Session1:
Define patient advocacy and why is it important to you?

- Being a voice for patient
- Education and empowerment, educate learners and patients
- Patient centered care, focus on outcomes– tied to equity. Need to model that for learners
- Patient safety
- Public policy, act of listening. Advocate 1:1. Translate to larger impact on system
- Excellent health care and standard of care.

Small Group 1:

- 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?

- At UC davis - community health scholars for med students- tools to teach level advocacy- local community members come and talk to med students (from community members). Students love this. Know more about the community they care about
- Website aafp web site, has search engine for healthy neighborhoods, put zip codes, show social need they may have and suggest orgs that may help. 3rd year, get to analyze w/ needs and identify org. When discuss - things hospital may offer, d/w social workers - nationally and locally (our hospital, or system - med assistance program)
- Community medicine rotation- residents have a scavenger hunt. 2 orgs have to call, visit, see what they offer and do for patients. Salvation army, planned parenthood, health department.
- Pain management - use mr to benefit to communicate w/ pts. Lots of new procedures, and evolving field. Pt advocacy in terms of recognize breadth of things we offer. Ex neuromodulatory procedures. In EMR - dot phrase that can teach modality and give to patients and learners.
- Qi projects – residency community medicine projects targeted to the population they serve. Most primary care/FM have community medicine that is required to do. How do we gauge how well we did? Stellar/checkboxes
- Issues w/ M and M in didactics – zebras not on system/outcome issues. Mentored case presentation. Wrote slides to address system issues- access, cost to system/patent, required faculty mentoring in processes.Recognize systems issues.
- Integrating safety and fishbone - political determinants of health.
- Narrative medicine - incorporated in 1st yr med school
- Incorporate WHO pt safety objectives, grown to incorporate fishbone to systemic issue of bad things that happened. So it doesn't happen again. 6 students/group 120 students. Excited - lots click. Fishbone shows whole slew of things
- Interprofessional understanding of what goes into health care - QI w/ RN/pharmacy, community health. Lots w/ MPH/MPP but always additional be more open minded to what social workers do.
- Ex./ Complex care rounds - significant discharge barriers. Patients may not have interesting medical issues - but lots to learn from interdisciplinary discussion.

Small Group 2: 15 min

- 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?

- Lack of time –
    - Engage support personnel - nurse/nurse assistant.
    - When there are learners - may have some more time, some learners may have time to do something else w/ patient. Objectives, goals, structure visit. Learner can also recognize advocacy tools to implement
- Teach a more concise presentation. More concise a/p. Pare down.
- Change is a barrier. People know something needs to be changed, when a tight environment -now needs to make change, and barriers - hire faculty to teach what needs to be changed, pandemic lots of changes, even people who agree needs to be changed there is a problem. Small group assignment to change curriculum, then to the bigger group. Professor doesn't want to give up one hour for HSS module.
    - Add one slide, rather than a new session. Integrate throughout. Lots of work, but not necessarily asking for extra hours
    - Incorporation of themes back into things already happening as reflection of how medicine practices (or want it to be practiced). Not an additional issue.
- Broad – applies to multiple different pt populations, different interventions.
    - Narrow to specific topic. Housing instability, measuring outcomes for readmission, HLOS.
    - Canada - advocacy is required. Most recent paper : pt advocacy behavior : "go above and beyond".
    - True to QI methodology- SMARTIE - SMART+ (inclusive and equitable)

Wrap up / Take away:

- Health equity bundle x3
    - - something simple to implement with every patient. Incorporate to learners and outpt setting.
    - Time efficient way to incorporate
- Community resources, integrating that in the teaching moment. Way to within and what's in community
- Use AAFP, get bogged with "only have this" but we have the internet
- Actual patient and look up actual resources.
- Sheet of resources, but you sit with a patient and start deciding which one to call.
- Z-code- "family circumstances" so we all know where to go.
- Diagnostic equity and reasoning.
- Teach earlier learners to help understand what resources are available on a multidisciplinary team.
- Lots of practice for complete social hx. For example - right questions to speak language for sexual questions.
- Health equity slide at each morning report. HE teaching points.
- Emphasis on case conferences, and diagnostic reasoning
- Patient narrative with residents. Most difficult patients – why they refuse.
- Students look up services.
- Need to prep learners to emphasize
- Incorporate Health Equity Bundle
    - Easy, wonderful, starts conversation
- Internal medicine clerkship - similar project
- Integrate into curriculum, not nebulous learn on job, but standardized and in curriculum to get skills in
- In Epic keep information, "family circumstances"

- Iterative process of trying to assess advocacy.
    - Students very supportive of this
- Family medicine built in , comes up with a clear descriptor of what outstanding is. Highlight and residents will make it important.
- Pt Hx in sticky note.
- How to measure impact in community and measure on residents at itself. Reflection - “over reflected”. But reflection narratives can make leadership pay more attention to the topic.
- Continue discussion with residents.
- M + M that change is hard. Will ask question about this
- Bias –implicit bias assessment
- Pt advocacy when in discussion with patients. Correct diagnoses when not correct. Start there and do a health equity bundle.