How would you rate the following? (Place a check mark in the appropriate column.)

Poor	Fair	Average	Good	Excellent
1	2	3	4	5

	1	2	3	4	5
1. Your ability in managing the street homeless population's medical needs					
2. Your ability in managing the street homeless population's social and behavioral needs					
3. Support material including articles, orientation material, and resources					
4. Your learning experience					
5. Effectiveness of the street medicine fellowship program in your future career					

Comments:

_____

_____

_____

FIGURE
Post-Street Medicine Fellowship Evaluation Form

Although our program is young, our graduates have affirmed that formal fellowship training in street medicine is a viable yet heretofore unexplored avenue toward more effectively addressing society's responsibility toward PEUH.

References

1. American Medical Association. Homeless health care, ending homelessness are matters of justice. Published November 18, 2021. Accessed March 14, 2023. https://www.ama-assn.org/delivering-care/ethics/homeless-health-care-ending-homelessness-are-matters-justice
2. Withers J. Street medicine: an example of reality-based health care. *J Health Care Poor Underserved*. 2011;22(1):1-4. doi:10.1353/hpu.2011.0025
3. Kushel MB, Vittinghoff E, Haas JS. Factors associated with the health care utilization of person experiencing unsheltered homelessness (PEUH)s. *JAMA*. 2001;285(2):200-206. doi:10.1001/jama.285.2.200

Mehrshid Kiazand, MD, FACP
Clinical Associate Professor of Medicine, Associate Director, Internal Medicine Residency, Director of Ambulatory Medicine, Diplomate in Obesity Medicine, UPMC Mercy

A. J. Pinevich, MD, MBA
Vice President of Medical Affairs, UPMC Mercy

James S. Withers, MD, FACP
Clinical Assistant Professor, University of Pittsburgh School of Medicine
UPMC Mercy Street Medicine Fellowship Director
Medical Director, Pittsburgh Mercy's Operation Safety Net
Medical Director and Board Member, Street Medicine Institute

Corresponding author: Mehrshid Kiazand, MD, FACP, UPMC Mercy, kiazandm2@upmc.edu, Twitter @MKiaMD

NEW IDEAS

A Health Equity Fellowship Based in Experiential Learning Through a Rural Academic-Community Partnership

Setting and Problem

While rural communities continue to experience significant health disparities, investment in graduate

DOI: http://dx.doi.org/10.4300/JGME-D-22-00764.1

medical education (GME) focused on rural health remains uneven.[1] Investing in rural GME could allow early-career physicians to address health disparities by providing leadership training and mentored experience generating systems change. Leadership skills and systems change are especially important when physicians work in communities they are not from. There is a steep learning curve to understanding a community's priorities, governance structures, and building their trust. Despite best intentions, unprepared physicians may fail to make lasting beneficial change for the community, and communities risk losing physicians to burnout and turnover.

Intervention

The Massachusetts General Hospital Fellowship Program in Rural Health Leadership teaches skills in leadership and health systems change to early-career primary care physicians through a rural-based experiential learning model based on Kolb's Learning Styles Inventory.[2] Fellows develop attitudes, knowledge, and skills in leadership and health equity by moving through 4 stages of learning: (1) experiencing and reflecting on the rural experience; (2) acquiring new knowledge and concepts; (3) practicing new ideas through discussion; and (4) taking action and learning from the result.

Fellows spend a quarter per year of the 2-year program at the rural community partner site in Rosebud, South Dakota, working clinically as independent attending-level physicians. Rosebud is the home of the Sicangu Lakota Oyate and Indian Health Service Rosebud Service Unit and has long experienced some of the worst health outcomes in the country due to sustained historical, systemic, and infrastructure challenges. As the Rosebud community experiences many of the same challenges facing rural communities across the United States, fellows learn skills in leadership and health equity that can be translated in their future careers to other sites with challenged infrastructure.

Faculty support is provided by a network of academic teaching physicians experienced in rural health through a combination of asynchronous/synchronous and remote/on-site forums, including weekly meetings where difficult clinical cases and systems improvement work is discussed, a de-identified encrypted group chat, monthly discussion exchanges with other global and rural fellowships, weekly fellow seminars, and shared reading lists. These teaching interactions provide fellows with new concepts to apply to their experiences, as well as opportunities to articulate their reflections and test their new ideas through discussion.

A key aspect of the fellowship is the completion of a mentored capstone project in any aspect of systems change—research, policy, advocacy, quality improvement, or education are a few examples. Focused mentorship and a program-funded Master of Public Health are pillars of the capstone project support. These capstone projects allow fellows to apply their lessons learned to new practice and to observe the results.

