The rise of social media use, specifically Twitter, among the medical community has extended the potential reach and influence of scientific conferences, such as SGIM’s Regional and Annual Meetings. Attendees tweeting these events can form lasting connections, gain real-time feedback, and amplify thought-provoking ideas and new research findings to an international audience and colleagues, friends, and family. As members of social media committees of the American Psychosomatic Society’s Annual Meeting (#APS2019VAN) and the University of Pittsburgh’s Division of General Internal Medicine (@PittGIM), we reviewed the recent business literature, exchanged ideas, and developed twelve “Twitter Power Tips.” Try them to make your tweets stand out and promote your visibility and influence.

Before the Conference

1. **Build an online community.** Search the conference hashtag #SGIM2019 to find and follow organizers, keynote speakers, colleagues whose work you follow, and friends you know will be attending the meeting with you.
2. **Announce your attendance.** Let followers know when and where you will be presenting a paper, leading a workshop, or attending a special interest group. Include the poster number, session name, and a link if possible.
3. **Add your Twitter handle to your presentations and posters.** Make it easy for friends and colleagues to follow you.

---

**Why Tweet the Conference?**

- **Form lasting connections.** Following conference attendees and their research creates a relationship that extends beyond the conference.
- **Increase the impact of your research.** Share your publications and gain followers to read and forward your work.
- **Provide and receive real-time feedback.** Engaging directly with speakers and conference organizers.
- **Communicate new findings** to colleagues, friends, and family back home.
- **Attract outsiders and the press.** Attract the attention of academic journals and news-media platforms to amplify the event.

---

**At the Conference**

4. **Include the conference hashtag #SGIM2019 in your tweets.** This will archive your messages along with other conference tweets and help users follow the meeting.
5. **Limit hashtags to two per tweet.** While the presence of a hashtag or two can increase engagement, studies find that adding too many actually decreases engagement.
6. **Add speakers’ and institutions’ handles.** This opens potential conversations with speakers, acknowledges their work, and may increase the impression count of your tweet if it is retweeted by their institutions and others.
7. **Post photos.** A picture is worth 1,000 characters! People engage with tweets that have pictures at rates up to 30 times higher than similar tweets without them.

*continued on page 5*
## FROM THE EDITOR

### ADVOCACY: SGIM AND ITS MEMBERS LOUD AND CLEAR!!

Joseph Conigliaro, MD, MPH, Editor in Chief, SGIM *Forum*

“We must always take sides. Neutrality helps the oppressor, never the victim. Silence encourages the tormentor, never the tormented.”

—Elie Wiesel

SGIM members never cease to amaze me. Last fall, when I announced on GIMConnect that April would be *Forum*’s Advocacy Issue to coincide with the national meeting’s theme of “Courage to Lead: Equity, Engagement, and Advocacy in Turbulent Times,” I never imagined the response we would receive. We generated enough outstanding material that April will not be enough to feature them all, and I have decided that the May issue will also feature advocacy related content.

Merriam-Webster’s defines advocacy as the act or process of supporting a cause or proposal or the act or process of advocating something. The current meeting theme has been part of the fabric of SGIM’s membership for as long as I can remember. With the current healthcare and political climate, it’s no wonder why these qualities have been invigorated, and that there is so much energy and passion out there among our Society and its membership. I don’t think that we were ever in a state of dormancy but rather the deteriorating state of health of our democracy requires that we titrate up the dose of our advocacy and engagement lest we risk losing the patient.

This month’s *Forum* features outstanding examples of advocacy by our SGIM members’ as well as informative pieces on how to disseminate your work. Finally, our esteemed president, Giselle Corbie-Smith recounts her extraordinary challenging and productive year as president.

My goodness has it been a year already?!!!
To be continued. . . .
I have been incredibly honored to serve SGIM as your president. SGIM has given me so much since I became a member in 1996, so I am grateful to have had the opportunity to give back in this way to my professional home. Over this last year, I’ve been fortunate to be surrounded by SGIM staff and leaders who have supported me and the challenging work we have undertaken. I want to express my sincere gratitude to each of them for their commitment and engagement. None of what we have accomplished together this past year would have been possible without each of you, so thank you.

Our current political and social landscape is changing quickly and unpredictably. In the midst of the turbulence in our profession and in our country, we decided to take this time to clarify our vision, refocus our mission, better understand our organization’s capacity, and identify how we may capitalize on our collective strengths. I hope the hard work of this year will put SGIM in a better position to serve our members and address issues at the forefront of our field in the coming years. This year has been a time of active reflection, planning, and gearing up for forward momentum. This would not have been possible without the incredible hard work of council, staff, and members of our organization.

