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

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.

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 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

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

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

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,

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

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,

RESIDENCY MEnME

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.

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Redistribution

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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

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 custn2aC3.33 T.(n2aC3.33 T.(n2aC3n T.(n 0Ere)-14( )-124m(ELA)-6(TI)-6(O)7(N)-6(S)-6(H)7(I)-6(P)7

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.

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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

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

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

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.

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 documenta314 anS6(s)-6(e)7(nt)7( )-124(c)7(ri)-13(t)7(i)ЈTJE-20(-124(t)7=

- 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”

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