MEDICAL SCHOOL METRICS

1. RECRUITMENT AND ADMISSIONS

Police and Prison Abolition

- ❑ In alignment with the national Ban the Box movement, applicants to medical school are not asked to disclose whether or not they have a history of criminal punishment system involvement.

  All applicants to our medical school apply through AMCAS. AMCAS requires applicants to disclose if they have criminal convictions (felony or misdemeanor). Our Admissions Committee is instructed to disregard any charges or arrests that are related to social justice protests. Without disclosing specifics, we routinely accept students who have had legal system involvement as we take a holistic approach in our admissions process. For those accepted students who later have a situation that involves the legal system, there is a subcommittee of the admissions committee that reviews that legal action and determines if the admission should be rescinded. This has not occurred in at least the last five years.

- ❑ Undocumented students are encouraged to apply to the medical school, and have access to institutional grants and loans to cover the full cost of attendance.

  We do not accept undocumented students to our medical school at this time.

Redistribution

- ❑ To facilitate progress towards a representative physician workforce, Black, Indigenous, and Latinx students and faculty are overrepresented in the medical school class and faculty at all levels (instructor, and assistant, associate, and full professor) by at least a factor of two relative to their share of the U.S. population (26% Black, 2% Indigenous, and 34% Latinx).

  Our rate of interview offers is greater for our students of color (25%) versus other applicants (10%), however, despite our targeted pipeline programs and outreach, students of color are not overrepresented in our medical school class. It should be noted that the way the above goal is worded, it implies that a quota is being supported/requested. The medical school does not have quotas as this would be legally questionable.

- ❑ At least 40% of the incoming medical students received or would have been eligible to receive Pell grants as an undergraduate student.[1]

  Pell is an undergraduate need-based federal grant. Pell eligibility determination comes from the FAFSA. The FAFSA for undergraduate students requires parental information (income and assets). The FAFSA for a graduate/professional student does not require parental information. If the FAFSA website sees that the student is a graduate/professional student, it will automatically skip the parental income/asset questions. As a result, it is not possible for the school to obtain valid information to address this question.

[1] https://nces.ed.gov/datapoints/2016407.asp

With a needs blind admissions policy that uses holistic review to offer positions in the medical school class, to look at undergraduate debt and/or make conclusions about someone related to their grant status is not the spirit of our medical school.

- ❑ Students of color who participate in recruitment and other admissions activities are compensated for their time at a rate at least equal to the local living wage.

  While we cover expenses for students who participate in off-site recruitment efforts, in fostering an atmosphere of community contribution, we do not compensate any students who participate in admissions activities.

- ❑ The medical school publishes an annual report on the race and gender distribution of financial aid funds. All Black, Indigenous, and Latinx students receive grants that cover at least 50% of the cost of attendance.

  We do not publish an annual report on race or gender and financial aid distributions. Given our small school size, to publish this information would be a violation of privacy. At this time, we do not have data on students who receive grants that cover at least 50% of the cost of attendance.

Community Control and Self-Determination

- ❑ Black, Indigenous, or Latinx alumni of local public schools comprise at least 10% of enrolled medical students.

  We have several pipeline programs with local public schools, particularly the Rochester City school system. For K-12, we do not have at least 10% of enrolled medical students from this population. Our pipelines programs include those targeted toward local residents and would ideally lead to participants being admitted to our medical school. They may choose to go to another medical school and we consider that a success of our program.

- ❑ As a part of the medical school admissions processes, all applicants participate in interviews with local BIPOC local leaders, who are compensated at a rate equal to or greater than the local living wage.

  While interviewers receive meals, no one who interviews medical students is compensated for this activity. All students of color who participate in our second look experience, meet with BIPOC local leaders.

Total score: __/8 = __% = _____(letter grade)

2. CURRICULUM

Police and Prison Abolition

- ❑ The medical school curriculum includes teaching from medical historians regarding the abuse of enslaved and incarcerated peoples for medical research.

The medical school curriculum in December of Phase 1, provides instruction about ethics in medical research and is deliberate about addressing abuses of incarcerated individuals and persons of color in conducting medical research. This instruction is provided by faculty in Medical Humanities (Medical Humanities includes history and the arts).

- ❑ The medical school curriculum explicitly addresses that race is a social construct, not a biological one. Pre-clinical lecturers avoid describing race per se (rather than racism) as a risk factor for disease, cause of health disparities, or basis for diagnostic reasoning.

  In achieving our newly established objectives related to content around Racism, Discrimination and Bias, instruction is provided that addresses race as a social construct and racism as a social determinant of health. Guidelines are given to course and clerkship directors to review, be thoughtful, and use any descriptions of race appropriately. Throughout our curriculum we integrate clinical and basic science throughout all four years without isolated fully pre-clinical, clinical or science years or phases. We believe we currently achieve this goal.

- ❑ Students in their preclinical years hear from individuals who have been incarcerated and their experiences receiving healthcare.

  In our Phase 2, there is content about interactions with law enforcement and mental health. In Year 3/Phase3, there is a session in which students hear from an individual who has been incarcerated and has had mental health issues. This patient shares their experiences with healthcare as a person of color. As noted above, we integrate clinical and basic science throughout all four years without isolated fully clinical or science years or phases. There are optional programs for students to volunteer that work with individuals who have recently been released from incarceration.

Redistribution

- ❑ BIPOC community advocates and qualified faculty lead the planning and execution of all sessions on community health and health inequities, and are compensated at a rate commensurate with the average honoraria for a guest lecturer at the medical school.

  The committee that created the objectives and reviewed the educational programs that address Racism, Discrimination, and Bias provides oversight of the educational sessions that address these topics. This committee includes faculty of color from the university who are also members of the local Black Physician's Network.

  In accordance with accreditation standards, individuals who provide curriculum oversight must have a faculty appointment. As teaching is required for a faculty appointment, we do not provide honoraria to faculty for direct teaching.

Community Control and Self-Determination

- ❑ The medical school funds a Community Leadership Board or equivalent body composed in its majority of BIPOC community leaders, which has an independent budget to initiate and lead efforts within the medical school with complete autonomy. The board oversees

and has a role in all major activities within the medical school, and votes on major decisions. All board members are compensated as medical school faculty.

The University of Rochester Medical Center's Community Advisory Council (CAC), created in 2006, provides significant community input and guidance to the URMC in a variety of areas across all missions of the medical center - research, education, patient care, and community health. The CAC is comprised of leaders of key organizations and constituencies within the greater Rochester community, with a focus on organizations that represent and/or serve those most in need. CAC membership focuses on those organizations and institutions that represent or serve traditionally underserved segments of the population. The CAC has representation from health and social services agencies, the faith community, local government, the city school district, and media.
The functions of the CAC are to:

- Act as a resource to URMC to strengthen community partnerships with an aim to reduce disparities and improve access to health care and services
- Contribute to the assessment and identification of community health-related priorities
- Promote constituent engagement in community health improvement initiatives
- Review community-engaged projects and research, as requested

Since its inception, the CAC has contributed to building an infrastructure for the URMC's community engagement activities. CAC members have discussed compensation and do not feel it is necessary as they feel their contributions to this committee fall within their organizational leadership role.