In my final column, I want to take a moment to reflect on and celebrate the following accomplishments of SGIM this past year:

Pyramid Communications Audit: We started the year with an organizational assessment by an out-

continued on page 14
RESIDENTS LEAD THE CHARGE

ADVOCATING FOR IMMIGRANT PATIENTS

Leah Harvey, MD, MPH*; Krupa Patel, MD*; Muna Sheikh, MD*; Catherine Rich, MD*; Jennifer Siegel, MD*

*Department of Medicine, Boston University School of Medicine

Dr. Harvey (Leah.Harvey@bmc.org) is a PGY-3 resident in internal medicine at Boston Medical Center; Dr. Patel (Krupa.Patel@bmc.org) is a PGY-4 resident in preventive medicine at Boston Medical Center; Dr. Sheikh (Muna.Sheikh@bmc.org) is a PGY-3 resident in internal medicine at Boston Medical Center; Dr. Rich (Catherine.Rich@bmc.org) is an assistant professor of medicine at Boston University School of Medicine; Dr. Siegel (Jennifer.Siegel@bmc.org) is an assistant professor of medicine at Boston University School of Medicine.

“Can’t apply for food stamps anymore.” “I’ll lose my housing.” “I’m afraid to keep coming to clinic.” Following the leaked report of a proposed revision of the definition of what constitutes a ‘public charge’, our patients were anxious and wary. According to the U.S. Citizenship and Immigration Services (USCIS), a public charge currently refers to a person who is considered “primarily dependent on the government for subsistence, as demonstrated by either receipt of public cash assistance for income maintenance or institutionalization for long-term care at government expense.” Under the proposed expanded definition, immigrants considered likely to use Medicaid, supplemental nutrition assistance, or housing support could potentially be denied lawful permanent residence. As primary care residents at an academic, urban, safety-net hospital, we directly witnessed the impact of the proposed rule change. Patients missed more appointments, their fears surrounding deportation having escalated, and families suddenly needed to weigh their immigration status against their health, housing, and food security. “Staying on Medicaid just wouldn’t be in my best interest,” one patient explained. She had recently fled her home country with her young son, escaping intimate partner violence and domestic conflict, and sought security in the United States.

For the residents of our hospital, which serves thousands of immigrant patients, stories such as these served as a call to action. We see firsthand how essential nutrition and immunization services. As physicians and as neighbors, we want to help our patients to build a life in this country.

For the last six years, the primary care track of our internal medicine residency program has provided protected time for a resident led advocacy project. Residents identify timely causes that directly affect their patients, and then serve as educators and leaders to teach the relevant subject matter, identify community partners, and bring the group together to create a particular deliverable. While some elements of the curriculum are repeated annually, such as written advocacy and effective communication skills, the curriculum is fluid and adapted to match the annual cause—in this case, the development of written comments to be published on the Federal Register opposing the revision of the public charge definition. Past projects have included increasing access to interpreter services, advocating for state legislation to increase funding for homeless services, and hosting an educational debate on the value of supervised injection facilities.

This year, our residents took a multi-pronged approach to develop this curriculum, teach each other, and spread the word to our larger hospital community. Residents led multiple didactic sessions to explore immigrant access to health care and the current public charge issue. This included familiarizing ourselves with current immigration policy, as well as researching the clinical implications of losing access to non-cash federal assistance programs. We formed a partnership with a local advocacy organization, the Massachusetts Immigrant and Refugee Advocacy (MIRA) Coalition, and collaborated with our hospital-based Office of Government Affairs. With these partners, we joined the nationwide effort to submit public comments to the Federal Register, voicing our concerns about the rule change. Furthermore, during the open comment period, our residents ran several workshops on writing public comments for the hospital-community at large, co-hosted an Internal Medicine Grand Rounds on the impact of the proposed rule change, and partnered with Boston University School of Public Health to consider the public health implications of the changes to public charge. Each of these efforts ensured that the advocacy around this key issue was embraced by groups beyond the scope of the residency program.

Our curriculum is one example of how residency programs may teach advocacy skills to their residents. It also exemplifies the following key elements that can be applied in a variety of other settings:

continued on page 5
• First, it was resident driven. As residents, we were not only involved in planning the curriculum, but we also served as teachers and provided important connections to community partners. We led the sessions, tailoring each of them to the level of training and interests of our co-residents, and served as primary contacts to MIRA and the hospital’s Office of Government Affairs.

• Second, it was directly relevant to our local community and patient population. Our hospital serves a diverse and often vulnerable population. One-third of our patients do not speak English as their primary language and over half of our patients receive care funded through Medicaid, Children’s Health Insurance Program (CHIP), or free care. The change to the public charge rule would affect many of our patients and neighbors, and this created an urgent need to act.

• Last, as in prior years, this year’s curriculum was focused on building a toolkit of skills that our residents can use and apply as lifelong advocates throughout their careers. In writing our comments, we practiced how to combine patient stories with clinical evidence to effectively argue our position. This skill is an invaluable tool in effecting change and can be called upon for a variety of future advocacy efforts including op-eds, letters to policymakers, or verbal testimony.