The key values of the program are imbued in the structure of experiential learning and are seen in the fellows' activities during the program and beyond (TABLE).

Outcomes to Date

In a 2021 GME survey of fellows, the clinical breadth and intense experiential learning in clinical and

TABLE
Examples of Fellowship Project Activities in 5 Leadership Domains

Fellowship Project Activity	Clinical	Policy/ Advocacy	Education	Quality Improvement	Research
HCV micro-elimination pilot	X	X		X	
First medications for opioid use disorder treatment program in the regional IHS	X				
Initiating a gender-affirming care program	X			X	
Updated policies and strengthened procedures on controlled substances prescribing		X		X	
Just-in-time COVID-19 education series			X		
Settler colonialism curriculum		X	X		
An ethical framework for crisis standards of care		X			
Improved coordination of care for people facing incarceration	X			X	
Qualitative study on the impact of rural health experiences on academic physicians				X	X
Continuing education lecture series for rural HCPs			X		

Abbreviations: HCV, Hepatitis C virus; IHS, Indian Health Service; HCPs, health care professionals.
Note: Projects were completed in partnership with the community site.

leadership roles was consistently named as a major strength of the program.

Successful graduates from the program should be prepared to move directly into a leadership position in rural and community health. Since the first fellowship class graduated in 2017, the fellowship has produced 7 graduates. Since graduation, fellows have gone on to positions in medical education leadership, policy, and leading innovative clinical programs with rural and underserved populations.

References

1. Committee on the Governance and Financing of Graduate Medical Education; Board on Health Care Services; Institute of Medicine. *Graduate Medical Education That Meets the Nation's Health Needs*. Eden J, Berwick D, Wilensky G, eds. Washington (DC): National Academies Press (US); 2014.
2. Armstrong E, Parsa-Parsi R. How can physicians' learning styles drive educational planning? *Acad Med*. 2005;80(7):680-684. doi:10.1097/00001888-200507000-00013

Stephanie W. Sun, MD, MS, MPH
Director, Rural Health Leadership Fellowship, Massachusetts General Hospital
Instructor in Medicine, Harvard Medical School

Aislinn O'Keefe, MBA
Program Manager, Rural Medicine Program, Massachusetts General Hospital

Matthew Tobey, MD, MPH
Director, Rural Medicine Program, Massachusetts General Hospital
Assistant Professor, Harvard Medical School

Corresponding author: Stephanie W. Sun, MD, MS, MPH, Massachusetts General Hospital, swsun@mgh.harvard.edu

NEW IDEAS

Facilitated Peer Mentorship for Women Internal Medicine Residents: An Early Intervention to Address Gender Disparities

Setting and Problem

A gender gap persists in academic medicine, most clearly demonstrated in disparities in advancement in rank and leadership roles. Though the number of women entering medicine has been steadily rising for decades, the number of women in prominent positions such as medical school deans, full professors, and department chairs remains low.[1] One potential solution to address this continued gender disparity has been intentional mentorship and sponsorship for women trainees and junior faculty.

Past literature has suggested that newer mentorship models, unique from the traditional mentorship dyad, may be more effective for women.[2] Multiple mentoring or peer mentorship models allow for increased collaboration and can foster a sense of community. We hypothesized that facilitated peer mentorship (pairing multiple mentees with senior group facilitators) may benefit residents by fostering community building and collaboration with their peers, in addition to receiving guidance and mentorship from senior faculty. Additionally, this mentorship model allows for flexibility in terms of time commitment and engagement at different times in the academic year, which may align well with resident schedules. While successful use of these novel mentorship models has been previously described for women faculty,[3] there is a paucity of literature about their use at the resident level.

Intervention

We developed a faculty-facilitated peer mentorship program for the women residents in our internal medicine residency program and women faculty volunteers from our department's Clinical Excellence Society (which recognizes well-established, respected clinicians in our department). We recognize the nonbinary nature of gender identity; for the purpose of this program, all residents identifying with she/her pronouns were invited to participate. Groups of 4 to 5 residents (categorical, primary care, medicine-pediatrics, and transitional) were paired with 2 faculty facilitators. Resident groups were intentionally composed of individuals in differing years of training (postgraduate year [PGY]-1 to PGY-4). Residents were paired with at least one faculty

DOI: http://dx.doi.org/10.4300/JGME-D-22-00765.1