❑ BIPOC and other marginalized students are excused from workshops on content redundant with their lived experience (e.g. Black students are excused from workshops on anti-Black racism).

Our medical school is committed to an inclusive environment where students learn from each other. For all small group instruction, attendance is required of all students. We believe that diversity of backgrounds and thoughts enhances the educational experience. The intent is not to have any group of students responsible for the education of another group but learning and discussing issues in an inclusive learning environment.

Total score:___/6 = ___% = _____(letter grade)

3. CLINICAL EDUCATION

Police and Prison Abolition

❑ All students receive comprehensive training on techniques for protecting the privacy and safety of undocumented patients and patients presenting in police or prison custody.[2]

Instruction of all students regarding the care of patients in police custody or who are in

[2] https://www.aha.org/system/files/2018-03/guidelinesreleasinginfo.pdf

prison and brought for care is provided annually. Instruction on privacy is required of all students annually and applies to all populations. We do not have specific policies for undocumented patients as our institution provides them care in a safe environment. Any violations of privacy lead to disciplinary action.

- ❑ All residents and fellows receive comprehensive training on techniques for protecting the privacy and safety of undocumented patients and patients presenting in police or prison custody.[3]

  All residents and fellows do receive comprehensive training on techniques to protect the privacy and safety of all of the patients under their care.

Redistribution

- ❑ The medical school does not operate student-run free clinics or health fairs, because all members of the local community have full access to the healthcare they require at the primary teaching hospital and its affiliated clinics.

  Our medical school operates healthcare delivery sites for individuals who are uninsured, underinsured or have difficulty obtaining healthcare access. This is in accordance with our philosophy that all patients are cared for with equity, therefore, all patient encounters are seen and supervised by licensed physicians who are practicing within the scope of their specialty training.

Community Control and Self-Determination

- ❑ There are uniform guidelines for the level of supervision of medical students practicing at all clinical sites (for example, trainees do not have more autonomy when caring for patients at a public hospital, free clinic, or VA hospital).

  In accordance with medical school accreditation standards, we provide guidelines on the level of supervision and expectations of students overall and in specific clerkships. Additionally, we have a policy that outlines what a student does if he/she/they is/are not comfortable with the level of responsibility given to them.

- ❑ Procedural training is not disproportionately performed on patients of color (i.e. in public hospitals with an overrepresentation of Black and brown patients, resident clinics, etc.)

  Procedural training is not performed disproportionately on patients of color or of any demographic.

Total score:___/5 = ___% = _____(letter grade)

[3] https://www.aha.org/system/files/2018-03/guidelinesreleasinginfo.pdf

4. STUDENT AFFAIRS

Police and Prison Abolition

- ❑ The medical school has a system for collecting student feedback on racism and other forms of oppression, with a clear and transparent mechanism for following up on all complaints that is led by an ombudsperson who is not a part of the medical education leadership, and which includes non-punitive options such as mediation with a trained facilitator.[4]

  The medical school and the university have several mechanisms including confidential mechanisms for students to report bias, discrimination, mistreatment. There are ombudspersons and others available to them. These resources are explained to students annually and they are required to complete online activities that demonstrate their knowledge of this information. In addition to this information being in our student handbook and links in the syllabus of every course and clerkship, students receive a sticker for their ID badge that takes them to the vanity website where this information can also be found.

Redistribution

- ❑ Black, Indigenous, and Latinx medical students have access to designated physical spaces, as well as support staff, including administrators, physician mentors, mental health providers, and peer counselors who are themselves BIPOC.

  We recently identified a room and are in the process of renovating a multicultural space for BIPOC learners. There are senior BIPOC leaders and administrators that are mentors for our scholars and learners. We work closely with the Black Physicians Network of Rochester to continue mentorship support. Within our University Counseling Center, there are culturally responsive and trauma informed BIPOC counselors that work with our scholars. URSMD has a Rochester Association of Minority Residents and Fellows (RAMRF) who serve as peer counselors. There are a number of affinity groups to support scholars with intersecting identities – SNMA, LMSA, Spectrum, APAMSA, AMWA, RMAC.

- ❑ The medical school does not participate in AOA.[5]

  Our medical school participates in AOA. A group is currently being formed to review our criteria for nominating students for AOA consideration.

- ❑ The medical school conducts a publicly-available annual review of racial and other inequities in pre-clinical and clinical grades, accompanied by a clear strategy to rectify any inequities.

  We do not have publicly-available reports. Our small medical school size would jeopardize privacy with any report.

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[4] https://deanofstudents.umich.edu/campus-climate-support

[5] https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2607210, https://pubmed.ncbi.nlm.nih.gov/30234509/

- ❑ The medical school has provided students with appropriate supportive resources during the COVID-19 pandemic, including increased financial aid, access to affordable housing, and leave to care for ill family members.

  As we have been able to conduct our medical school curriculum for the most part, during the COVID pandemic, our students have maintained access to financial aid and additional resources for emergencies/special circumstances. Housing costs in our community are low. We have policies in place to allow flexibility for individual illness or family needs. Additionally, designated faculty (Assistant Dean Student Affairs, Advisory Deans, and others) are available to assist students. An OAS staff member currently is on the Campus Climate & Care Committee. She can assist with facilitating delivery from the food pantry if needed for groceries and toiletries. She also can assist with connection to mental health services.

Community Control and Self-Determination

- ❑ The medical school offers excused absences, extensions on coursework, and robust mental health resources in the wake of incidents of police violence and other forms of racialized violence.

  URSMD has policies in place for absences and extensions that apply to all challenging situations students may experience including experience and reaction to police violence and racism.

- ❑ The medical school complies in a timely manner with student and community activists' requests for meetings, and takes substantive steps to meet their demands as judged by members of the activist groups.

  The medical school has facilitated student protest activities and has directly addressed student requests.

Total score:___/7 = __% = _____(letter grade)

5. PHYSICAL SPACE

Police and Prison Abolition

- ❑ The medical school campus is free from surveillance cameras.[6]

  Unlike most academic medical centers, URSMD is interconnected with SMH, the region's largest trauma center. SMH is often the caregiver for those who commit or are the victims of serious crimes. Surveillance cameras are an important tool used by our highly trained Public Safety department to ensure the safety of our faculty, staff and patients.

  SMH policy, 9.02.5 Photographing, Filming or Recording of Patients, Workforce Members and Medical Center Environment Policy, determines parameters for video use. Public

[6] https://www.aclu.org/other/whats-wrong-public-video-surveillance

Safety uses video as needed to assist in finding lost or missing children, patients, reported criminal activities, and as an investigation tool.

An example of this is an AMBER Alert from the Children's Hospital NICU. Camera use was vital in locating the child in the hospital's main lobby where officers were able to stop the abductor and determine the child was not breathing. A call for life saving measures enabled the resuscitation process and returned the child to critical care for a successful outcome.