As the social determinants of health assume greater importance in the scope of medical practice, physicians increasingly find themselves in the role of advocates. In this context, it becomes crucial to empower and teach residents key advocacy skills and approaches and to share these efforts with the wider academic community. With this in mind, we hope that other programs may draw from our experience in developing their own advocacy curricula.

References

8. Live-tweet talks. First, create a “thread” by tweeting the introduction to the person and presentation and then comment on your original tweet with main points and important graphics throughout the talk giving audiences the opportunity to follow along. Number each tweet to let followers know they should keep reading.

9. Pose questions. This popular crowdsourcing technique opens discussions to audiences who may or may not be present at #SGIM19 and allows them to input their expertise and ask questions.

10. Retweet with comments. Too busy to create original content? Retweet others’ posts and add a question, opinion, new hashtag, or handle.

After the Conference
11. Follow-up with attendees. Review your Twitter feed and the conference hashtags. Then, follow people you enjoyed meeting or with whom you hope to collaborate in the future, engage with their tweets, read their work, and direct message or email them to follow-up.

12. Review your analytics. Twitter Analytics is a built-in report on the engagement rate of your posts. Note types of tweets, times of day, hashtags, and handles that drew the most and least attention to your feed and adjust your future tweeting habits.

Following these tips and engaging effectively on Twitter will allow you to share your conference experience with a wider audience. For more advice on optimizing social media use during #SGIM2019, visit SGIM’s official guide here: https://connect.sgim.org.sgim19/connect/social-media and benchmark the Twitter campaign we created for American Psychosomatic Society’s Annual Meeting held this March.

We look forward to connecting with you virtually and in person at SGIM in May!

References
The climate of fear created by anti-immigrant rhetoric and immigration policies that target vulnerable immigrant populations critically undermines the health and wellbeing of immigrant patients. Healthcare professionals have an ethical and professional obligation to provide care to anyone who needs it, regardless of their immigration status. In addition to providing high-quality health care for immigrants, developing interventions that promote their legal and human rights is a potent form of advocacy that is critical for ensuring the health and wellbeing of vulnerable immigrants. Though there is concern that immigrants will avoid the use of healthcare services due to fear of deportation, healthcare providers’ direct contact with immigrant populations puts them in a unique position to address immigration legal needs. Given this contact, healthcare providers can advocate for patients by providing resources and linking patients to legal counsel and immigration organizations.

The Medical-Legal Partnership (MLP) movement is an example of an evidenced-based intervention to address the unmet civil legal needs of patients. MLPs have demonstrated social and clinical impact by reducing patients’ stress and visits to the emergency room, while also improving housing outcomes and economic prospects in the communities they serve. Unfortunately, few MLPs provide immigration-specific legal services due to the complex and intensive nature of such services. Our experience working with patients in the Immigrant and Refugee Health Program (IRHP) at Boston Medical Center (BMC) has taught us that there is a tremendous need for immigration legal support in our patient population, and we have a potent opportunity to provide crucial support for immigrant patients when they come into clinic.

At the IRHP, we implemented a program in which an Immigration Legal Navigator (Navigator) was embedded into our clinic. The Navigator advocated for patients by referring them to community immigration legal resources and supporting them as they navigated the immigration legal process. The Navigator was an AmeriCorps member who received training from AmeriCorps on immigration-related issues and was employed by the clinic for the duration of a year. In the first year of this pilot, the immigration legal navigator worked with 271 patients, whose needs included asylum support (35%), documentation support (22.5%), green card support (21%), general immigration questions (10%), citizenship support (5.2%), family reunification support (4%), medical deferred action support (1.5%), and deportation defense (0.7%).

To better understand the barriers immigrant patients face, and the efficacy of the program at successfully advocating for immigrant patients, we used thematic analysis to analyze the Navigator’s monthly reflections detailing her greatest successes and challenges with immigrant patients. Here, we focus on three themes identified that highlight the importance of the Navigator as an advocate for patients with vulnerable immigration status:

1. **Immigration status is a social determinant of health:**
   Increasingly, immigration status is recognized as an independent social determinant of health, driving health disparities through structural inequalities. Many of the Navigator’s cases demonstrated how immigration challenges complicate and are inextricably linked to health outcomes. The combination of a serious illness and immigration vulnerability can be difficult for patients to overcome without assistance. As the Navigator described in a journal entry:
   “I met with a husband and wife who both did not speak English. The wife had cancer and was receiving treatment at BMC, but had overstayed her visa. The husband needed a green card renewal.... I contacted [an immigration legal organization], but the patients needed an in-person interpreter to help fill out the forms, which was an added challenge.”

