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# Empowering Learners with Patient Advocacy Tools to Promote Health Equity in Clinical Practice

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# Introductions

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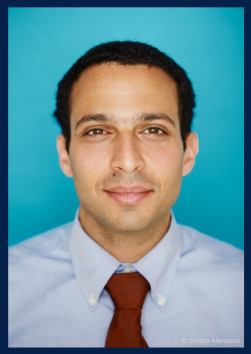

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**Audience**: Intros & How do you define patient advocacy and why is it important to you?

# Disclosures

No conflicts on interest

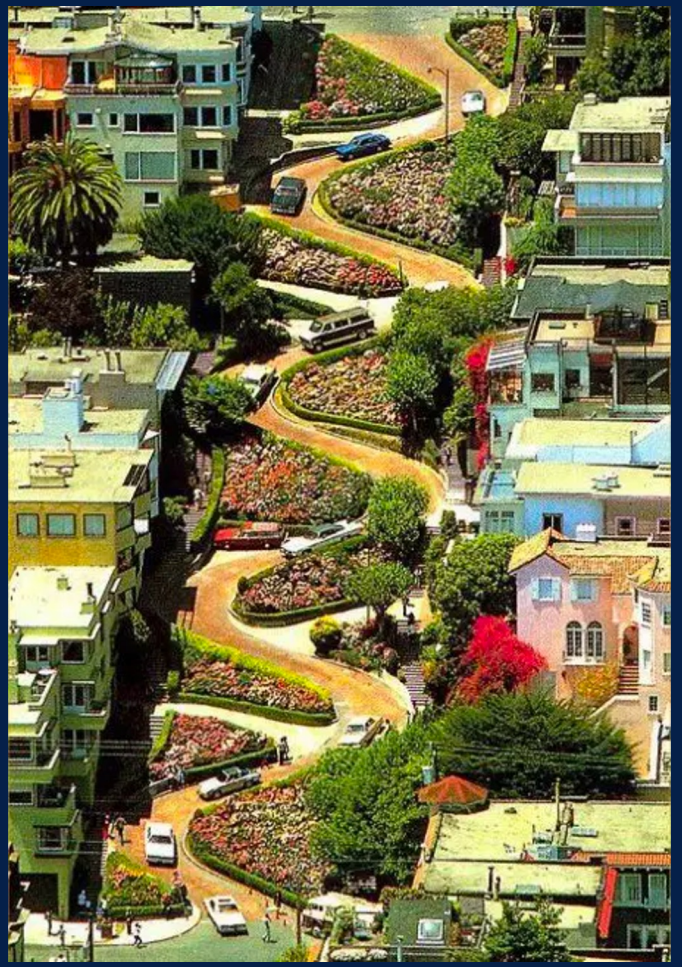
# Learning Objectives

At the end of this workshop, you will be able to:

- 1. **List** educational and practice-based skills that trainees can apply within clinical rotations to practice patient advocacy and promote health equity
- 2. **Consider** how to incorporate patient advocacy skills into student assessments.
- 3. **Brainstorm** ideas about how similar skills or curricula for trainees can be implemented at or adapted to your current institution.
- 4. **Anticipate** barriers to implementing change and brainstorm ways to overcome these.

# Roadmap

- Defining patient advocacy
- Educational methods for teaching patient-level advocacy
- Breakout #1: Ideas for adapting for your clinical setting
- Breakout #2: Anticipated challenges and solutions
- Wrap-up



# What does advocacy mean?

*Advocacy*: the act or process of supporting a cause or proposal; the act or process of advocating for something

*Patient* advocacy

•The process of supportive actions to help a patient within the context of their unique determinants of health, with the goal of reducing health/healthcare inequities

# Some educational methods to teach patient-level advocacy

- Diagnostic equity and social risk
- Inpatient advocacy skills and a “health equity bundle”
- Patient narrative project and reflection
- Patient advocacy assessment
- Advocacy beyond the individual patient level

# Background - Diagnostic Equity


- **Patient advocacy includes diagnostic equity:**
  - Providing timely and correct diagnoses
  - Correcting prior incorrect diagnoses
  - Communicating diagnoses effectively
- Diagnostic errors **occur more often** in non-white patients, women, people without English proficiency and people with mental health and substance use comorbidities.
- Although most **medical education on the diagnostic process occurs during diagnostic reasoning conferences**, we rarely use those as opportunities to discuss bias, oppression and health equity.