In addition, the LCME accreditation regulations spell out the need for appropriate security systems at educational sites; section ER-5. Given the size and openness of our campus, surveillance cameras are a key element in our ability to do this.

Redistribution

- ❑ The physical spaces of the medical school acknowledge the contributions of alumni and health care workers of color (through plaques, statues, portraits, and building names) and do not celebrate racist or white supremacist individuals.

URSMD has acknowledged our history of racial injustice and removed the name of George Whipple, MD, the first dean of the school, from the auditorium, the Whipple Circle, and his old office that was being used as a museum. His former office is being renovated as a multicultural learner space for BIPOC scholars and learners. The medical school has honored the contribution of Black and Latinx alumni with displays. Medical students, in partnership with the Office of Medical Student Inclusion and Enrichment Programs (formerly the Center for Advocacy, Community Health, Education and Diversity), curated an exhibit titled "Remembering 1619" that looks at racial injustice through a healthcare lens.

Community Control and Self-Determination

- ❑ There is a clear and accessible process for community organizations to use the physical space of the medical school free of charge during weekends, evenings, and other times when it is not in use.

This process is in place but is currently on hold due to the pandemic and the need to optimize the health and safety of all of our students.

Total score: __/3 = __% = _____(letter grade)

6. RELATIONSHIP TO THE CARCERAL STATE

Police and Prison Abolition

- ❑ Campus police have been abolished. If necessary, these structures have been replaced with alternative safety structures such as crisis intervention teams.[7]

[7] https://theintercept.com/2020/06/10/ruth-wilson-gilmore-makes-the-case-for-abolition/

Public Safety ensures the safety and protection of all within the hospital. An example of critical need is an extremely violent patient who attempted to stab staff with scissors and other sharp implements. DPS was able to intervene protecting clinical staff and restrain the patient without harm to anyone, including the patient. There is no local law enforcement capable of responding to violent patients with weapons or to investigate crimes that is mandated to follow OMH and DOH guidelines.

Redistribution

- ❑ The medical school has divested from private prisons, security forces, prison profiteers and prisons and companies that facilitate Israeli apartheid.[8]

The University's Procurement (Purchasing) Department is committed to supplier diversity. As part of the University's diversity initiative, the department has defined supplier diversity to include businesses owned by women, African-Americans, Hispanics, Minorities, Veterans, the Disabled, Lesbian, Gay, and Bisexual and Transgender individuals, as well as historically underutilized business zone and small business.

As for our endowment investments, On May 13, 2020 the Investment Committee adopted this resolution:

> *"The Ethical Investment Advisory Committee recommends that the University of Rochester Investment Committee adopt a policy of making no direct investments in any publicly-traded company that owns or operates private prisons, including CoreCivic and its subsidiaries, GEO Group, and G4S. Additionally, the Investment Office will notify the EIAC of any private prison equity holding that may appear in the portfolio, and it will notify its investment managers of this policy."*

As a result, the endowment does not currently include any of these securities.

Total score: __/2 = __% = _____(letter grade)

7. TREATMENT OF WORKERS

Police and Prison Abolition

- ❑ Hiring processes for workers at the medical school do not incorporate inquiries about the person's history of criminal punishment system involvement.[9]

The University of Rochester does not make hiring decisions based on history of criminal punishment system involvement. The application process does not include questions with regards to an individual's criminal history. Current training with regards to ethical and legal obligations include guidance on questions that cannot be asked during the interview process, including questions related to criminal punishment system involvement (i.e. arrest record and conviction record).

Redistribution

- ❑ All medical school staff are paid a living wage for a family of four with a single wage-

[8] https://bdsmovement.net/what-is-bds
[9] https://www.nelp.org/wp-content/uploads/Fair-Chance-Ban-the-Box-Best-Practices-Models.pdf

earner as defined by local advocacy organizations.

The Office of Human Resources' Wage and Salary Program supports managers and employees through the employee lifecycle including job offer, performance evaluations, service milestones and job changes. Its components allow several factors to be taken into consideration for an employee's pay, such as individual performance, internal equity, pay relationship to the external market, and the value of our benefits programs. The University is committed to pay parity with the City of Rochester's Living Wage. All active, full-time and part-time, non-bargaining unit employees are to be paid at least the equivalent of the City of Rochester's Living Wage. Employees who receive minimum wage adjustments are still eligible for consideration for any performance-based and/or additional components of the Wage and Salary Program.

- ❑ All full-time medical school staff have comprehensive health insurance that is accepted at the health system affiliated with the medical school.

  The University of Rochester offers all full-time staff comprehensive health insurance and has established an extensive network of providers within our system to ensure staff have options that utilize their coverage to its fullest.

- ❑ Publicly-available annual data demonstrates equitable median compensation by race and gender for medical school staff, and a ratio of executive/dean to median worker compensation of less than 10. [10, 11, 12]

  The University is an Equal Opportunity Employer committed to pay equity and Affirmative Action. To that end the University conducts annual reviews to ensure internal staff equity as well as reviews to understand the University's pay position relative to market. As a federal contractor with specific obligations to the OFCCP the University maintains an affirmative action plan committed to equitable practice relating to recruiting for open positions. The University has recently started a three-year Career Pathway Modernization Project designed to modernize its job architecture and create transparency around the career pathways that support equitable advancement and job opportunity for its staff.

Community Control and Self-Determination

- ❑ The medical school respects workers' rights to organize unions and do not engage in counter-campaigns against worker organizing (including firing or threatening workers, unnecessarily delaying union elections, or paying outside consultants to coordinate anti-union campaigns).[13]

  The University fully supports employee's right to decide for themselves whether to unionize. That said we always want that important decision to be an informed one. To that

[10] https://dash.harvard.edu/bitstream/handle/1/13348081/kiatpongsan,norton_how-much-%28more%29-should-ceosmake.pdf?sequence=1
[11] https://aflcio.org/paywatch
[12] https://lownhospitalsindex.org/
[13] https://www.jwj.org/wp-content/uploads/2013/12/UROCUEDcompressedfullreport.pdf

end, we do provide information to employees in line with the NLRA. Never would we condone any illicit actions taken against any employee for exercising their right to organize. In fact, we educate our leaders that it is illegal to "fire or threaten workers" for exercising their right to organize. However, we do not believe unions are necessary at the University as the University works best when there is a strong and direct bond forged between employees and their departments and schools. We believe unions undermine these direct relationships. In addition, we have numerous avenues in our existing structure to give employees a voice in governance, dispute resolution and grievance resolution.

- ❑ The medical school makes a payment in lieu of taxes (PILOT) to their local government equivalent to at least 75% of what they would pay in real estate taxes if their property were taxable.[14] Plans for the construction of any new facilities include community-designed strategies to prevent displacement of surrounding BIPOC communities.

  Our medical schools are non-profit organizations. Tuition fees, NIH funds, and gifts/endowment proceeds together do not cover the full cost of operating the school. To stay afloat, schools like UR SMD depend on their clinical enterprises for tens of millions of dollars each year.

