, the 3rd partner. No surprise would be our home Medical School, which is University of Washington School of Medicine. And what is unique about University of Washington is that they are the 5 State

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00:15:01.790 --> 00:15:28.740
Dr. Terry Maresca: Medical School for Alaska, Washington, Idaho, Montana, and Wyoming. And so the interesting advantage there was having already in place an Indian health pathway curriculum for medical students who wanted more exposure to indigenous health issues. And the person who ran that program. Dr. Walt Hollow is kind of legendary within native health circles. He was the

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00:15:29.747 --> 00:15:44.479
Dr. Terry Maresca: the original program director there, and that program had already been sending. It was a small program at that time, and was sending some of the students, both native and non-native, to our clinic for some clinical exposure.

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00:15:44.590 --> 00:15:57.440
Dr. Terry Maresca: The University was also sending other students related to like issues associated with like physical exam, you know, training as part a part of the curriculum. So we were already on their radar. The

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00:15:57.440 --> 00:16:25.479
Dr. Terry Maresca: the Residency has also something that they call the Family Medicine Residency Network, which was an association of the 18 different Residency programs in our 5 States. And they were. That was a natural avenue for students who were interested in our region to get information. So they were clearly a partner plus. They had a specific faculty Development

fellowship which was open to all family medicine physicians who were working in medical education.

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Dr. Terry Maresca: The school had other allies that were on our board and in the community, particularly in pediatrics and in psychiatry that were willing to provide support to us. And the 4th partner was actually Indian Health Service. And this was an interesting collaboration that came about with the regional area director for our Pacific Northwest region, with what we call the Portland area

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00:16:50.950 --> 00:17:06.690
Dr. Terry Maresca: and the finance director who thought that this program might be an innovative way to help increase the health workforce within the Pacific Northwest. And so they were on board, and they happened to have a person who in mind who would be able to help us achieve that goal.

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00:17:07.089 --> 00:17:20.099
Dr. Terry Maresca: So the second phase of this is design and design of the program initially for us had to do with choosing advisors. Who were we gonna be able to work with? And it wasn't just the partners that was a critical piece of it.

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00:17:21.550 --> 00:17:33.499
Dr. Terry Maresca: excuse me, but was also people within the community, and it was also people within our Seattle Indian Health Board in terms of who would be helping us to shape this particular program. So you have to know who's part of your team

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00:17:33.780 --> 00:18:00.690
Dr. Terry Maresca: and part of the homework assignment for them had to do with knowing the clinic demographics really, really well, who were we serving? What were those numbers? How was that getting paid for? Because we had a lot of people who were completely, completely uninsured. And what was the example of future growth? What were we predicting? Did we have the right spectrum of services from elders to newborns to be able to support a residency training program.

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Dr. Terry Maresca: And our decision was, yeah, that yes, that we could, and that the numbers would be our initial class size would be what we call a 2 2. So we would be phasing this in with 2 residents in the 1st year 2 as second year trainees and 2 more for the 3rd year. So a total of 6. Ultimately, when the program was was in full operation.

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Dr. Terry Maresca: we have to think about anticipating clinic changes, and some of it had to do with having 6 new people on our team who are going to be seeing patients. So did we have the space. And how would that look? What were some of the personnel changes that we would need to make to make this work in terms of our support team everything from the lab to pharmacy, and the full, the full spectrum of services that we were offering. Could we support these 6 new doctors.

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00:18:54.030 --> 00:19:19.460
Dr. Terry Maresca: We also had to think about what the academic leadership would be at that site because there wasn't a specific training director of any kind, even though we were training medical students periodically within our system. And that meant developing a new position of what we call a site director. And that person ultimately ended up being me who would be overseeing the whole operation at our particular site?

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00:19:19.770 --> 00:19:31.640
Dr. Terry Maresca: And where does that person fit into the clinic structure. So it turned out that that was really important in terms of our involvement with administration of the clinic to be able to make system changes locally.

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00:19:32.700 --> 00:19:43.690
Dr. Terry Maresca: Another critical piece of this was who was part of the non-physician team who were going to be part of our educational process. This involved nursing. This involved our pharmacy team. This involved behavioral health.

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Dr. Terry Maresca: And the woman who's pictured here is the fabulous Robin Snyder, who was our 1st Residency coordinator, and that's a position that was a necessary one for us to be able to offer support to both faculty and residents. A lot of scheduling issues involved. They handled a number of things related to credentialing and other operations. To make the training program flow smoothly.

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Dr. Terry Maresca: the bulk of development had to do with the fine, you know, with really hashing out finances, and although we were looking for support from the State of Washington, and also private foundation support that was not forthcoming initially. And so our choice was to

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Dr. Terry Maresca: actually look at the funding that we had, which was coming from over 2 dozen smaller grants and contracts, besides what patients that did have insurance, which was primarily both either Medicare or Medicaid if they were insured. Not that much in the way of 3rd party, Billings.

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00:20:44.150 --> 00:20:50.919
Dr. Terry Maresca: how could we make that work with the funding that we had, and that was essentially our choice. In moving forward.

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Dr. Terry Maresca: the other financing piece had to do with with memorandums of agreement which I'll get to in just a minute.

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Dr. Terry Maresca: We did have to do some work related to curriculum, and of course there's a national curriculum for certification in family medicine, and

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Dr. Terry Maresca: our choices with this were to start to alter that immediately, to be able to get more experience for our residents at other tribal sites. So it is possible for a program to allow residents to leave the program. It could be up to 2 months, and we chose that. And we actually made. Our residents leave us to be able to get additional experience

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Dr. Terry Maresca: at a different clinic, and it could be again, you know, within a Federal Indian health service or with the tribal organization.