# "Situated cognition theory"

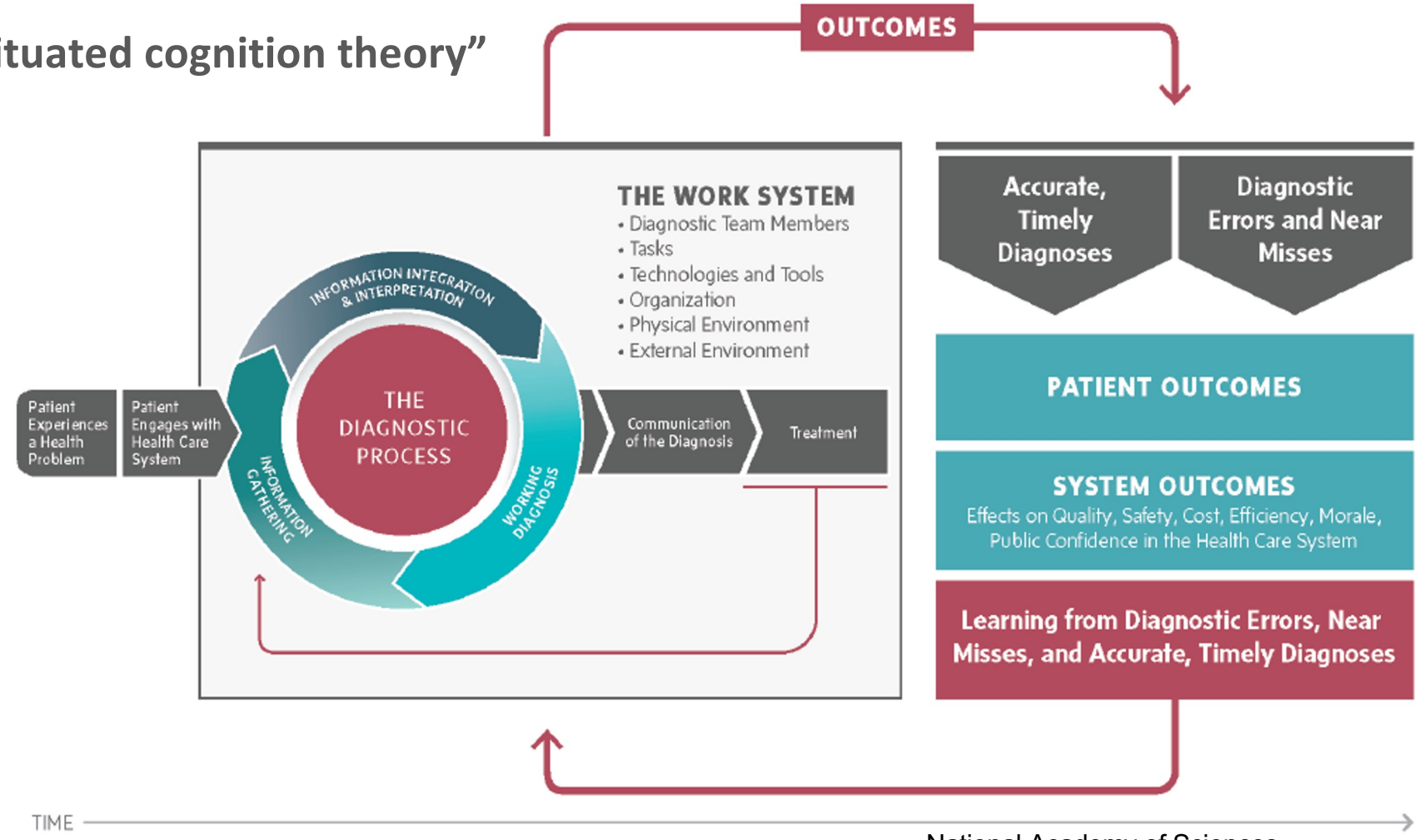



FIGURE S-3 The outcomes from the diagnostic process.