  Exemption from income tax allows us to make the most of our revenues, including providing nearly $42 million in unreimbursed Medicaid services, $20.6 million in charity care, and $7 million in unrecoverable patient debt. This is in addition to $35 million in community-based research and $81,000 in free exams and screenings. In total, this commitment to our community far exceeds any tax liability that may be levied.

  A major focus of our Equity and Anti-Racism Action Plan has been to increase accessibility to our services for those in underserved areas, both urban and rural. To achieve this, we are looking at how to revive the city's currently vacant properties to house these services. Far from displacing residents, our goal is to make those neighborhoods more attractive and livable.

Total score: __/6 = __% = _____(letter grade)

8. RESEARCH

Police and Prison Abolition

- ❑ The medical school conducts no joint research endeavors with Israeli academic institutions or corporations.[15]

  Research partnerships at URMC are forged in many ways, but none are dictated by the URMC leadership as the strength of our research emanates from the expertise of our research faculty:

  - The large majority of our research is funded by our U.S. Government sponsors, specifically with the NIH. Our research faculty submit research proposals that are

[14] https://www.boston.gov/finance/payment-lieu-tax-pilot-program
[15] https://bdsmovement.net/pacbi/academic-boycott-guidelines

reviewed by their peers and recommended for funding to conduct both basic (bench) and clinical research;
- Many collaborations are built upon existing relationships with our research faculty and their students, postdocs and colleagues that have moved on to other institutions and universities;
- Inter-institutional consortia, both domestic and international, build upon the expertise of research faculty to solve disease specific problems;
- Pharmaceutical partners assess the patient population and clinical expertise of our faculty to place clinical trials and research at the URMC to test new vaccines, therapeutics and devices to heal and support patients;
- Internal research support and internal seed funding seeks to provide support for faculty to gather additional data for external funding, or provide "proof of concept" support to enable IP protection and eventual commercialization.

Redistribution

Community Control and Self-Determination

❑ Any human subjects research studies that recruits from the local community is conducted in partnership with local BIPOC and/or Latinx-led community organizations.

Virtually all of our approximately 2,000 clinical trials and observational studies recruit subjects from the local community, and we are committed to continuously improving the methods, diversity and inclusiveness of these studies by fully using resources developed in our Clinical and Translational Science Institute.

Our community engagement consultations address issues of implicit bias, diversity and inclusion. The purpose of these consultations has been to improve research methods to make the science more equitable and inclusive, and to better engage underrepresented groups as research partners and participants. For example, our Community Studios enable research teams to meet with community members for a facilitated discussion to gather input on study methods, recruitment, etc. Over time, the goal is to require most, if not all investigators to make use of these services without creating an overly burdensome system. Simultaneously, our Community Based Participatory Research Course and Pipeline Pilot Awards support the development of university-community teams to address research questions generated by the community.

Our Community Advisory Council (which advises our research effort through the Clinical and Translational Science Institute) includes representatives from a broad range of community health planning organizations like Common Ground Health, the Latino Health Coalition, and the African American Health Coalition, along with leaders from the Urban League, Ibero American Action League, Empire Justice Center, Charles Settlement House, St. Joseph's Neighborhood Center, etc. See full list here.

❑ The medical school financially supports the formation of community IRBs at local BIPOC-led community organizations.[16]

[16] https://www.ccphealth.org/wp-content/uploads/2017/10/Shaping_the_Future_of_CEnR.pdf

In the past, we have explored the idea of a community-based IRB-like board. However, the Community Advisory Council (CAC) felt that participation would be too burdensome (this is a highly regulated function) and time consuming for most community members. So, we chose to present especially relevant studies to the CAC. Now, the Community Studios serve as a key forum for in-depth input and support. Meanwhile, we are always seeking individuals from diverse backgrounds as members of our IRB.

- ❑ IRB approval process requires researchers involved in any research that uses race to precisely define race and how it is being used in the research project. Projects based on race-based genetics or any other biological definitions of race are not approved.

  While it occurs very rarely, our IRB is very careful when approving research that uses race as an eligibility criterion or when a study plans to over-enroll a specific racial group. The background and science must support this study design and why a particular race is targeted.

  Research conducted by University investigators that collects race data generally does so to explore the impact of race, as a social construct, on the development and prevention of disease.

  At the annual University of Rochester All-IRB meeting to be held in the first quarter of 2021, we will discuss whether or not projects based on race-based genetics or any other biological definitions of race should ever be approved. To date, we are not aware of any studies that have proposed this. This discussion will allow the members of the board, including our community to members, to fully vet this topic to enable the University of Rochester to move forward with codifying a policy such to ensure that this type of research is not approved at UR.

Total score: __/4 = __% = _____(letter grade)

9. INSTITUTIONAL RESPONSE TO STUDENT ACTIVISM

- ❑ There have been no episodes of retaliation, either by the medical school administration or classmates, against medical students engaging in anti-racist activism on campus. (This includes but is not limited to the following: lowering student grades or giving unfavorable evaluations, subjecting student activists to disciplinary actions, allowing unchecked harassment from fellow medical students, intimidating students in meetings with medical school faculty, etc.)

  There have been no incidents of retaliation and no participants were singled out.

- ❑ Medical school faculty have made no attempts to single out student activists during the RJRC grading process. All email communications were directed to a group email address when faculty were asked to do so and appropriate questions were addressed to the WC4BL national working group.

When provided a group email address that is within our medical center, we have used that as our primary method of corresponding. Due to issues of email fraud and privacy issues, the MD program does not respond to non-university email accounts for issues related to the MD program. This is outlined in our student handbook.

Total score: __/2 = __% = _____(letter grade)

Medical School Metrics Summary

	Letter Grade
Recruitment and admissions	
Curriculum	
Clinical Education	
Student Affairs	
Physical Space	
Relationship to the Carceral State	
Treatment of Workers	
Research	
Institutional Response to Student Activism	

RESIDENCY METRICS

1. RECRUITMENT AND ADMISSIONS

Police and Prison Abolition

- ❑ In alignment with the demands of the Ban the Box movement, applicants to residency and fellowship programs are not asked to disclose whether or not they have a history of criminal punishment system involvement.

  Resident applicants utilize the AAMC ERAS application which does require applicants to disclose if they have criminal convictions (felony or misdemeanor). Programs will evaluate the conviction and its potential bearing on the practice of medicine in that specialty.

Redistribution

- ❑ Black, Indigenous, and Latinx residents/fellows are represented in all programs at rates corresponding to the demographics of the U.S. population (13% Black, 1% Indigenous, 34% Latinx).

  All programs actively recruit applicants underrepresented in medicine. A higher percentage of US medical school underrepresented in medicine applicants are interviewed and ranked compared with non-underrepresented applicants.

- ❑ Black, Indigenous, and Latinx faculty are represented on residency/fellowship admissions committees at rates corresponding to the demographics of the U.S. population (13% Black, 1% Indigenous, 34% Latinx).

  Residency and fellow admissions committees do include underrepresented faculty but the percentages noted are not available due to low numbers of these groups within the faculty.