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00:21:39.230 --> 00:22:02.919
Dr. Terry Maresca: We also built in the infrastructure to make sure that they had training in indigenous ways of knowing, particularly in certain aspects of native medicine, because our community was using that would continue to use that had always used that. And we wanted our residents to be familiar with how to collaborate with our medicine people, not just in our clinic, but within our region

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00:22:03.560 --> 00:22:32.480
Dr. Terry Maresca: we had to work on the development of either additional staff or and who was going to be the core faculty doing the clinical training, and this was both inpatient as well as in the outpatient setting, and our choice was to really stay in house none of the people until I got there. No one else had had experience working in medical education before, so that was an interesting piece, but they were experienced clinician who had a strong background in working with native people.

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Dr. Terry Maresca: and we also have to think more about, how are we going to get the word out to students, even though the program wasn't operating yet? How would we do this? So that they would, you know, just to create some interest in our particular program, and we thank the Residency network at University of Washington for some help with that. And some of it was our work in terms of just being present for a different student functions around the State, and also nationally to create some interest.

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00:23:03.760 --> 00:23:17.709
Dr. Terry Maresca: to go back to the issues of funding. I know this is kind of a busy slide. The interesting piece for us was actually the memorandum of agreement with Indian Health Service, and what they chose was to fund their epidemiologist, Dr. Jonathan Sugarman.

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00:23:17.710 --> 00:23:37.209
Dr. Terry Maresca: to be the original site director. I joined them into Year 2 of their once the program started. So he was the original site director and still maintaining his role with epidemiology within our region. And so they funded him on a halftime basis. But the rest of our clinic faculty was funded by our clinic.

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00:23:37.210 --> 00:24:01.170
Dr. Terry Maresca: The other interesting piece was that our residents were initially paid for by us, and that's unusual within the context of graduate medical education. Usually it's the hospital sponsor, that is, who gets the funds from the Federal government is the one who pays the salaries and benefits. That wasn't the case for us. We actually paid the 1st 4 residents salaries, and then the hospital did kick in

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00:24:01.490 --> 00:24:27.529
Dr. Terry Maresca: the rest of the team support for everyone else who was involved in this process was from us, with one exception, for a grant that we were able to get related to faculty, development and curriculum improvements specifically related to traditional Indian medicine, which was a novel issue for not just for Hrsa. But for us

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Dr. Terry Maresca: the program funding today is still split mostly us, but the hospital does cover some of our core faculty people who are doing inpatient as well as our site director, and we Fund. The rest related to our other team, as well as this Residency coordinator working within the Residency, and we no longer have funding through Indian Health Service.

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00:24:50.180 --> 00:24:52.740
Dr. Terry Maresca: The next phase of was Startup.

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Dr. Terry Maresca: and one of the considerations there is the cost of graduate medical education to be able to become accredited as one of the satellites of Providence. And so this is a bit of a paperwork trail, homework assignments for how the system would function, and then, having onsite visits to be able to get the Residency approved.

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00:25:16.090 --> 00:25:31.209
Dr. Terry Maresca: There was some need for faculty training again. Our team were good, solid clinicians, but they were not being a good doctor doesn't mean you're necessarily a good teacher. And so that turned out to be an area that we needed to work with.

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00:25:31.210 --> 00:25:49.340
Dr. Terry Maresca: and a consideration for those who may be thinking about starting residencies. If you don't have a mothership with a larger established program, there's still some need for your faculty to be doing scholarly work, and that is absolutely it's essential, because you have to report on that every year in terms of what people are doing.

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00:25:49.490 --> 00:26:01.339
Dr. Terry Maresca: And of course, you know our residents were being expected to do some work related to health disparity, reduction within our clinic population, so they needed some of that academic skill set to.

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00:26:01.580 --> 00:26:22.809

Dr. Terry Maresca: We needed to work on the onboarding. How would orientation work? That is very different for a new brand new graduate medical student coming into a Residency situation very different than a staff physician onboarding. And what the scheduling would actually look like, because that's a phased in a process. And our system was not used to that.

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00:26:23.610 --> 00:26:42.929
Dr. Terry Maresca: We spent a lot of time, needless to say, on, how are we going to recruit the 1st class? What would this recruitment process look like getting into the match, and to our for better or worse for us. The accreditation happened after the match had already begun, so we had to

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00:26:42.930 --> 00:27:00.179
Dr. Terry Maresca: do some off the record recruitment to be able to get our 1st class of 2 residents, and that was a beautiful word of mouth through multiple organizations which included the University of Minnesota, I might add, in terms of just looking for students who might have an interest in what we had to offer.

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00:27:00.190 --> 00:27:28.460
Dr. Terry Maresca: Some of our recruitment strategy had to do with making sure we were visible to students at the national level because we were interested in non-native students who had the right skill set to work with our population. So we worked with aafp. We worked within our network, of course, within the State. We had outreach to indigenous health organizations, including the Anams, which is the Association of Native American Medical students.

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Dr. Terry Maresca: It required some of us more than others to be out there in terms of giving talks and being present in different community events, with students to talk about our program and what we have to offer.

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00:27:42.860 --> 00:28:11.390
Dr. Terry Maresca: and we had already done our homework in terms of what we thought our unique program strengths were, even though it was an untested program, and we were very clear about what we needed from our applicants what would be highly desired, and that had to do with them, being very family medicine focused in their values, that we thought that they were consistent with that, and that we could provide skills to train them. But we wanted them to be very mission aligned, and to have lived experience among

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00:28:11.390 --> 00:28:28.749
Dr. Terry Maresca: American, Indian or Alaska native people, and secondarily, other underserved communities. They had to show some substantive experience. So it wasn't just. Oh, I think I might want to work with you. It was, show us that you have done so, and what you've done with that. And then does that align with your future goals.