National Academy of Sciences, Improving Diagnosis in Healthcare, 2015

# Routine Evaluation of Social Risk in Diagnosis

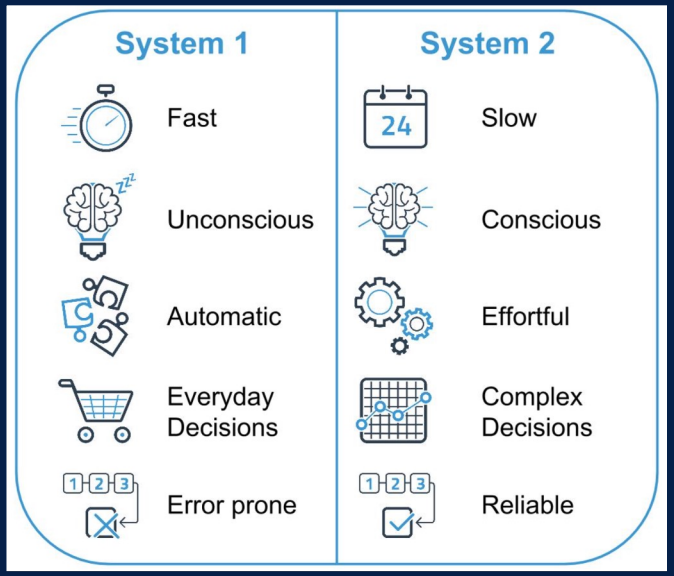
Funded by UCSF Academy of Medical Educator Innovation Grant with Sumant Ranji

1. **Identify a case for case report presentation**. Through chart review or personal history taking, identify any of the patient's potential social risk factors.
2. **Consider how the presence of identified social risk factors and the ways that biases might influence the diagnostic process in this case**. During the conference, initiate a diagnostic pause to solicit group feedback on this question.

# Routine Evaluation of Social Risk in Diagnosis

3. Review these evidence based approaches for **Bias Recognition and Management** and describe how you might practice one or more in this case.

- Enhance motivation to recognize biases
- Individuation and perspective taking
- Promoting positive emotions

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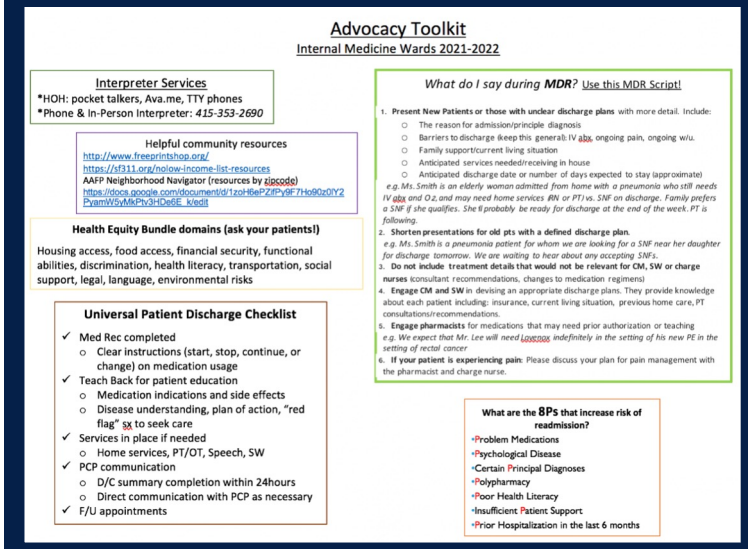
# An inpatient medicine clerkship curriculum: Strategies from Advocacy in Action



Advocacy Toolkit

Internal Medicine Wards 2021-2022

Interpreter Services

*HOH: pocket talkers, Ava.me, TTY phones

*Phone & In-Person Interpreter: *415-353-2690*

Helpful community resources

http://www.freeprintshop.org/

https://sf311.org/nolow-income-list-resources

AAFP Neighborhood Navigator (resources by zipcode)

https://docs.google.com/document/d/1zoH6ePZfPy9F7Ho90z0IY2PyamW5yMkPtv3HDe6E_k/edit

**Health Equity Bundle domains (ask your patients!)**

Housing access, food access, financial security, functional abilities, discrimination, health literacy, transportation, social support, legal, language, environmental risks

**Universal Patient Discharge Checklist**

- ✓ Med Rec completed
  - Clear instructions (start, stop, continue, or change) on medication usage
- ✓ Teach Back for patient education
  - Medication indications and side effects
  - Disease understanding, plan of action, "red flag" sx to seek care
- ✓ Services in place if needed
  - Home services, PT/OT, Speech, SW
- ✓ PCP communication
  - D/C summary completion within 24hours
  - Direct communication with PCP as necessary
- ✓ F/U appointments

*What do I say during **MDR**?* Use this MDR Script!