   Additionally, the navigator described the financial burden associated with acquiring legal representation for patients:
   “Without [my support], I think that this patient
Many patients with legal vulnerability have to navigate a complex legal system that presents challenging demands, such as acquiring the right paperwork despite language barriers. This is complicated by imminent deadlines for paperwork, which if not met, could lead to deportation. Through the Navigator, patients were supported while learning how to navigate the complex immigration legal system, which in turn led to a higher sense of self-empowerment among patients. As the Navigator described:

“I saw a patient who was an asylum seeker... The patient seemed very symptomatic. I had referred this patient to [a legal collaborator], and I actually got a call from [them] about this patient saying they were worried about him and wanted to schedule him for an appointment. She wanted to know if I would be able to accompany him to his next appointment... The fact that I had formed a working relationship with [this organization] meant that she was able to reach out to me directly about the patients I referred to her.”

3. **Interprofessional collaboration to secure legal representation:**

The Navigator frequently noted how crucial interprofessional collaboration was for resolving cases. By serving as an intermediary between clinicians and attorneys, she was able to overcome many of the barriers that typically make this type of collaboration difficult. For instance, she said: “This month, a patient came to see me who needed an urgent letter from her primary care provider. She was put into deportation proceedings, and was given an extremely short timeline to get this treatment letter. I was able to connect with the patient’s lawyer and PCP, and provide the PCP with guidelines for writing the letter... I think it was really helpful having this experience and also the time to coordinate all the different pieces on an expedited timeline.”

This collaboration was bidirectional, and allowing legal collaborators to also get support with medical concerns.

“I think this patient would not have been able to find legal resources on her own. She, like many of the other patients who have been in contact with, had trouble advocating for herself. In the time that I have known her, she has become increasingly independent, and I feel it is because she knows she is not alone in the process.”

**References**


Although not always apparent, young adults—both those who are healthy and those with chronic medical conditions—constitute a uniquely vulnerable population. Young adulthood refers to the ages of approximately 18 to 26 years old and represents a critical time of social, economic, physical, and mental development. Many health behaviors established during young adulthood persist into older adulthood and can have significant consequences for health.

**Young Adults: A Vulnerable Population**
The vulnerability of young adults was highlighted in a 2015 report published by the Institute of Medicine and National Research Council to review the health, safety, and well-being of young adults and make recommendations for research and policy. This report highlighted the unique health needs of young adults, who are less likely than younger and older groups to exercise and attend regular check-ups, but are more likely to eat poorly, contract sexually transmitted infections, smoke cigarettes, binge drink, and use marijuana and other drugs. Approximately 1 in 4 young adults are obese, and obesity rates continue to rise. Obesity-related conditions like hypertension and diabetes often go undetected in this population which all too often has little contact with the health care system. Mental health disorders and substance use account for two-thirds of disability in young adults. Substance use rates steadily increase during adolescence and peak during young adulthood. Furthermore, the emergence of psychotic disorders and depression is of concern, and young adults have the highest rate of completed suicide.

One contributor to the poorer health of young adults is the transition from pediatric to adult care. This transition is particularly challenging for those with chronic childhood conditions, such as type 1 diabetes and sickle cell disease, where morbidity and mortality increase around the time of transition. For example, young adults with type 1 diabetes have 2.5 times poorer glycemic control when transitioning. However, all young adults’ health can be affected during this transition. In 2018, the American College of Physicians, American Academy of Pediatrics, and American Academy of Family Physicians issued a joint clinical report on the transition from pediatric to adult care in the medical home. Compared to the prior report in 2011, this update highlighted the identification of adult care clinicians to assume care as a key component of successful transfer of care.

Young adults need increased access to medical care, particularly for the preventive services that internists provide. However, healthcare utilization among young adults is low, and many (22%) receive fragmented care. Young adults have significantly higher emergency room visit rates than older adults. Barriers include lack of comfort with adult providers or the adult healthcare system, long wait-times/difficulty scheduling appointments, and a perceived lack of benefit to preventive care. Additionally, though young adults saw the greatest improvements in insurance coverage under the Affordable Care Act, they still have the lowest coverage rates of all Americans. Beyond access, there is evidence to suggest that lack of knowledge among adult providers of young adult-specific health conditions may also play a role in inadequate care. For example, although 48 percent of young adults reported having had a “routine checkup” in the past 12 months, a minority (2-12%) receive care for mental health disorders and substance use, despite the known high prevalence of these conditions.

**General Internists as Advocates for Young Adults**
As general internists, we have an opportunity to improve the health of young adults and advocate for them on an individual patient-provider level, as well as in our health systems, professional societies, and nationally.