- ❑ Residents and fellows of color who participate in recruitment and other admissions activities are compensated for their time at a rate at least equal to the local living wage.

  All residents and fellows are paid equally. Trainee participation in recruitment activities is encouraged by providing them time within their work day to participate.

Community Control and Self-Determination

- ❑ As a part of residency and fellowship admissions processes, all applicants participate in interviews with local BIPOC local leaders, who are compensated at a rate equal to or greater than the local living wage.

  Local BIPOC leaders who are not faculty members do not interview applicants. Applicants do have the ability to meet with local leaders during our Second Look activity day.

Total score: __/5 = __% = _____(letter grade)

2. CURRICULUM

Police and Prison Abolition

- ❑ All residency and fellowship programs include didactic sessions that cover the history and contemporary manifestations of racism and racist inequities in the field. Note: No points will be given for "implicit bias" training sessions.

  Residency program faculty are aware of and include the effect of health care disparities and the effect of racism on them in resident teaching activities. All programs are working to do this on a more robust basis.

- ❑ Residency didactic lecturers avoid describing race per se (rather than racism) as a risk factor for disease, cause of health disparities, or basis for diagnostic reasoning.

  Residency program faculty are aware of and include the effect of health care disparities and the effect of racism on them in resident teaching activities. All programs are working to do this on a more robust basis.

Redistribution

- ❑ BIPOC community advocates and qualified faculty lead the planning and execution of all sessions on community health and health inequities, and are compensated at a rate equal to or greater than the local living wage.

  Qualified faculty including members of the BIPOC community do engage in planning and execution of all sessions on community health inequities via the Center for Community Health. Financial decisions regarding payment policies are unknown to GME Program Directors.

Community Control and Self-Determination

- ❑ BIPOC and other marginalized residents and fellows are excused from workshops on content redundant with their lived experience (e.g. Black students are excused from workshops on anti-Black racism).

  BIPOC and other marginalized residents and fellows are not currently excused from workshops on content redundant with their lived experience. It is hoped that these individuals will share their experiences with their colleagues to promote better understanding of everyone's pathway to and experience of medicine.

Total score: __/4 = __% = _____(letter grade)

3. CLINICAL EDUCATION

Police and Prison Abolition

- ❑ All residents and fellows receive comprehensive training on techniques for protecting the privacy and safety of undocumented patients and patients presenting in police or prison

custody.[17]

All residents and fellows do receive comprehensive training on techniques to protect the privacy and safety of all of the patients under their care.

Community Control and Self-Determination

- ❑ There are uniform guidelines for the level of supervision of trainees practicing at all clinical sites (for example, trainees do not have more autonomy when caring for patients at a public hospital, free clinic, or VA hospital).

  Our guidelines are absolutely universal regarding the level of supervision of trainees practicing at all University of Rochester clinical sites regardless of the patient population they may serve.

Total score: __/2 = __% = ____(letter grade)

4. TRAINEE AFFAIRS

Police and Prison Abolition

- ❑ The GME program has a system for collecting residents' and fellows' feedback on racism and other forms of oppression, with a clear and transparent mechanism for following up on all complaints that includes non-punitive options such as mediation with a trained facilitator.

  GME Programs, as part of the University of Rochester community, utilize the university's system for collecting feedback from its trainees on racism and other forms of oppression with a clear and transparent mechanism for following up on all complaints that includes non-punitive options such as mediation with a trained facilitator.

Redistribution

- ❑ The GME program conducts a publicly-available annual review of racial and other inequities in evaluations, accompanied by a clear strategy to rectify any inequities.

  An annual review of any potential inequity in evaluation has not been conducted to date.

- ❑ Residency and fellowship programs have provided residents and fellows with appropriate supportive resources during the COVID-19 pandemic, including access to affordable childcare options, accommodations for trainees with underlying health conditions, and leave to care for ill family members.

  All GME programs have provided additional assistance for trainees to address stresses related to the COVID-19 pandemic. Benefits regarding child care and leave are outlined for all trainees who apply to the University's programs and are similar to that of university faculty and staff.

[17] https://www.aha.org/system/files/2018-03/guidelinesreleasinginfo.pdf

Community Control and Self-Determination

- ❑ Hospital and GME leadership comply in a timely manner with trainee and community activists' requests for meetings, and take substantive steps to meet their demands as judged by members of the activist groups.

  As described elsewhere in this document, there has been significant interaction between hospital leadership and members of activist groups which has led to the development of substantive steps to address concerns raised by these groups. The underrepresented in medicine residents have formed a community (Association of Minority Residents and Fellows) to discuss concerns that they may have. Members of GME leadership communicate frequently with this group to address concerns.

Total score: __/4 = __% = _____(letter grade)

5. TREATMENT OF WORKERS

Community Control and Self-Determination

- ❑ The medical hospital respects residents' rights to organize unions and does not engage in counter-campaigns against resident organizing (including firing or threatening workers, unnecessarily delaying union elections, or paying outside consultants to coordinate anti-union campaigns).[18]

  The University fully supports employee's right to decide for themselves whether to unionize. That said we always want that important decision to be an informed one. To that end, we do provide information to employees in line with the NLRA. Never would we condone any illicit actions taken against any employee for exercising their right to organize. In fact, we educate our leaders that it is illegal to "fire or threaten workers" for exercising their right to organize. However, we do not believe unions are necessary at the University as the University works best when there is a strong and direct bond forged between employees and their departments and schools. We believe unions undermine these direct relationships. In addition, we have numerous avenues in our existing structure to give employees a voice in governance, dispute resolution and grievance resolution.

Total score: __/1 = __% = _____(letter grade)

[18] https://www.jwj.org/wp-content/uploads/2013/12/UROCUEDcompressedfullreport.pdf

Residency Metrics Summary

	Letter Grade
Recruitment and admissions	
Curriculum	
Clinical Education	
Trainee Affairs	
Treatment of Workers	

HOSPITAL METRICS

1. PHYSICAL SPACE

Police and Prison Abolition

- ❑ The hospital is free from surveillance cameras (with the exception of those used for clinical monitoring, such as in performance of EEG).[19]

  As the region's largest trauma center, SMH is often the caregiver for those who commit or are the victims of serious crimes. Surveillance cameras are an important tool used by our highly trained Public Safety department to ensure the safety of our faculty, staff and patients.

  SMH policy, 9.02.5 Photographing, Filming or Recording of Patients, Workforce Members and Medical Center Environment Policy, determines parameters for video use. Public Safety uses video as needed to assist in finding lost or missing children, patients, reported criminal activities, and as an investigation tool.

  An example of this is an AMBER Alert from the Children's Hospital NICU. Camera use was vital in locating the child in the hospital's main lobby where officers were able to stop the abductor and determine the child was not breathing. A call for life saving measures enabled the resuscitation process and returned the child to critical care for a successful outcome.

Redistribution

- ❑ The physical spaces of the hospital acknowledge the contributions of alumni and health care workers of color (through plaques, statues, portraits, and building names) and do not celebrate racist or white supremacist individuals.