1. **Present New Patients or those with unclear discharge plans** with more detail. Include:
   - The reason for admission/principle diagnosis
   - Barriers to discharge ikeep this generali IV abx, ongoing pain, ongoing w/u.
   - Family support/current living situation
   - Anticipated services needed/receiving in house
   - Anticipated discharge date or number of days expected to stay (approximate)

   *e.g. Ms. Smith is an elderly woman admitted from home with a pneumonia who still needs IV abx and O2, and may need home services @N or PT/os. SNF on discharge. Family prefers a SNF if she qualifies. She ll probably be ready for discharge at the end of the week. PT is following.*
2. **Shorten presentations for old pts with a defined discharge plan.**
   *e.g. Ms. Smith is a pneumonia patient for whom we are looking for a SNF near her daughter for discharge tomorrow. We are waiting to hear about any accepting SNFs.*
3. **Do not include treatment details that would not be relevant for CM, SW or charge nurses** (consultant recommendations, changes to medication regimens)
4. **Engage CM and SW** in devising an appropriate discharge plans. They provide knowledge about each patient including: insurance, current living situation, previous home care, PT consultations/recommendations.
5. **Engage pharmacists** for medications that may need prior authorization or teaching
   *e.g. We expect that Mr. Lee will need Lovenox indefinitely in the setting of his new PE in the setting of rectal cancer*
6. **If your patient is experiencing pain:** Please discuss your plan for pain management with the pharmacist and charge nurse.

**What are the 8Ps that increase risk of readmission?**

- Problem Medications
- Psychological Disease
- Certain Principal Diagnoses
- Polypharmacy
- Poor Health Literacy
- Insufficient Patient Support
- Prior Hospitalization in the last 6 months

- Experiential curriculum:
  - Bridging gap between pre-clinical knowledge of SDH and direct patient care
  - **Workshop**:
    - Inpatient-specific strategies and resources
    - Frameworks for applying advocacy skills
    - Students tasked to apply these skills for patient encounters
  - **Debrief + reflection**:
    - Large group share and written reflections

Curricular components of the AiA curriculum.

| Curricular Component | Activities |
|---|---|
| 1) Introductory workshop | • Faculty-led introductory workshop reviewing social determinants of health and their impact on patient care<br>• Role-playing about how to ask patients questions related to SDH<br>• Review of an "advocacy toolkit" with resources and tools to help practice individual advocacy during hospitalization and at time of vulnerable transitions, such as discharge<br>• Meeting with social workers and case managers to discuss roles and responsibilities in patient advocacy |
| 2) Direct Patient Advocacy | • Students use the skills they obtained from the introductory workshop to advocate for their patients<br>• Students perform a post-discharge patient follow-up phone call to assess how they are and determine if there were any barriers to care that arose |
| 3) Active Reflection | • Students complete a written reflection focusing on successes, challenges, and lessons learned from the activity |
| 4) Debriefing workshop | • Faculty-led to facilitate reflection of student experiences<br>• Peer-to-peer sharing of challenges and successes<br>• Large group sharing of advocacy resources discovered during the rotation<br>• Large group brainstorm about the role of patient advocacy in their future careers |

## # Health Equity Bundle

- Use of a "bundle" at end of A+P to ask and store information related to SDoH domains and ensure a space for discussion/planning

### When to Consult Case Management:

Case Managers are Registered Nurses who are here to help you with utilization of resources and discharge planning! Consult with your Case Manager for:

- Assessment of prior living situation, services, and DME
- Discharge planning assistance
- Referrals to post-acute facilities (including SNF, Acute Rehab, LTAC)
- Coordination of home health services (RN, PT, OT, Speech, Social Work and Home Health Aide)
- Hospice referrals, including assistance with goals of care, referrals to home hospice or SNF with hospice services
- Repatriation or transfer to an outside hospital
- Medical transport (Ambulance, wheelchair van, etc.)
- Insurance questions (authorizations, resources, etc.)
- Admissions criteria/requirements (observation status, continued level of care, etc.)