Advancing young adult health starts with our approach to the care of each patient. Young adults do not end their developmental journey after the end of the second decade of life, or just because they have transferred care to an internist. Working with young adult patients often requires a shift in mindset to accept that many need additional guidance in self-efficacy and future-oriented...
BEST PRACTICES (continued from page 8)

decision making when it comes their health care—our role in this is essential. The key for us as physicians is to be patient and flexible, and to appreciate the role that we have in fostering this part of our patients’ development. It may be necessary to schedule more frequent follow-up, be in contact between visits, or repeat the same message multiple times and in different ways to support these patients.

Once we have engaged young adults in care, our greatest impact may not always be in treating the problems that bring them into the office. We should use each visit to actively screen for high-risk behaviors and health risk factors that may not be readily volunteered in the history, but where intervention has the potential to improve outcomes now and for a lifetime. Screening for mental health issues, such as depression and anxiety, as well as being aware of signs of serious mental illness like schizophrenia and bipolar disorder, allows us to engage patients in care before these conditions seriously impact their personal, educational, and professional lives. Screening for tobacco use, problem drinking, and illicit drug use provides an opportunity to help young adults understand the risks of these behaviors, support behavioral change, and engage in treatment, if necessary. Asking about diet and exercise can help curb rising rates of obesity and its well-established metabolic and cardiovascular consequences. Taking a thorough and non-judgmental sexual history can identify patients with high-risk behaviors, and potentially direct them to life-saving preventative measures, including safe sex practices and pre-exposure prophylaxis for HIV.

Of course, we cannot treat young adults if we cannot get them through the door of our offices; we must make a conscious effort to make our practices more welcoming and accessible to these patients. For a young person who has never independently navigated the healthcare system, something as “simple” as scheduling an appointment or getting a refill can seem overwhelming. Others may not access health care because of fear of discrimination or judgment; for example, against their sexual orientation or gender identity. The following are examples of how practices can become more young-adult friendly:

- Promoting e-mail messaging or patient portal usage to empower patients to ask questions or book appointments on a flexible schedule;
- Identifying your practice as a safe-space for LGBTQ+ patients;
- Providing more flexible weekend or evening hours;
- Creating a “Welcome to the Practice” guide explaining procedures for contacting providers, accessing urgent care, and requesting refills; and
- Simplifying the office phone tree or providing direct numbers for patients to call for issues like scheduling, refills, and triage.

While these changes may be targeted at young adults, many of them will make the practice more accessible to all patients. For those seeking resources to welcome young adults into their practices, the 2018 Clinical Report on Transition details the transition process from pediatric to adult care with evidence-based standards for providing optimal care for young adult patients. In addition, the Got Transition Web site (www.gottransition.org) offers a wealth of resources practices can use to better serve the young adult population, along with a step-by-step guide designed to help adult practices develop processes for young adult care.

Beyond our clinical practices, internists can serve as strong advocates for the health and well-being of young adults, especially those with chronic health care needs. Involvement in regional and national professional societies is one opportunity to promote education and focus on young adult topics, as well as to connect with others interested in care for this group. Within SGIM, there are two interest groups dedicated to advancing and promoting the care of young adults through education, research collaboration, and advocacy: the GIM for Young Adults Interest Group and the Adults with Complex Childhood Onset Conditions Interest Group. On a state and national level, there are many opportunities to advocate for young adult health. Maintaining the provisions of the Affordable Care Act, continuing to expand opportunities for coverage, and increasing access to mental health and substance abuse care are just a few of the issues being debated on the national stage with particular impact on young adult health.

It is clear that the role of general internal medicine in the health and well-being of young adults is critical. As internists, we should feel empowered to care and advocate for our young adult patients in a way that recognizes their vulnerability and their potential.

References

continued on page 11
It started with a simple question: “Let’s get creative. What could we do to keep you here?” That was the question my mentor posed to me about a year ago, when I wasn’t yet sure that academic medicine was the right place for me and my passion. Since before I started medical school, when I worked in the California State Assembly and later the U.S. House of Representatives during the passage of the Affordable Care Act, my passion has been to advocate for a more equitable healthcare system with improved access to affordable care.

Over the years, in an effort to find a better defined place within academic medicine, I have tried to fit this passion into quality improvement efforts or health policy research. But, days after President Trump’s election, as I presented my quality improvement project to my co-residents, one of them stopped me in my tracks by asking, “Which part of this are you most passionate about?” I took a deep breath, swallowed hard, and spoke my truth: “None of it. What I really want to do is my advocacy work, but I just don’t know how that fits into an academic project.”

Over the course of the last several decades, the roles of academic physicians have continued to expand. Traditional roles in clinical care and research first expanded to include formal clinician-educator tracks. Opportunities for advancement based on educational scholarship have been enhanced with the introduction of the Educators’ Portfolio. More recently, health systems innovation and quality improvement have made their way into a widely recognized career path as well as formal promotions criteria. But while many professional organizations have taken the stance that physicians must advocate on behalf of patients and social justice, formal academic roles and advancement based on an expertise in physician advocacy remain limited. While an Advocacy Portfolio, similar to an Educators’ Portfolio, has been proposed, thus far it has not been widely adopted.