  In the last several months, the office of the founding Dean has been transformed into a multicultural center, and his name has been removed from one of the large auditoriums. It is well documented that Dean Whipple maintained strict racial quotas that blocked admission to the school on the basis of race and gender.

  Large, moveable displays celebrate the achievements of dozens of our Black and Latinx alums. These have been displayed prominently in the atrium/entrance to the Medical School, in the URMC Board Room, and at the main University as part of alumni events.

  As part of the University's 2020 Celebration of Women (honoring Susan B. Anthony's 200th birthday) campaign, Ruby Belton was featured. Dr. Belton is the first African American women to graduate from the UR SMD. The year-long celebration honored a number of other women of color, including Olivia Hooker, Beatrice Amaza Howard, Naomi Lee, Connie Mitchell and Ruth Holland Scott.

  The Hospital Aesthetics Committee is discussing ways to strengthen multicultural artwork

[19] https://www.aclu.org/other/whats-wrong-public-video-surveillance

throughout the facility.

Total score: __/2 = __% = _____(letter grade)

2. RELATIONSHIP TO THE CARCERAL STATE

Police and Prison Abolition

- ❑ Hospital security forces have been abolished. If necessary, these structures have been replaced with alternative safety structures such as crisis intervention teams.[20]

  Public Safety ensures the safety and protection of all within the hospital. An example of critical need is an extremely violent patient who attempted to stab staff with scissors and other sharp implements. DPS was able to intervene protecting clinical staff and restrain the patient without harm to anyone, including the patient. There is no local law enforcement capable of responding to violent patients with weapons or to investigate crimes that is mandated to follow OMH and DOH guidelines.

  Over half of the members of the Department of Public Safety is trained in Crisis Intervention techniques and serve as members of a dedicated Crisis Intervention team. Documentation of additional training of DPS officers above what local law enforcement receives is available upon request.

- ❑ ICE personnel are not allowed on any of the hospital campuses.

  The same SMH policies for law enforcement apply to ICE.

- ❑ The hospital has clear policies requiring that: a) incarcerated patients be interviewed and examined in private without the presence of law enforcement or ICE officials, and b) patient health information is shared with law enforcement only in cases explicitly required by law. This policy is clearly communicated to all providers, and there is a mechanism for providers to engage an attorney or other support person with any questions or concerns if faced with resistance to the policy from law enforcement officers.

  SMH Policy 9.10, Patient Prisoners, addresses the response for all patients who are in custody of law enforcement.

  SMH Policy 9.09.1, Contacts with Law Enforcement Agencies Policy, addressed the response to law enforcement requests.

  SMH Policy 9.06, Reporting Certain Wounds to Law Enforcement; Evidence: Wounds/Removal of Foreign Body & Clothing from Patients Injured by Assault Policy.

  The UR Office of Council advises all employees on any questions regarding law enforcement requests not specifically outlined in policy and acts as the employees'

[20] https://theintercept.com/2020/06/10/ruth-wilson-gilmore-makes-the-case-for-abolition/

representative.

- ❑ All providers are trained to exclude from the medical record any information that may be used in legal proceedings against patients, particularly information about the patient's immigration status. Providers are trained to obtain drug and alcohol screens on patients only in cases where the screen would alter the patient's clinical care.

  Providers are taught to document only information about a patient's history in the record that will affect their care. Residents are not taught to enter immigration status as a piece of demographic information in the medical record that is "searchable". They may mention it in a note as it relates to their ability to access certain elements of care via insurance etc, to enhance their care. Drugs and alcohol are known health influencers, as a result it is appropriate to inquire about drug and alcohol use in the context of caring for patients. If those questions are asked, they are asked of ALL patient cared for by a resident physician not a specific social/racial group. So, if a patient is drug tested because they are on a narcotic pain contract, it is the pain contract that drives the testing. Residents are not taught to test patients randomly for these issues, or based on their race/ethnic/social groups. It is via the medical issues they are presenting with that drives the decisions.

Redistribution

- ❑ The hospital has divested from private prisons, security forces, prison profiteers and prisons and companies that facilitate Israeli apartheid.

  The University's Procurement Department is committed to supplier diversity. As part of the University's diversity initiative, the department has defined supplier diversity to include businesses owned by women, African-Americans, Hispanics, Minorities, Veterans, the Disabled, Lesbian, Gay, and Bisexual and Transgender individuals, as well as historically underutilized business zone and small business.

  As for our endowment investments, On May 13, 2020 the Investment Committee adopted this resolution:

  > *"The Ethical Investment Advisory Committee recommends that the University of Rochester Investment Committee adopt a policy of making no direct investments in any publicly-traded company that owns or operates private prisons, including CoreCivic and its subsidiaries, GEO Group, and G4S. Additionally, the Investment Office will notify the EIAC of any private prison equity holding that may appear in the portfolio, and it will notify its investment managers of this policy."*

  As a result, the endowment does not currently include any of these securities.

Community Control and Self-Determination

The hospital has policies in place to protect undocumented patients including:

- ❑ Designated staff who are the only people authorized to speak to immigration agents. These staff are trained to request a warrant from agents and to determine if one presented is valid. Otherwise, employees are instructed not to provide information to immigration agents unless legally required.

All SMH Policies for contacts with law enforcement apply. Public Safety is the liaison with law enforcement and does not allow the release of information unless required by law. As a UR employee, Public Safety seeks the advice of Office of Council on issues not specifically mentioned in policy. Public Safety never asks for citizenship or status and has no mechanism to record such data.

- ❑ Existence of an alert system to inform staff of the presence of immigration officials on the hospital campus.

  We do not have such an alert system.

- ❑ Clearly-outlined response to requests from ICE or CBP that protects patients' privacy to the maximum extent allowed by law.[21]

  We would rely on our standard SMH Policy 9.09.1 which covers Contacts with Law Enforcement Agencies to guide all of these types of interactions, including ICE or CBP. Hospital staff have the primary responsibility to ensure that high quality patient care is maintained at all times while responding to requests for assistance from law enforcement officials. Patients also have the right to refuse to provide information.

Total score: __/8 = __% = _____(letter grade)

3. TREATMENT OF WORKERS

Police and Prison Abolition

- ❑ Hiring processes for workers at the hospital do not incorporate inquiries about the person's history of criminal punishment system involvement.

  The University of Rochester does not make hiring decisions based on history of criminal punishment system involvement. The application process does not include questions with regards to an individual's criminal history. Current training with regards to ethical and legal obligations include guidance on questions that cannot be asked during the interview process, including questions related to criminal punishment system involvement (i.e. arrest record and conviction record).

Redistribution

- ❑ All hospital staff are paid a living wage as defined by local advocacy organizations.