98
00:28:29.810 --> 00:28:59.810
Dr. Terry Maresca: the issue of the maintenance of our program, lots of things to continue to work on. Once residents were there. Tracking turned out to be a really important piece of their experience, not just for us, that we were doing a good job, but also for the requirements of the time,

which had to do with a certain number of patient encounters that a person needed to graduate. We were also interested in tracking what was happening to our graduates. Were they able to meet the Mission, where they sufficiently trained to do the work that we hoped they would do.

99
00:29:00.980 --> 00:29:22.860
Dr. Terry Maresca: We did have to make some team adjustments. Some of that had to do with. We did hire a person on a part time basis to do some extra work with us on behavioral health and substance use disorder. This was a curriculum change that was kind of ahead of its time in the nineties, where chemical dependency training was a part of it, but not in any robust way, and

100
00:29:22.860 --> 00:29:35.910
Dr. Terry Maresca: our team had already decided that that was something that people needed a lot more experience with in terms of behavioral health skill sets. So we brought someone on on a part time basis to be part of our faculty.

101
00:29:36.800 --> 00:29:45.899
Dr. Terry Maresca: Being able to deal with accreditation changes. Since those are happening periodically, you know, every so many years to make sure that we were staying certified.

102
00:29:45.990 --> 00:29:59.900
Dr. Terry Maresca: making alterations in the budget for work, with residents and some opportunities for them to also get additional education and be visible, to be able to continue our recruitment work

103
00:29:59.980 --> 00:30:21.430
Dr. Terry Maresca: and the issues of training needs was turned out to be really important. It's easy when everything's going well. And you've got, you know, great people that are functioning well and within our systems and just human nature and the stresses of the work that we do need to make us aware of the need for some of our trainees to be able to take time off.

104
00:30:21.430 --> 00:30:35.270
Dr. Terry Maresca: And so the issues of expansion, because of personal health or family health issues. And in some we had a few cases of residents actually realizing who they thought, realizing that family medicine wasn't for them, so they had great

105
00:30:35.270 --> 00:30:47.000
Dr. Terry Maresca: skill sets, but many of them chose public health. So we had a few people who who left the program because they were retooling in public health and not direct patient care.

106
00:30:49.710 --> 00:31:07.190
Dr. Terry Maresca: 1997 was our. We had the joy as a true family would, for seeing our 1st 2 residents graduate, and many of you know one of them, Dr. Arne Vagno, who's currently who went to Fond du Lac, and is still in Fond du Lac, and

107
00:31:07.190 --> 00:31:34.940

Dr. Terry Maresca: just so glad for his amazing success with it within the community there, and also Dr. Shannon Wiegand, who has tribal roots in the State of Minnesota, but who had been living in Alaska, and who returned home to Alaska, still working in Fairbanks there. So this is part of our team which also included Carl Encu, who was our medicine person, who was very much a faculty member for our residents.

108
00:31:37.380 --> 00:31:55.169
Dr. Terry Maresca: We've tracked our graduates since the beginning, what they do with their 1st job and what they do afterwards. We've had a total of 54 complete the full program. And in addition to what I just mentioned, about a few residents who did choose to leave the program to pursue another field.

109
00:31:55.290 --> 00:32:17.269
Dr. Terry Maresca: Incidentally, we also had several physicians who were training in pediatrics, and this didn't have anything to do with our Residency. But it was a different collaboration between Children's Hospital in Seattle with the Seattle Indian Health Board. So we sometimes had simultaneous family medicine and pediatric residents with us. But our group of family docs, a total of 54 graduates to date.

110
00:32:17.270 --> 00:32:35.060
Dr. Terry Maresca: and we were quite amazed. Both our non-native and our native residents had very high rates of meeting the mission. They really did go on to work. 50% went on to work in tribal sites. Specifically, there was another 25% who were in rural or underserved settings.

111
00:32:35.060 --> 00:32:36.970
Dr. Terry Maresca: and we also track them

112
00:32:36.970 --> 00:32:59.480
Dr. Terry Maresca: to date. So we know that of our grads, 50% are still within are still meeting the mission. They may not be in the exact same setting, but they are still at sites that are doing that kind of work, and we're really proud of that. I'm proud of them, because it was clear that their vision really did meet the opportunities that we had.

113
00:33:00.070 --> 00:33:19.760
Dr. Terry Maresca: We were surprised at the fact that a lot of our graduates really wanted to stay involved in medical education, particularly indigenous education, but not exclusively so, and so. More than one in 5 of our grads is actually working either within a medical school or as Residency faculty, and that was definitely not on our radar.

114
00:33:19.760 --> 00:33:34.769
Dr. Terry Maresca: I thank University of Minnesota again, one of your graduates, Dr. Eric Brot, is actually a full professor and is working within our region over at Oregon health sciences. And we also have a person who became a medical school admissions team.

115
00:33:34.950 --> 00:33:56.800

Dr. Terry Maresca: The leadership skills that they were coming to us with, and that we hope that they, some of which they had seen modeled within the program, I think, had something to do with the fact that many of them went on to really take on leadership roles within their healthcare systems and sometimes other national organizations. For example, Robert Wood Johnson. We didn't see that coming, either.

116
00:33:57.780 --> 00:34:22.630
Dr. Terry Maresca: There were challenges some of those challenges had to do with the financial sustainability, and despite the best efforts of the original team thinking about projecting costs the 1st couple of years we did not do that, and so there was a lot of some austerity measures. The clinic was really committed to making this program work, and so we were able to cover those support costs. But that was definitely a challenging time.