With this in mind, I was skeptical about the ability of academic medicine to allow for a role in advocacy. However, if there has been one advantage to the tumultuous political times in which we are living, it is that physicians increasingly recognize the importance of engaging in advocacy on behalf of our patients. As Don Berwick warned us: “Physicians who want politics out of health care are going to be disappointed. If they value the principles to which they pledged as healers, then they ignore politics at their peril and their patients’. The sidelines are safe places for neither.”

Fortunately, my own Division of General Internal Medicine (DGIM) has begun to recognize that we cannot sit on the sidelines either. Last year, the theme of our faculty retreat was advocacy, and the passion in the room was palpable. I decided to follow the advice of my mentor and “get creative” to find a place for advocacy in academic general medicine. With the support of my division chief and others, I took on the role of director of health care advocacy for our division, working to find a place for advocacy in academic medicine.

Looking around our DGIM, so much hunger for this work was already apparent. When our Wellbeing Committee asked faculty to identify activities that could promote their wellbeing, some focused on relaxation techniques, such as massage, but just as often groups proposed activities such as “a community facing activity with a community organization around social justice.” In other words, the group proposed activities involving advocacy to combat the moral distress that often drives burnout.

Moreover, several of our faculty, both researchers and clinician-educators, were already known around the campus and more broadly as advocates on topics such as tobacco use prevention, health care workforce, and health disparities. What quickly became apparent, as anyone who is engaged in advocacy knows, is that this is a team sport. So, we began to assemble our team. Two clinician-educators and two clinician-researchers in our division teamed up to found the Social Justice, Policy, Advocacy & Community Engagement (SPACE) Committee to provide information and engagement opportunities to DGIM community members who want to improve the health of our patients through advocating for policy change and working with community partners toward a goal of health equity and social justice. More than 20 faculty, staff, and residents have so far joined the Committee.

continued on page 11
Our Committee provides updates, calls to action, and faculty development on relevant topics; we have also begun a collaboration with our hospitalist colleagues to deliver joint Grand Rounds and faculty development workshops. We are currently in the process of putting together a Speakers Bureau to allow the community to benefit from our faculty’s expertise and vice versa, with leaders of community organizations invited to present at our Grand Rounds. We also look forward to improved networking with our colleagues from across the university, many of whom have deep passion and expertise in these topics.

As is so often the case, trainees have led the way in many of our university’s efforts, with both their passion and expertise. For years, UCSF’s medical students have been incredible advocates, with a plethora of student organizations focusing on particular issues. This year, they have come together to form the Health Justice Collaborative as a way of coordinating their work, and have also been key in advocating for the formal curriculum to include topics of social justice.

For the first time in our primary care residency history, all primary care residents in our division have engaged in an advocacy curriculum to complement their health policy curriculum and this spring will engage in legislative advocacy in either Sacramento or Washington, D.C. Many faculty, including program leadership and those involved in the SPACE Committee, will join the residents in these activities. We also plan to host a corresponding evening event locally, including direct outreach to our elected officials and an advocacy skills workshop for those interested but unable to travel.

Looking outward toward community partners and professional organizations, we have found many exceptional potential partners. Most notably, the SPACE Committee has begun a partnership with the San Francisco Marin Food Bank and the San Francisco Department of Public Health to bring a Food Pharmacy, complete with nutritious, whole foods and nutritional education, to our clinic site and our patients. We look forward to beginning to serve our clinic’s patients experiencing food insecurity later this year, as our clinic takes its first steps toward truly addressing social determinants of health.

The story of academic medicine over the last few decades has been one of continually expanding and valuing roles that do not always fit the traditional model of clinician-researcher. If academic medicine is to lead the way in serving our communities and training the next generation of physicians, we must find a way to welcome the many trainees who are, like I was a year ago, passionate about advocating on behalf of their patients and communities but skeptical about how to do so within academia. I am fortunate to have found a team with incredible interest, expertise, and passion in advocacy, as well as a DGIM that supports this work. During these turbulent times, my sincere hope is that others will too.

References
Employee well-being is an important issue for healthcare institutions. Increasing evidence links burnout and demoralization to decreased quality, safety, and efficiency as well as staff turnover with estimated costs of up to $1 million per physician recruited and hired. Strategies adopted by health systems to increase efficiency, safety, compliance with mandates, and market competitiveness are associated with known drivers of burnout. Yet, current trends seem to show organizations opting to create wellness initiatives focused on individual resilience as opposed to making the systems-based long-term, and sometimes costly, changes to address the fundamental drivers of burnout.

In this setting, advocates of clinician well-being can rightfully feel overwhelmed, isolated, and discouraged. A grassroots approach unifying these advocates to promote institutional change may counter these adverse outcomes.