  The Office of Human Resources' Wage and Salary Program supports managers and employees through the employee lifecycle including job offer, performance evaluations, service milestones and job changes. Its components allow several factors to be taken into consideration for an employee's pay, such as individual performance, internal equity, pay relationship to the external market, and the value of our benefits programs. The University is committed to pay parity with the City of Rochester's Living Wage. All active, full-time

[21] https://phr.org/wp-content/uploads/2019/09/PHR-Sanctuary-Hospitals-Fact-Sheet-FINAL.pdf

and part-time, non-bargaining unit employees are to be paid at least the equivalent of the City of Rochester's Living Wage. Employees who receive minimum wage adjustments are still eligible for consideration for any performance-based and/or additional components of the Wage and Salary Program.

- ❑ All full-time hospital staff have comprehensive health insurance that is accepted at the health system where they work.

  The University of Rochester offers all full-time staff comprehensive health insurance and has established an extensive network of providers within our system to ensure staff have options that utilize their coverage to its fullest.

- ❑ Publicly-available annual data demonstrates equitable median compensation by race and gender for hospital staff, and a ratio of executive to median worker compensation of less than 10.[22, 23, 24]

  The University is an Equal Opportunity Employer committed to pay equity and Affirmative Action. To that end the University conducts annual reviews to ensure internal staff equity as well as reviews to understand the University's pay position relative to market. As a federal contractor with specific obligations to the OFCCP the University maintains an affirmative action plan committed to equitable practice relating to recruiting for open positions. The University has recently started a three year Career Pathway Modernization Project designed to modernize it's job architecture and create transparency around the career pathways that support equitable advancement and job opportunity for its staff.

Community Control and Self-Determination

- ❑ The hospital respects workers' rights to organize unions and do not engage in counter-campaigns against worker organizing (including firing or threatening workers, unnecessarily delaying union elections, or paying outside consultants to coordinate anti-union campaigns).[25]

  The University fully supports employee's right to decide for themselves whether to unionize. That said we always want that important decision to be an informed one. To that end, we do provide information to employees in line with the NLRA. Never would we condone any illicit actions taken against any employee for exercising their right to organize. In fact, we educate our leaders that it is illegal to "fire or threaten workers" for exercising their right to organize. However, we do not believe unions are necessary at the University as the University works best when there is a strong and direct bond forged between employees and their departments and schools. We believe unions undermine these direct relationships. In addition, we have numerous avenues in our existing structure to

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[22] https://dash.harvard.edu/bitstream/handle/1/13348081/kiatpongsan,norton_how-much-%28more%29-should-ceosmake.pdf?sequence=1

[23] https://aflcio.org/paywatch

[24] https://lownhospitalsindex.org/

[25] https://www.jwj.org/wp-content/uploads/2013/12/UROCUEDcompressedfullreport.pdf

give employees a voice in governance, dispute resolution and grievance resolution.

- ❑ The hospital makes a payment in lieu of taxes (PILOT) to their local government equivalent to at least 75% of what they would pay in real estate taxes if their property were taxable.[26] Plans for the construction of any new facilities include community-designed strategies to prevent displacement of surrounding BIPOC communities.

  Our medical schools are non-profit organizations. Tuition fees, NIH funds, and gifts/endowment proceeds together do not cover the full cost of operating the school. To close the School's structural deficit, we depend on the clinical enterprise for tens of millions of dollars each year. Exemption from income tax allows us to make the most of our revenues, including providing nearly $42 million in unreimbursed Medicaid services, $20.6 million in charity care, and $7 million in unrecoverable patient debt. This is in addition to $35 million in community-based research and $81,000 in free exams and screenings. In total, this commitment to our community far exceeds any tax liability that may be levied.

  A major focus of our Equity and Anti-Racism Action Plan has been to increase accessibility to our services for those in underserved areas, both urban and rural. To achieve this, we are looking at how to revive currently vacant properties to house these services. Far from displacing residents, our goal is to make those neighborhoods more attractive and livable.

Total score: __/6 = __% = _____(letter grade)

4. PATIENT CARE

Police and Prison Abolition

- ❑ Publicly-available data demonstrates that chemical and physical restraints are used sparingly inpatient care, and are not used disproportionately in the care of BIPOC patients.[27, 28]

  URMC does not use chemical restraints. SMH policies, 10.02.1, restraints and seclusion for Violent/Self-Destructive Behaviors Policy and 10.02, Restraints for Non-Violent, Non Self-Destructive Behaviors Policy to guide staff on the proper use of restraints. SMH has an oversite committee in place to review the use of restraints and address concerns.

  DPS assists clinical staff with patient restraints only by medical order of a clinician.

Redistribution

- ❑ Publicly-available data demonstrates that BIPOC patients are represented in all hospital services (including specialist services) and practices at their rate in the local population.

[26] https://www.boston.gov/finance/payment-lieu-tax-pilot-program
[27] https://pubmed.ncbi.nlm.nih.gov/24432487/
[28] https://onlinelibrary.wiley.com/doi/abs/10.1111/acem.14092

Unfortunately, URMC observes the same disparity found in many academic medical centers. BIPOC patients are significantly more likely to be seen by a resident physician as opposed to an attending physician. As we complete our health disparities data initiative, we will be better able to quantify, monitor and address this disparity.

Addressing this problem requires cultural changes – including changes in the racial composition of our workforce – to make our services more welcoming to BIPOC individuals. It will also require major changes to improve accessibility in neighborhoods that are currently underserved. Both of these are foundational platforms in our new Equity and Anti-Racism Action Plan.

- ❑ Publicly-available data demonstrates that BIPOC patients are cared for by attending physicians at the same rate as white patients, and are not disproportionately cared for by trainees.

  We have launched a health disparities information initiative that aims to give everyone in our health system from leadership to providers and staff the EMR tools and data they need to identify disparities and answer exactly these questions. We plan to make these data easily available in order to measure and improve. Our approach is three-fold:
  - Identify the demographics of the patients we currently serve,
  - Identify disparities with a special focus on the social determinants of health, and
  - Easily connect patients with URMC and community resources to improve outcomes.

  We expect to have the tool which enables basic demographic information ready in early 2021; by August of 2021 the tool will be able to show social determinants of health, and by November of 2021, it will have functionality that allows referrals to community resources.

- ❑ The medical school and hospital support local, state, and national efforts to establish a single-payer healthcare system via lobbying efforts (i.e. any paid lobbying includes advocacy for a single-payer system), formal position statements, and hosting of supportive organizations and events.

  We unequivocally support universal health care coverage. To do this, we need to change the value equation, not simply the payer. NYS hospitals and health systems are already working on change, redesigning care systems to both improve care and reduce the growth of spending.

  If we simply cut payments to these health systems, we risk upsetting their already tenuous financial status – possibly sacrificing their viability as health providers and employers. We support a bipartisan, long-term approach that manages cost growth over time, takes advantage of technology and innovation, and continuously seeks more effective ways to deliver high-quality care.

Community Control and Self-Determination

- ❑ The hospital and affiliated clinics have posted multilingual public signs stating that patients are welcome regardless of immigration status.

  This idea is being discussed by the Hospital's ICARE Steering Committee. We are certainly open to doing this.

- ❑ Bilingual members of local immigrant communities are preferentially hired for patient-facing roles including nurses, physicians, and aides.