117
00:34:22.800 --> 00:34:39.530
Dr. Terry Maresca: and some of it had to do with the awareness that the trainees who were seniors when they left us for the 2 months that we asked them to for their time away were clearly not. It wasn't bringing in revenue to the clinic, and that definitely had an impact.

118
00:34:40.065 --> 00:34:51.440
Dr. Terry Maresca: The other awareness is that as much as we love education, it's not always the same thing as as the service mentality. There's 2 different. There's differences there in terms of how operations have to change.

119
00:34:51.560 --> 00:35:09.940
Dr. Terry Maresca: and that had to do with how much time it takes sometimes to supervise trainees. Our nursing team had some turnover, and how to educate them about a young physician. Skill set is different than experienced attending. We had to change some of our processes, for example, how we did prescriptions

120
00:35:09.940 --> 00:35:35.039
Dr. Terry Maresca: in referrals, and we did expect this, but we did have to still deal with patients being distressed that their doctors just weren't available all the time. The clinic team structure had essentially full-time docs. And so the residents were coming in as the only part-time people, and their patients really loved them and wanted to see them, and could not always do so because of the other obligations they had.

121
00:35:36.080 --> 00:36:00.640
Dr. Terry Maresca: There were other challenges. We did have some patient volume variability as an urban clinic. Seattle has a number of people who come to us at our Fqhc. Because they are in transition, and so sometimes the numbers were hard to predict, and it turned out to be the case for obstetric patients, and that's a requirement for our specialty to have a certain number of deliveries.

122
00:36:00.640 --> 00:36:13.970
Dr. Terry Maresca: And so we some of it had to do with some of the payment structure of Medicaid within the State of Washington. So we did have to work through that to make sure that our residents had adequate ob training, which they certainly do. Now.

123
00:36:13.970 --> 00:36:27.789
Dr. Terry Maresca: the data sets for certification. We also had to work to be able to improve that and expand that which is something that the clinic was also not used to. But we were successful with overcoming, that

124
00:36:28.200 --> 00:36:51.729
Dr. Terry Maresca: there were some real challenges in terms of issues of bias in the beginning related to how we were going to select interns. And perhaps that's a discussion point for later. But there was some of the leadership within the hospital system were really looking at students who had high exam scores and perhaps had lots of other honors nationally and regionally, and

125
00:36:51.730 --> 00:37:01.119
Dr. Terry Maresca: and thought that those would be our best choices and our team did not in terms we were again really looking for lived experience, for for

126
00:37:01.120 --> 00:37:10.899
Dr. Terry Maresca: residents working with with underserved communities. And so there was a fair amount of tension that that occurred in the beginning, which ultimately did get worked out.

127
00:37:11.310 --> 00:37:35.980
Dr. Terry Maresca: The hospital had a takeover situation that also changed their mission not necessarily underserved, still nonprofit. And so we had to be able to work with some of the funding changes that occurred associated with this. And then our happy challenge was meeting the community's demand for incorporating traditional medicine within. Within the clinic system which we were able to do.

128
00:37:36.130 --> 00:37:54.750
Dr. Terry Maresca: there were positive outcomes related to revenue. We were also able to improve some of the clinical services that were offered. For example, we started a separate surgical procedure clinic. Normally we'd been doing procedures real time with our residents, but this was a separate

129
00:37:54.900 --> 00:38:16.699
Dr. Terry Maresca: clinic that was open to trainees. That also allowed us more time to be able to do more complex procedures that was seen as a positive. We definitely improved our local recruitment and retention of our doctors, and there were multiple quality of care improvements especially related to chronic disease. For example, asthma management as one of them

130
00:38:16.730 --> 00:38:29.260
Dr. Terry Maresca: that was seen as real positive. This is one of our for our grads. We're out in the field, actually talking about indigenous food and what this looks like, and actually doing some harvesting there.

131

00:38:30.670 --> 00:38:31.480
Dr. Terry Maresca: So

132
00:38:31.550 --> 00:39:01.039
Dr. Terry Maresca: we exceeded our expectations for workforce development, and really stimulated the clinic to expand their thinking, to include as many domains as possible, to offer education within our clinic system for behavioral health, for pharmacy, team members for nurse practitioners, just as some examples. And we were surprised that our program turned out to be kind of a model for how one could combine indigenous medicine with a Western model of care.

133
00:39:01.380 --> 00:39:08.939
Dr. Terry Maresca: These are everyone in this slide is now a graduate, and almost all of them are involved in some degree of medical education.

134
00:39:09.140 --> 00:39:31.130
Dr. Terry Maresca: Remarkable people. So we had a lot of lessons learned. One of them includes. You got to have the right team, and even if it's not large, they need to be mighty, and they need to be risk takers. Because and and with a really strong vision. I think that's what sustained us that we believe really believed in this mission. Despite the initial bumps in the road.

135
00:39:31.190 --> 00:39:43.010
Dr. Terry Maresca: you got to get good strategic partners and having them be politically aware, not just in medicine, but the whole healthcare domain. And what's going on at the local, regional and national level was really important.

136
00:39:43.350 --> 00:39:48.559
Dr. Terry Maresca: Having good data systems for tracking it was is A is a must.