We took this approach at our institution, a large academic health center (AHC) closely affiliated with a Veterans Affairs medical center. Longstanding concerns about employee well-being had been spotlighted from results of system-wide employee engagement surveys. Many of us were already working on wellness initiatives in individual silos to address manifestations of staff and trainee burnout (e.g., depression, turnover, closing of programs). We felt the institutional response to the survey results were likely insufficient: they were uncoordinated and lacked an overarching strategy and appropriate investment of resources.

A visit by an expert in leadership and organizational transformation gave us an opportunity to bring together some of the people working on wellness initiatives. During our informal breakfast meeting, the discussion illuminated a common feeling that the institution could do more. Attendees decided to form an ad hoc group to collectively advocate for an enhanced institutional approach to employee wellness.

Advocacy and Community Building
That decision, by a group of mostly strangers from different departments and disciplines, to come together outside of normal channels to work for change, was our first step into grassroots mobilization. Such an approach is not typically seen within AHCs, where approaches to organizational transformation tend to be driven by central leadership through technical plans disseminated to frontline workers. There, leaders focus on the creation of such plans and enforcement and compliance.

Outside of health care, grassroots approaches to change tend to be more common. Examples include efforts by teachers to change school policies, collective mobilization of workers in large retailers to shift working conditions, and targeted collective action by concerned consumers to shift policies at various companies.

The common feature of these approaches and what makes them powerful lies in groups of people, with similar stories and values, coordinating efforts in a longitudinal way to effect changes they could not bring about on their own. In a world where AHCs are increasing in size and power and leaders are increasingly pressured to optimize financial margins with little input from important frontline stakeholders, collective action represents a unique means for concerned parties to be heard and felt. But how can this be done in a way that appropriately balances concerns about clinician well-being with pre-existing organizational priorities, norms about dissent and an overarching need to maintain a level of professionalism and collegiality with institutional leadership?

Our Approach
With our ad hoc group launched, we used our meetings and conversations as opportunities for collaboration and synergy, forming new bonds built from shared stories and values. One of our first steps was to agree to a distributive leadership model where all take turns running meetings and advancing various subcommittee work. We were fortunate to have a project manager who lent time to schedule meetings, create a listserv, and send reminders. Our meetings start with introductions and emotion-
al check-ins; our agenda is fluid to respond to newly made connections. We named ourselves the Leaders for Wellness and use an inclusive decision-making process.

Another step was to create an inventory of people and programs involved in well-being efforts to build relationships across the institutional silos of departments, schools, and hospitals. We agreed to open membership with the intent that every participant invites others in their respective networks to join. This has been key to building a diverse community and decreasing the likelihood our group would be painted as advocating for a self-interested agenda. Instead, we used our relationships to mobilize and unite many voices and perspectives to build a larger constituency. Our group engaged with leaders of the AHC through active involvement in town hall events, email-based surveys, institutional strategic planning, as well as holding individual meetings and joining pre-established committees addressing employee wellness.

A sense of community and possibility has emerged as groups realized they could combine constituencies, partner, coordinate, amplify, share best practices, and support each other’s programs. This has built momentum for wellness initiatives and has been a positive disruption to the traditional processes for decision-making at our AHC. Our social network, with its diversity of perspective, inclusivity of position, and numbers of people, has contributed to the influence this group has had. New sets of ideas, ideals, and identities are spreading through our network likely because our people are more closely connected and—as increasing amounts of sociological research suggests— Influenced by one another.6

This is an unfamiliar approach to change at AHCs. It is meant not to replace the pre-existing approach that relies on structure, data, and formal lines of decision-making but to complement it.4 The focus on relationships and finding programmatic synergies has breathed new life into well-being work at our AHC and has amplified previously unheard perspectives. The open, trustful, and cooperative space that enabled such common purpose also ended up proving therapeutic, improving participants’ sense of wellness and agency.

Our Challenges
This process has had challenges, beyond finding time to meet and a project manager willing to coordinate efforts. Success has required the ability to hold the tension of a leadership model that is dispersed and strategies and tactics that feel fluid due to shifts in response to evolving issues, opportunities, and realities. Meeting outcomes initially prioritized relational over task goals, which felt odd at first, given the highly structured nature of traditional healthcare committees. It can feel foreign and create conflict that needs to be managed as members navigate a group without clearly defined structures and team processes.