### WHEN TO CONSULT SOCIAL WORK....

- Psychosocial Assessments (e.g. addressing discharge needs/barriers, advanced medical therapies, transplantation, or vulnerable/high risk patients)
- Counseling Services (e.g. adjustment to illness, new diagnosis, grief/loss issues, depression/anxiety)
- Abuse/Domestic Violence
- Hospice/End of Life
- Patient/Family Meetings (e.g. addressing goals of care, dealing with complex family dynamics)
- Substance Abuse (e.g. assessment, treatment planning)
- Linkage to Community Resources (e.g. support groups, mental health follow-up, lodging, transportation, assisted living)
- Behavioral/Non-Adherence Issues/AMA Risk
- Advance Directives
- Psychiatric Placements (inpatient only)
- Conservatorship/Guardianship
- Financial/Insurance (e.g. disability benefits/entitlements)
- Linkage to Hospital Resources (e.g. hospital-based support groups, Volunteer Services)

*Please call or page your service line social worker directly or call the Department of Case Management/Social Work office at (415) 353-1504 if you need assistance.*

# *Student reflections on advocacy and patient care*

"It was not until I spoke with his partner that I was able to elicit the constant tension between the partner's management of the patient's health needs and the patient's tendency to ignore them completely. In the future, I aim to always seek collateral information about patients with functional limitations, historical challenges with medications, etc…"

"I learned to communicate with team members such as social workers, in finding the best possible resources for our patients. While these services are not available at every hospital, I know have knowledge about community resources available for my future patients and can contact them on my own."

"[The patient] taught me a lot about the conditions in SROs (single room occupancies). It is easy to assume that any housing is better than no housing, but I learned that people can feel even more unsafe in a building than they do outside. [The patient] experienced sexual violence in her SRO and genuinely fears the drug-related activity that occurs in her hallways."

"I learned…the joy it brought me knowing that I could be a source of help to my patients in times of difficulty. I believe … we need to understand our patient's backgrounds and what barriers to care they face so that we can give them the most comprehensive and competent care. Learning more about my patients, who they are and what is important to them, is something I do plan on incorporating into my clinical practice."

"The most important skill I've learned through this curriculum and through this rotation generally is the tremendous gift we can give of time, attention, and listening. There was little I could do to fix the underlying problems, but I could create space by listening attentively."

# Patient narrative project and advocacy

Firsthand hear from patients

Patient voice in EMR


**Reduce Bias?**

1. Common identity
2. Other perspectives
3. Counterstereotypic exemplars

(Capers 2020)

# Patient narrative project - Design

1) Introduction
2) Review Structural Competency

3) Interview patient

4) Summarize, review with patient and enter into EMR


5) Structured reflection assignment

Based on VA's My Life My Story

6) Group reflection and debrief

Ringler et al 2015,
Neff et al 2020

# Patient narrative project - prelim results

- Pilot and current study
- Student comments
- Themes from written reflection assignment
- Faculty comments

# Patient Advocacy Assessment

- Initially piloted by medicine clerkship
- Idea came from focus groups with students from groups underrepresented in medicine
- Evaluated advocacy definition & behaviors, necessary context and impact of patient advocacy assessment
- Methods: thematic analysis of narrative comments (split into 3 tiers by score), focus groups w students & evaluators