137
00:39:48.720 --> 00:40:12.429
Dr. Terry Maresca: and having some understanding of those people who are, if you're trying to organize the system. You really need to understand medical education financing. And I know our CEO has given us some ideas about how they might want to see this change nationally. For, for example, Hrsa. Health resources and Services administration which does fund different aspects of medical education. They have

138
00:40:12.430 --> 00:40:27.090
Dr. Terry Maresca: fairly low indirect funding rates, that you may not see that if you are working within a university or tribe, because that's allowed to be much higher. But the low rates impacted us because we that was urban programs were not included.

139
00:40:27.090 --> 00:40:43.650
Dr. Terry Maresca: There's also been some discussion about whether or not rather than funds which normally flow to specific entities like Hrsa to be able to then distribute to training sites. Whether or not Congress could do some of that directly, as what we could call an earmark, and I know our CEO is working on that. Politically.

140
00:40:44.070 --> 00:41:02.690
Dr. Terry Maresca: we learned that training programs. We always hope they would benefit patient care quality. The answer is, they do. They have definitely helped recruitment retention and helped us advocate for other policies on a regional and national level. So there have been so, and there have been some of these unexpected benefits as well.

141
00:41:04.140 --> 00:41:31.570
Dr. Terry Maresca: I've listed a couple of resources on 2 slides. This is the 1st one. The 1st article is a journal that's about to be article being published in the summer of this year. That's specifically related to landscapes in native health, and the others are some roadmaps on how to. You know some of the nuts and bolts of the other things to consider. And I'll go to slide number 2 for this for other Residency program

142
00:41:31.880 --> 00:41:34.830
Dr. Terry Maresca: startups. Good advice there.

143
00:41:35.880 --> 00:41:42.370
Dr. Terry Maresca: And with that I'll say, Now, thank you, and I'll turn this back to Dr. Owen and Dr. Nunez for for

144
00:41:42.810 --> 00:41:44.080
Dr. Terry Maresca: further discussion.

145
00:41:46.280 --> 00:41:48.979
Dr. Mary Owen: Big wish, Dr. Maresca, that was fantastic.

146
00:41:49.210 --> 00:42:02.999
Dr. Mary Owen: I will be asking you for copies of your slides, so we can use this as a marker or some training guides for us. We have several questions already from the audience that we'll get to first.st

147
00:42:03.390 --> 00:42:05.000
Dr. Mary Owen: Here, let me see. Here.

148
00:42:05.160 --> 00:42:18.859
Dr. Mary Owen: 1st one is, what do you foresee? The impacts will be on your program with the current Administration's actions, particularly with funding cuts to health service and research grants and rural and underserved population programs like Hrsa. What steps are you taking now to address the possible impacts?

149
00:42:19.220 --> 00:42:20.720
Dr. Mary Owen: You knew that one was coming.

150
00:42:21.220 --> 00:42:21.865
Dr. Terry Maresca: Yeah.

151
00:42:23.040 --> 00:42:36.240
Dr. Terry Maresca: yeah, we have some. We have some concerns. The there's a grant currently going on that's called healthy tribes that funds some of our chronic disease management programs and our our

152
00:42:36.520 --> 00:43:04.210
Dr. Terry Maresca: our CEO and our Vice President are actually actively lobbying Congress. So so they have been really, directly involved. They are flying to DC a lot. They're working with our teams within the State. They're working within within Hrsa, just working at the national level to try to try to make them realize the impact of these programs. There's definitely some concern because we do serve communities where of

153
00:43:04.571 --> 00:43:16.859
Dr. Terry Maresca: again, we're we're an Fqhc, so we're we're open to a lot. We're open to all persons. And and we have programs that are specifically supporting areas that the current administration is not.

154
00:43:16.860 --> 00:43:31.220
Dr. Terry Maresca: has has shown to have some bias against. For example, gender affirming care, and our our clinic is completely committed to this in terms of making sure our team is aware, and having a having direct

155
00:43:31.450 --> 00:43:32.240
Dr. Terry Maresca: oh.

156
00:43:32.790 --> 00:43:50.000
Dr. Terry Maresca: approaches for all of our employees to understand what we're doing. You know what we're doing. This comes up in team meetings all the time with over 250 employees about what we're doing and how to direct those questions, to to keep people, you know, keep people just safe and also continue to advocate. So that's what we're doing.

157
00:43:51.230 --> 00:43:52.660
Dr. Mary Owen: Thank you, Dr. Maresca.

158
00:43:53.450 --> 00:43:59.969
Dr. Mary Owen: I do want to call out before I get to this next question you had at least 4 different people from the University of Minnesota over in your Residency program. There.

159
00:43:59.970 --> 00:44:03.639

Dr. Terry Maresca: And we thank you done the work.

160
00:44:03.640 --> 00:44:04.390
Dr. Mary Owen: More. I just saw.

161
00:44:04.390 --> 00:44:08.399
Dr. Terry Maresca: Set it up, and we took the ball, so.

162
00:44:08.400 --> 00:44:09.519
Ana Nunez MD: Finding the talent right.

163
00:44:09.816 --> 00:44:10.410
Dr. Terry Maresca: That's it.

164
00:44:10.410 --> 00:44:25.110
Ana Nunez MD: I could actually jump in with a couple questions before we get to some of the other questions, because this was really a compelling talk and sort of a lot of things that have came to mind. You mentioned that when you started that there was a medical student curriculum on native health.

165
00:44:25.490 --> 00:44:48.179
Ana Nunez MD: How did that influence or impact? So the curriculum that you've developed in terms of sort of the residents, or did it not? And now that it's been going on for a while. What's that interconnectivity between those like? Was the native health curriculum for the medical students, for everybody, for some people like, how did? How did that all work out? I was curious in terms of the original details, and how it is now, as it evolves.