Lessons Learned
A grassroots effort such as ours can complement traditional strategies for change. The following are suggestions for getting started:

1. Find a core group. Be inclusive and break bread together when possible—it’s the fastest way to put hierarchy aside and connect to each other as humans.
2. Focus on relationships initially and resist the tendency to strictly adhere to a traditional meeting agenda. Instead, spotlight personal stories, shared values, and connections, and later, how these connections have subsequently made a difference (e.g., collaboration in programs that would not otherwise have occurred).
3. Understand your institution’s stakeholders and decision makers. Listen to what they care about and identify resources and relationships you possess to leverage those interests to move a wellness agenda forward.
4. Commit to distributed leadership. Making room for diverse membership requires that the leadership not be held too tight by any single person or group.
5. Be flexible in the outcome and trust the process. One of the most valuable outcomes of our group has been the act of connecting people from across the mission areas and silos of our AHC. The power and synergy this created is an outcome of an intentional process of relationship building.

Bringing strategies of advocacy and grassroots organizing into the world of AHCs may accelerate change as well as enhance participants’ sense of wellness, connection, and purpose. As we collective-ly undertake the marathon that healthcare reform represents, such benefits of collective action may not only raise our chances of ultimately reaching the finish line—where the wellness of the workforce is no longer an afterthought—but potentially arriving in a better state than when we started the journey.

References
side firm. Feedback from the assessment highlighted positives and identified opportunities for SGIM to come into better alignment enabling us to leverage our strengths as a professional society. The audit recognized the extremely strong foundation that SGIM has upon which to build, highlighted important strengths of SGIM, and commended our commitment to equitable care of our patients. Opportunities for strengthening the organization included the need to refine our organizational priorities and sharpen our focus. We needed a more clear articulation of our “true north” (why we exist) and increased intentionality in how we deployed organizational resources. As a result, we undertook several efforts which I have summarized below.

Vision, Mission, and Values: We worked to clarify our statement of our WHY. Eric Bass, our CEO, guided Council and Staff members through a comprehensive and iterative process in which we collectively reviewed and revised our mission (Revised: Be the professional home for innovators and scholars in academic general internal medicine leading the way to better health for everyone), vision (Revised: A just system of care in which all people can achieve optimal health), and values statements.

Strategic Planning: With a clearer vision and mission, and a renewed commitment to our values, we articulated four broad organizational goals and strategic priorities for the next five years of our organization:

1. Foster the development of future leaders in academic general internal medicine
2. Catalyze and disseminate innovations and scholarship in high-value, evidence-based, person-centered, population-oriented approaches to improving health
3. Advocate for our vision of a just health system that brings optimal health for all people
4. Ensure organizational health and a thriving SGIM staff.

We also developed a set of metrics and targets by which we can judge our organization’s progress toward meeting our goals.

Staff and Leadership Engagement Commitments: Together, SGIM staff and Council prioritized a draft set of commitments for our joint work and decided these guidelines should be used across the organization to bolster the shared understanding of the importance of our partnership. In SGIM, we are lucky to have not only an amazingly talented staff but also dedicated, passionate members who are excited and committed to the work we do as an organization. The strong level of passion and commitment provides the supporting structure for our work together.

Financial Sustainability and Growth: One key organizational goal is ensuring SGIM continues to have the fiscal resources needed to thrive and grow. Mark Schwartz led us in taking stock of our financial health and identifying opportunities not only to sustain us as an organization but also to grow while remaining focused on our “true north”.

Career Development Planning: We have outstanding content in our career development opportunities to which many of you have contributed and for which SGIM has become known. We are currently identifying the core components of our offerings, recommitting to the efficient way these programs are supported, harmonizing cross-program evaluation and identifying synergies across programs to better serve the professional growth of our members. While this work will happen over a longer trajectory, the end result will be to ensure coordination and synergy in the pedagogical approaches and logistics of implementation.

It has truly been a privilege to work alongside you over this past year to build a stronger organization for future generations of generalists. I continue to be inspired by the devotion and passion of SGIM staff and members. I’m excited that our work over this last year will provide SGIM a strengthened foundation upon which we can move boldly toward our vision of a just and equitable system of care for our patients.

SIGN OF THE TIMES (continued from page 13)

THE IMPORTANCE OF BEING OUTRAGED

Denise L. Davis, MD

Dr. Davis (denise.davis@ucsf.edu) is clinical professor of medicine, University of California San Francisco.

Outrage can motivate action. Because we can’t improve what we don’t measure, we need to assess the needs of those who are members of marginalized groups by convening focus groups of patients and community partners. I need to listen carefully to conversations about patient satisfaction because my identity as a woman of color in medicine does not mean I always understand what’s important to minority patients. Let’s pay close attention to the number of young African-American and Latin men who attend STEM pipeline programs and how many of them matriculate to medical school and go on to have meaningful careers. Let’s set goals to repair our leaky medical school to faculty pipeline by recognizing and dismantling structural racism and implementing interpersonal remedies for inequities in the physician work force through effective personal and professional mentoring that begins on day one of medical education.
and continues throughout the career of minority physicians. Dr. King said, “A time comes when silence is betrayal.” Time’s up. Speak up about inequity in the physician work force!

References