  The University recognizes the importance of supporting local immigrant communities and maintains an affirmative action plan committed to equitable practice relating to recruiting for open positions. The University cannot, however, give preferential treatment to any individual or group when hiring. We are required to utilized certified translators for any interpreting services need that are readily available the scheduling as needed.

- ❑ The hospital board of trustees or equivalent governing bodies include: a) at least 50% residents of the local community, b) BIPOC membership at least equivalent to the representation of these groups in the local community, and c) at least 50% women, femmes, or non-binary people.

  The 36-member URMC board is fully comprised of local residents. A concerted effort has been made to diversify our governance. The nominating committee actively seeks individuals with varied backgrounds and talents. In fact, we seek a greater percentage of diverse board members each year in order to effect change. Of the 7 new board members who start their term in January of 2021, 4 are Black, 1 is Latinx, and 2 are Caucasian.

  In total, the slate of Board members that begin its term on January 25, 2021, 31% are female vs. 69% male; 19% are Black, 75% are Caucasian and 5% are Hispanic/Latinx.

- ❑ The hospital has published publicly available demographic data on COVID-19 infection rates, morbidity, and mortality and resource allocation with regards to race.

  URMC faculty at the Center for Community Health and Prevention – through its work with the CDC-funded Emerging Infections Program – collects and analyzes data for the Monroe County Department of Health officials. As part of Monroe County's COVID dashboard, we provide a breakdown of age-adjusted cases, hospitalizations, ICU stays, total and in-hospital deaths by race, ethnicity, and gender. These dashboard data are updated monthly and are publicly available.

  The Center for Community Health is doing a study looking at explanatory variables for impact of race and ethnicity of COVID rates – poverty, crowding, education, etc. which is still in its preliminary phase.

- ❑ Hospital crisis standards of care for the allocation of scarce resources during the COVID pandemic are authored in close collaboration with BIPOC community leaders.

BIPOC community leaders provided, and continue to provide, critical leadership in the Coronavirus Ethics Response Group. Dr. Adrienne Morgan and Rev. Lawrence Hargrave lead the Community Engagement Committee and recommended community leaders to serve as both members of the committee and as triage committee members. While we continue to hope that we never need to invoke the protocol, the Community Engagement committee remains active to promote equity, transparency, and review of our approach to crisis standard of care.

The Community Engagement Committee includes diverse community members who share a mission to address fairness, equity, and potential bias in the dissemination of guidelines and procedures if hospitals experience a shortage of ventilators. Membership consists of community leaders who represent critical diversity in terms of race, ethnicity, religion, sexual identity, refugee and documentation status, and ability. Committee members: 1) contribute to informed decision-making during and after the crisis; 2) ensure transparency during and after the COVID-19 crisis; 3) recognize that social and economic determinants of health will disproportionately affect people from marginalized populations; 4) identify strategies to mitigate disproportionate effects of the Protocol; 5) commit to continuing the conversation after the crisis; and 6) respect diversity, equity, and inclusion throughout the process.

Total score: __/9 = __% = _____(letter grade)

5. RESEARCH

Police and Prison Abolition

❑ The hospital conducts no joint research endeavors with Israeli academic institutions or corporations.[29]

Research partnerships at URMC are forged in many way, but none dictated by the URMC leadership as the strength of our research emanates from the expertise of our research faculty:

- The large majority of our research is funded by our U.S. Government sponsors, specifically with the NIH. Our research faculty submit research proposals that are reviewed by their peers and recommended for funding to conduct both basic (bench) and clinical research;
- Many collaborations are built upon existing relationships with our research faculty and their students, postdocs and colleagues that have moved on to other institutions and universities;
- Inter-institutional consortia, both domestic and international, build upon the expertise of research faculty to solve disease specific problems;
- Pharmaceutical partners assess the patient population and clinical expertise of our faculty to place clinical trials and research at the URMC to test new vaccines, therapeutics and devices to heal and support patients;

[29] https://bdsmovement.net/pacbi/academic-boycott-guidelines

- Internal research support and internal seed funding seeks to provide support for faculty to gather additional data for external funding, or provide "proof of concept" support to enable IP protection and eventual commercialization.

Community Control and Self-Determination

❑ Any human subjects research studies that recruit from the local community are conducted in partnership with BIPOC-led community organizations.

Virtually all of our approximately 2,000 clinical trials and observational studies recruit subjects from the local community, and we are committed to continuously improving the methods, diversity and inclusiveness of these studies by fully using resources developed in our Clinical and Translational Science Institute.

Our community engagement consultations address issues of implicit bias, diversity and inclusion. The purpose of these consultations has been to improve research methods to make the science more equitable and inclusive, and to better engage underrepresented groups as research partners and participants. For example, our Community Studios enable research teams to meet with community members for a facilitated discussion to gather input on study methods, recruitment, etc. Over time, the goal is to require most, if not all investigators to make use of these services without creating an overly burdensome system. Simultaneously, our Community Based Participatory Research Course and Pipeline Pilot Awards support the development of university-community teams to address research questions generated by the community.

Our Community Advisory Council (which advises our research effort through the Clinical and Translational Science Institute) includes representatives from a broad range of community health planning organizations like Common Ground Health, the Latino Health Coalition, and the African American Health Coalition, along with leaders from the Urban League, Ibero American Action League, Empire Justice Center, Charles Settlement House, St. Joseph's Neighborhood Center, etc. See full list here.

❑ The hospital financially supports the formation of community IRBs at local BIPOC-led community organizations.[30]

In the past, we have explored the idea of a community-based IRB-like board. However, the Community Advisory Council (CAC) felt that participation would be too burdensome (this is a highly regulated function) and time consuming for most community members. So we chose to present especially relevant studies to the CAC. Now, the Community Studios serve as a key forum for in-depth input and support. Meanwhile, we are always seeking individuals from diverse backgrounds to serve as members of our IRB.

❑ IRB approval process requires researchers involved in any research that uses race to precisely define race and how it is being used in the research project. Projects based on race-based genetics or any other biological definitions of race are not approved.

[30] https://www.ccphealth.org/wp-content/uploads/2017/10/Shaping_the_Future_of_CEnR.pdf

While it occurs very rarely, our IRB is very careful when approving research that uses race as an eligibility criterion or when a study plans to over-enroll a specific racial group. The background and science must support this study design and why a particular race is targeted.

Research conducted by University investigators that collects race data generally does so to explore the impact of race, as a social construct, on the development and prevention of disease.

At the annual University of Rochester All-IRB meeting to be held in the first quarter of 2021, we will discuss whether or not projects based on race-based genetics or any other biological definitions of race should ever be approved. To date, we are not aware of any studies that have proposed this. This discussion will allow the members of the board, including our community to members, to fully vet this topic to enable the University of Rochester to move forward with codifying a policy such to ensure that this type of research is not approved at UR.

Total score: __/4 = __% = _____(letter grade)

Hospital Metrics Summary

	Letter Grade
Physical Space	
Relationship to the Carceral State	
Treatment of Workers	
Patient Care	
Research	