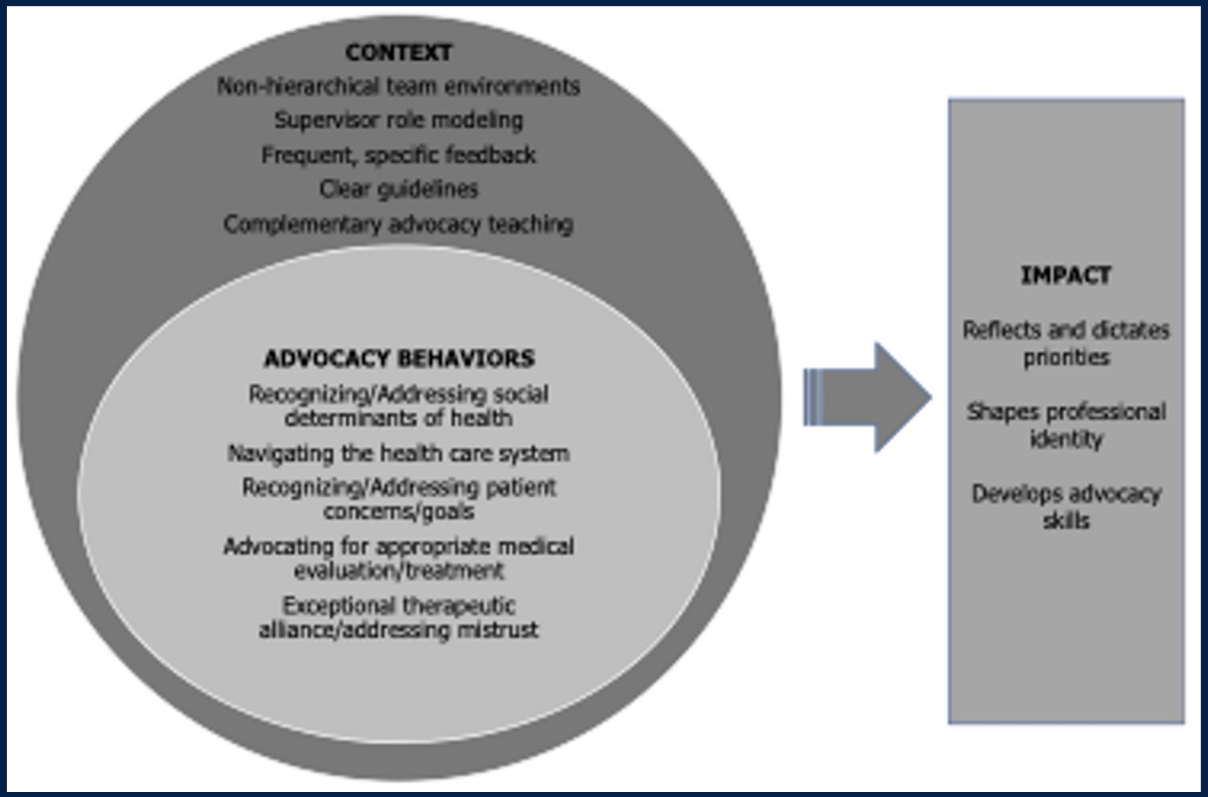
# Patient Advocacy Assessment

The patient advocacy assessment item asked clinical supervisors to rate "a student's advocacy in direct patient care activities." Anchor ratings from 1-4 were provided and range from:

1. Does not identify sociocultural factors that impact patient care, including (but not limited to) race, religion, culture, gender identity, sexuality, primary language, immigration status, and disability (ability) as important to patient care

2. Can identify sociocultural factors that impact patient care, including (but not limited to) race, religion, culture, gender identity, sexuality, primary language, immigration status, and disability (ability) BUT requires prompting to analyze these factors in the context of an individual patient's care.
3. Identifies sociocultural factors that impact patient care, including (but not limited to) race, religion, culture, gender identity, sexuality, primary language, immigration status, and disability (ability), AND is able to consider these factors in the context of an individual patient's care, demonstrating understanding of the specific factors impacting that individual's care.
4. Identifies sociocultural factors that impact patient care, including (but not limited to) race, religion, culture, gender identity, sexuality, primary language, immigration status, and disability (ability), AND incorporates these factors in the individual patient's care AND implements solutions to overcome barriers.

# Patient Advocacy Assessment



# Advocacy beyond the individual patient level

- Increasingly a required competency (e.g. ACGME, professional societies), but medical students don't agree on whether it should be
- Incorporated into MS4 community engagement rotation at UCSF, which is now being revamped into a longitudinal thread
- More robust at the residency level- advocacy skills & career speaker series, collaboration w CBO (GLIDE) to do policy advocacy

# Small group breakout #1

- Introductions
- Discussion questions:
  - What **educational methods** have you seen at your institution to teach about patient level advocacy?
  - What **goals or vision** do you have for teaching patient level advocacy?
  - How might you **envision developing teaching sessions** around patient level advocacy?

# Large group share

# Small group breakout #2

- What **challenges or barriers** do you anticipate?
- What challenges to **measuring outcomes** may there be?
- What are the group's ideas for **overcoming these challenges**?

# Large group share

# Wrap-up and take-aways

Please share an idea or take-away from this workshop that you plan on implementing in your educator role going forward.

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