166
00:44:48.960 --> 00:45:15.990
Dr. Terry Maresca: Honestly. Some of it is relationship, right? At least some of us who are native, working in indigenous health. It's a small community. And this was, this is a mentorship. So the person who started this at University of Washington was my mentor, and so he knew. I already had some expertise, for example, in indigenous plant medicine. And so his idea was, Hey, can you help build my program? And so some of it was a logical cooperation.

167
00:45:15.990 --> 00:45:34.429
Dr. Terry Maresca: you know, and he had connections with graduates that were within the whammy region. I had different connections. I had different experiences because I'd worked for Indian health service and other tribes. He did not, and so some of this was helping each other honestly. So there were students who wanted to come rotate with us.

168
00:45:34.430 --> 00:46:02.970
Dr. Terry Maresca: We were one of the sites. I was one of the specific preceptors related to sort of the indigenous medicine hands on for senior residents. 4th year medical students, I should say so. We were already working with the Index group, and we were also shaping those people who

weren't going into primary care, going into surgery, etc, so that they had some awareness when they were going, leaving the region or staying in the region of the people that they were working with in the domains that they were going to be serving as residents.

169
00:46:02.970 --> 00:46:07.700
Dr. Terry Maresca: So it was a. It was a very mutual curriculum that we had.

170
00:46:08.050 --> 00:46:31.770
Ana Nunez MD: And then I'm going to follow up, because I think that certainly there are a few folks here on this call who absolutely know the answer to this question, but there are many, perhaps, that do not. And so could you give some examples, just one or 2, because there's many in terms of you mentioned about teaching, about collaboration, so far as sort of Western care and working with sort of medicine people.

171
00:46:31.770 --> 00:46:44.290
Ana Nunez MD: Could you give some like real life examples of how that operates. You know, in the clinic, in terms of sort of how folks actually do that, what scenarios in terms of how they deliver that sort of collective care.

172
00:46:45.210 --> 00:47:07.929
Dr. Terry Maresca: So this happens pretty much every day that I'm precepting in clinic. So a resident will come to me with a specific case and part of the discussion in terms of what is the management plan is some of it may include just making sure that they're assessing people's worldviews about is the treatment, even a Western treatment, to begin with.

173
00:47:08.140 --> 00:47:28.740
Dr. Terry Maresca: And so and if the answer is not, it's like, is that person interested in plant medicine? Would that person be interested in working with our traditional medicine team? In other words, are we going to make a referral? And we currently have a structure where our residents are embedded in pods that has a traditional medicine person or an apprentice in the pod.

174
00:47:28.740 --> 00:47:41.319
Dr. Terry Maresca: so they can ask that person to come in. So someone who might be very traumatized. We may not see them right away. We may have the Traditional Medicine Person come in the room and work with them 1st before our young doctor goes in the room.

175
00:47:41.320 --> 00:47:50.880
Dr. Terry Maresca: So we're building the plan together, you know, and that may still involve whatever a behavioral health referral. But it may also involve traditional medicine referral. It may involve

176
00:47:50.880 --> 00:48:13.949
Dr. Terry Maresca: our resident who has some training in. I've helped the team develop a herbal formulary, so they know it's like, Oh, well, Terry, I, this person wants, you know, something to be able to support stress. It's like, Well, do you remember what's on our formulary? So so it's this

collaboration with the pharmacy team, with the traditional medicine team. That's real time. So this isn't like an abstract, you know. Lecture, it's it's real time training.

177
00:48:14.180 --> 00:48:26.639
Ana Nunez MD: And whomever sort of then, you know, on boards, or meets the patient at the get-go. I guess that sounds like a really important person to help in the triage about sort of where they start in that process.

178
00:48:27.664 --> 00:48:38.340
Dr. Terry Maresca: It might be, but sometimes, you know, it's sometimes it's our residents who are actually figuring out like, you know, Terry, I think this is a deeper issue, you know, and I'm wondering if they you know. You know I I

179
00:48:38.590 --> 00:49:08.039
Dr. Terry Maresca: mentioning this, you know the opportunity to be able to have a separate visit. That's not in the 4 clinic walls. They could go meet in a different area. They could meet in the clinic. If that's what the patient's preference is. So sometimes it's really the residents, the one who figures it out. It's not being triaged in advance. They understand real time that this is a sensitive area, that this is maybe a highly traumatized person and needs some special Tlc. And may need to visit with an elder.

180
00:49:08.787 --> 00:49:10.160
Ana Nunez MD: Great, very cool.

181
00:49:10.940 --> 00:49:11.720
Dr. Mary Owen: So no

182
00:49:12.480 --> 00:49:23.299
Dr. Mary Owen: one of the reasons we invited you out here, as you know, because I've talked to you about this for years now is that we need a residency out here. Clearly, I mean, all of our residents are going out to Seattle. That's a problem we can.

183
00:49:23.300 --> 00:49:24.500
Dr. Terry Maresca: Not all of them.

184
00:49:25.310 --> 00:49:50.010
Dr. Mary Owen: So. Yeah, not all of us right. Some of us stay here. Did you ever receive? This is a question from the audience. Did you ever see pushback? You've already answered some of this, like from the hospital, but pushback and establishing this program from administration clinicians, patient population, very important, and if so, how do you address them? Can you think of some of the challenges you said the hospital, and choosing your residents, but anything else, particularly from the population, I think, is important.

185
00:49:50.902 --> 00:49:52.559

Dr. Terry Maresca: I think there.

186
00:49:53.570 --> 00:50:08.759
Dr. Terry Maresca: I think some of the pushback was was, in fact, patients who really wanted, perhaps, to see an indigenous clinician, and we have a mixed group of people. That is the nature of the work. There's not enough.

187
00:50:09.020 --> 00:50:33.939
Dr. Terry Maresca: Even if I could wave a magic wand, you know, just. There's not enough of us. And that isn't to say that there are other humans who have lived experience and an open heart and mind to be able to be flexible and do the work. And the answer is, they did. But some of our patients really wanted to see someone who literally may really look like them who really had especially some of our folks coming from reservation or rural communities that were more used to

188
00:50:33.940 --> 00:50:42.870
Dr. Terry Maresca: in terms of some of the cultural nuances. And so I think there was a little bit of pushback with that with with our patient population

189
00:50:42.870 --> 00:51:11.730
Dr. Terry Maresca: from an administrative standpoint. Again, some of it was understanding the lived experience of some of our residents of color in terms of just some of the barriers that they faced. And so again, some of them were not coming in with, you know, all kinds of other different awards, but they had real lived experience dealing with adversity and and diversity. And we're bringing tremendous strengths to the program. And that's what we were able to emphasize and prove that they could be successful within our setting.

190
00:51:13.510 --> 00:51:14.360
Dr. Mary Owen: Thank you

191
00:51:14.590 --> 00:51:23.620
Dr. Mary Owen: if you had. This is what somebody sent this in ahead of time, and it's appropriate a great great question. If you had to start a program again. Now, what might you change in the process?

192
00:51:23.800 --> 00:51:26.890
Dr. Terry Maresca: Hmm, so

193
00:51:28.120 --> 00:51:43.799
Dr. Terry Maresca: I wasn't there again for the some of the initial, you know. Financial conversations. So some of it is really, you know. Very. I wish we had gotten some better, more advice or or thought of worst case scenarios earlier on, you know, for some of our funding, because this wasn't to get, you know.

194
00:51:43.800 --> 00:52:08.680

Dr. Terry Maresca: people. You assume that. Oh, if you get a grant, it's going to be forever. Well, we know that that isn't true, and we weren't grant dependent in that respect other than for the curriculum, the changes that we were making. But I don't think I think we were seeing the sunnier side rather than what could happen as a downside if some of those funding sources got lost. So I think we needed. We needed more work there. I think we needed to bring some of our data team on board

195
00:52:08.680 --> 00:52:28.599
Dr. Terry Maresca: quicker, because they were definitely, not clinically trained. And so some of the data sets we needed from them. Remember, we were also dealing with the paper chart era. So this was a very different scenario in the nineties. They were quite stunned by what we needed, because they had no infrastructure for that. So I wish we had done that.

196
00:52:28.600 --> 00:52:38.100
Dr. Terry Maresca: I wish we had done some bias training sooner with the team at the hospital in terms of, you know, just looking at our recruitment process. So it would.

197
00:52:38.450 --> 00:52:50.500
Dr. Terry Maresca: It would have it would have lasted. It would have been a shorter time, I think of of that discussion rather than a longer process over years for them to understand what we were looking for. I think

198
00:52:51.540 --> 00:52:54.469
Dr. Terry Maresca: I think we I I

199
00:52:54.800 --> 00:53:20.839
Dr. Terry Maresca: now that's a requirement for family medicine. But we didn't. Although we had a board, we didn't really have a patient advisory group, and I know that was something that I wanted. But that was something that didn't happen, and I really wish that that would have happened sooner in terms of some of the curricular changes and support for our program. Now, that's a requirement for family medicine is to have, you know, have users be part part of that decision process.

200
00:53:22.370 --> 00:53:30.759
Dr. Mary Owen: Thank you. Your comment about being aware of the downside makes me think of one you mentioned in there that you get that you

201
00:53:30.930 --> 00:53:43.280
Dr. Mary Owen: paid your residents for the 1st 2 years. That sounds like quite a gamble like you were quite. You were very confident that this would succeed if you were able to jump in and pay because you didn't know when the end might come where you didn't have to pay them.

202
00:53:43.530 --> 00:53:55.349
Dr. Terry Maresca: No, and that's what I mean. It's just like, you know the the. It was a small Admin team. It was a small governing board, and they when when they saw the numbers not being so successful, I actually looked at

203
00:53:55.350 --> 00:54:20.210
Dr. Terry Maresca: some of the notes were again the beautiful little handwritten notes that were in a part of that era, and some of it was skimpy. But you could see the worry, you know, in those notes, you know, for, oh, you know, behind the scenes what are we going to cut back on? Or how could some of this work be attached to some of the small grant funding that we have like. We hadn't thought of that. But maybe some of Terry's time is going to go to this, and that's going to fund her or her work.

204
00:54:20.210 --> 00:54:25.499
Dr. Terry Maresca: So they it really got granular. Yeah, but they were scrappy.

205
00:54:25.650 --> 00:54:29.830
Dr. Terry Maresca: They they meant business. And that's what I mean. You gotta really. You know they they

206
00:54:30.000 --> 00:54:34.820
Dr. Terry Maresca: they put all their cards out and said, We're gonna do it, you know. It was no, they weren't going back.

207
00:54:35.430 --> 00:54:38.810
Dr. Mary Owen: It sounds like a book in the making.

208
00:54:39.190 --> 00:55:01.880
Ana Nunez MD: One other question I have, and this has to do with the scalability of the healthcare needs in terms of tribal communities which is large, and the workforce, which is still unfortunately stagnant, if not tiny. What are some of the lessons learned from your perspective about training non-indigenous trainees just in terms of addressing some of those needs for sort of the healthcare community.

209
00:55:03.170 --> 00:55:13.730
Dr. Terry Maresca: That was one of the areas of bias, you know, within our system, too, you know, with some some of our team thinking like, wow! You know, our ideal would be a hundred percent, you know, native cohort of residents.

210
00:55:13.810 --> 00:55:42.410
Dr. Terry Maresca: And I know that was part of my discussions like, I don't think that that's going to. You know, I don't think that that's going to happen. And we're using Indian health services experience with this. So look who is fun, you know, who is staffing the whole of Indian health services, at least in terms of the physician cohort. It's mostly non-native people, and so our job is to do a good job with all of them. They're going to be safe for everyone, and that's our curriculum is making sure that that

211
00:55:42.410 --> 00:55:49.870

Dr. Terry Maresca: so I think that was the that was the message that. And and we needed the data to prove that those

212
00:55:49.960 --> 00:56:10.689
Dr. Terry Maresca: residents could be successful. And and it was quite clear from from our user population that the patients who wanted to see a native person were able to do so, the ones that were open to someone who was not, but who was an open caring person who was humble and willing to get support.

213
00:56:10.690 --> 00:56:31.089
Dr. Terry Maresca: You know they were successful, and so I think that the group was reassured over time that the trajectory was similar, and that those people still had the same access to the traditional medicine people. They still had the support of a diverse faculty to support them.

214
00:56:31.910 --> 00:56:53.389
Dr. Terry Maresca: and seeing us as native people in the room with non-native residents, I think, was also reassuring to our relatives to say, oh, they don't know, but they're not pretending. They don't know they're bringing in somebody who really does have more experience, and I'm reassured by that, you know. So, rather than feeling that there was no conversation.

215
00:56:53.560 --> 00:56:54.200
Dr. Terry Maresca: there was.

216
00:56:54.200 --> 00:57:02.900
Ana Nunez MD: So vouching endorsement and doing it as a team in terms of sort of raising the bar for sort of the type of the level of expert care that they're going to get.

217
00:57:04.300 --> 00:57:08.040
Dr. Mary Owen: Dr. Nunez. I'd like to end, if possible, with this last question. I think.

218
00:57:08.040 --> 00:57:10.339
Ana Nunez MD: Gotcha, go ahead. We have 1 1 min, so.

219
00:57:10.340 --> 00:57:21.669
Dr. Mary Owen: It combines. I'm going to combine them. What recommendations do you have for medical schools when it comes to addressing native health? And what can medical schools across country do to contribute to expanding the primary workforce in Indian country? I know that's a lot, but.

220
00:57:21.670 --> 00:57:22.120
Dr. Terry Maresca: Just give me.

221
00:57:22.250 --> 00:57:25.870

Dr. Mary Owen: Gestalt, tying it back to us.

222
00:57:28.265 --> 00:57:30.449
Dr. Terry Maresca: If you're if you're

223
00:57:30.550 --> 00:57:47.830
Dr. Terry Maresca: does this? Does the school have a Tribal Advisory Board? I know University of Washington does so, you know. So we have. We have tribal liaison specifically, who are working with our elected tribal officials. What is your perception of need? Because you are living within those communities.

224
00:57:47.830 --> 00:58:01.270
Dr. Terry Maresca: So, taking their advice, I think, has been really essential working in partnership for the advocacy that may need to happen again at the local or state or national level to change some of the

225
00:58:01.270 --> 00:58:18.945
Dr. Terry Maresca: policies and and funding mechanisms. For, you know, for medical education, for example, this Fqh, the indirect costs, for example, or how funding actually occurs advocating for within within our institutions for to support

226
00:58:19.630 --> 00:58:47.609
Dr. Terry Maresca: continued funding for some of the for some of the programs that that we have within our communities, you know, as dictated by us. So, for example, like the healthy, healthy tribes, you know, Grant, also supporting work that's being done by people such as yourself, Mary, with, you know, with aims and with, you know, with Iheart. And you know, collaborations to to try to keep an indigenous workforce going national on a national basis.

227
00:58:49.060 --> 00:59:15.480
Ana Nunez MD: Thank you so much. We're unfortunately out of time. We could probably talk to you for another couple of hours here, because it's just great stuff, kudos to you in terms of doing such wonderful work, and you know and thank you for joining us. It's been really wonderful sort of hearing from you. We're running out of time. So I'm going to sort of say, thank you. Turn it over to Matt to close us out. Please everybody fill out your evaluations. Let us know in terms of topics, Matt, off to you.

228
00:59:15.670 --> 00:59:25.329
Dean's Lecture Series: Yeah, thanks. And thank you so much, Dr. Maresca and Dr. Owen, for being here. So appreciate having your your experiences and expertise here and and sharing that with with our with our community.

229
00:59:25.575 --> 00:59:46.689
Dean's Lecture Series: For those of you are participating here today, a 1 question survey will appear in your Web Browser, immediately after ending the Zoom session. Please take the time to complete the survey, to inform us of future future topics, and reminder that this session was

recorded, and will be shared within 2 days to all of those who registered for the event, and otherwise the recording can be found under the education and training tab of the Odei website. Be well and take good care. Everyone.

230
00:59:48.670 --> 00:59:54.000
Ana Nunez MD: Thanks, Dr. Owen, thanks, Dr. Moresco. Appreciate your time and sort of having this conversation.

231
00:59:54.180 --> 00:59:55.440
Dr. Terry Maresca: You're welcome. Thank you.

232
00:59:55.800 --> 00:59:56.960
Dr. Mary Owen: Thanks. Terry.

233
00:59:56.960 --> 00:59:58.480
Ana Nunez MD: Happy Spring, Happy Spring.

234
00:59:58.920 --> 01:00:00.000
Dean's Lecture Series: Indeed, bye-bye.