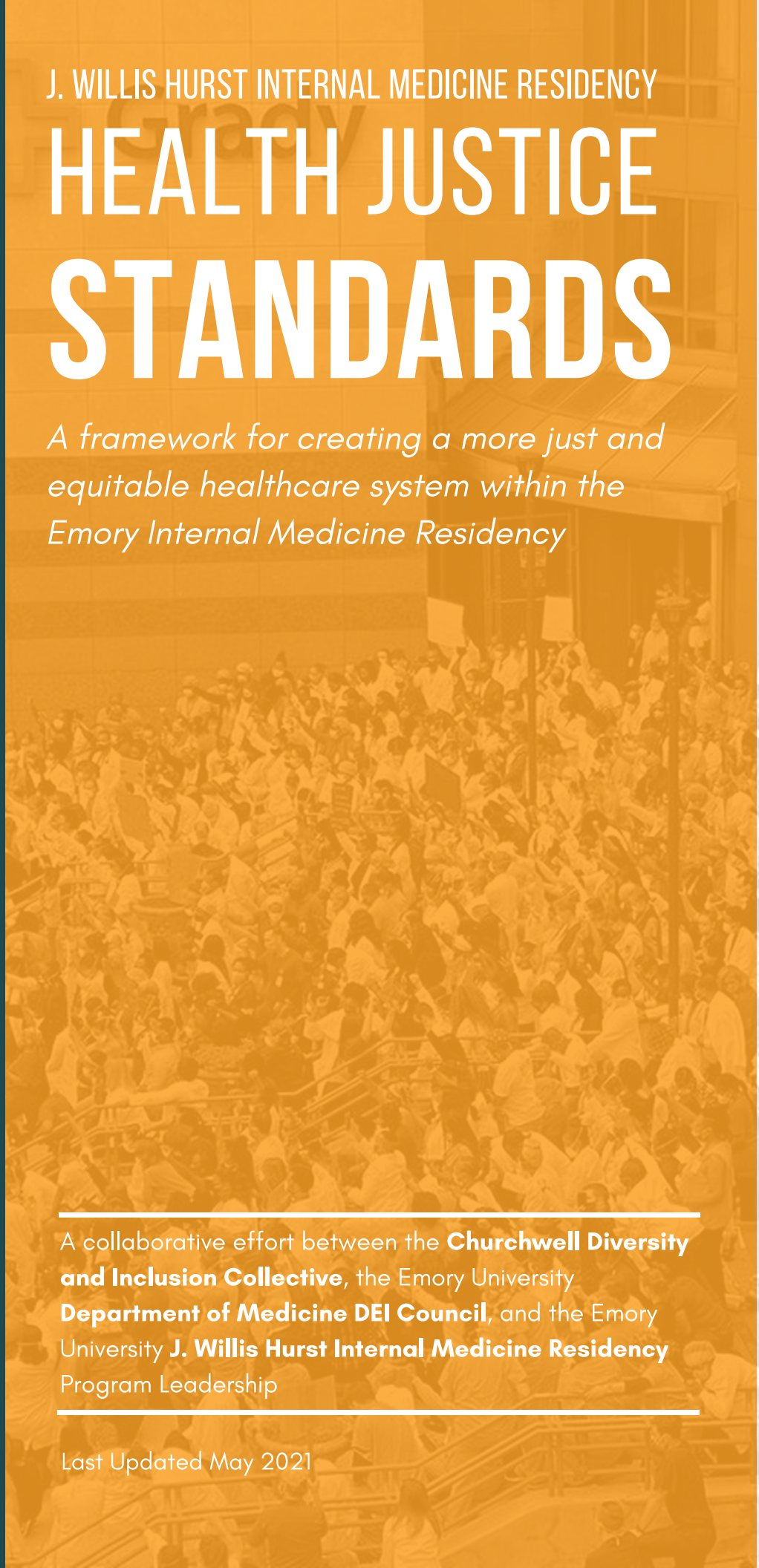
J. WILLIS HURST INTERNAL MEDICINE RESIDENCY

HEALTH JUSTICE STANDARDS

A framework for creating a more just and equitable healthcare system within the Emory Internal Medicine Residency



A collaborative effort between the **Churchwell Diversity and Inclusion Collective**, the Emory University **Department of Medicine DEI Council**, and the Emory University **J. Willis Hurst Internal Medicine Residency** Program Leadership

Last Updated May 2021

CREATORS

This list of health justice standards is the collaborative work of resident and attending members of the **Churchwell Diversity and Inclusion Collective (CDIC)** in concert with **Emory University Department of Medicine's Diversity, Equity, and Inclusion (DEI) Council** and the **Emory University Internal Medicine Residency Program** leadership. As physicians, we acknowledge that a long history of systemic racism and bias in medicine and medical education has led to inequitable health care and has significantly impacted the composition of the physician workforce. In addition to our broader departments, hospitals, and healthcare system, we believe that our residency programs share responsibility in mitigating this and that they must strive to build more diverse, welcoming, and equitable systems.

INTRODUCTION

We prepared to create these standards by reviewing recent articles, op-eds and petitions from local and national anti-racist organizations (see Resources section.) We used this research to build a framework for what an ideal system would look like. As much as possible, we included standards from similar advocacy work done by other organizations (the Student National Medical Association, White Coats for Black Lives, Emory medical students' "Addressing Racism in Medicine" proposal co-written by leaders of Emory's chapters of the Student National Medical Association, the Asian Pacific American Medical Student Association, and the Emory Medical Alliance).

WORKING TO BUILD A MORE EQUITABLE HEALTHCARE SYSTEM

CDIC residents wrote the initial version of these Standards in the Summer of 2020. We negotiated with Emory's Internal Medicine Residency Program leadership, Department of Medicine leadership, and our DEI Council over the subsequent year and a half to modify our work into the current document. We are using these standards to frame our approach to building a more equitable healthcare and training system within Emory's Internal Medicine Residency Program. As we learn and improve we expect that this framework will grow with us. Every spring, CDIC Advocacy plans to meet with the Internal Medicine Residency Program leadership and representatives of the DEI Council to review these standards and evaluate our progress, plan our next steps, and ensure continued progress. Some of these standards are already met by our program, but we retained them in order to make this framework more applicable to all residency programs. One of our longer-term goals is working with residents in other programs and specialties to advocate for national standards.

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Area 1: Representation

Underrepresented in Medicine (URiM) Resident Representation

STANDARD 1: Programs should endeavor to recruit residency classes that reflect population parity, meaning that the racial, ethnic, and gender composition of each class should be similar to the population we serve. This data should be published on their websites along with transparency in our recruitment efforts and plans to increase URiM representation. A comprehensive approach should be taken to achieve this goal, including: recruiting and admitting undocumented and URiM residents, ensuring that standardized (USMLE) exams are not the primary drivers of admissions decisions, compensating URiM residents who participate in recruitment, and ensuring that activism for equitable, just treatment of all people regardless of race, gender, gender identity, sexual orientation, disability, etc. will not negatively impact an applicant's consideration for interview or ranking.

Current Status:

- We host the RYSE Virtual Visiting Clerkship Program annually to recruit diverse residents and successfully matched ⅓ of the 2020 participants to our Internal Medicine Residency Program.
- We host the Minority Fellowship Applicant Experience (MFAX) program to recruit diverse fellows to eight of our ACGME-accredited subspecialty training programs: Cardiology, Pulmonary Medicine and Critical Care, Rheumatology, Renal Medicine, Digestive Diseases, Infectious Disease, Hospice/Palliative Care, and Endocrinology. We successfully matched 14 fellows from this program in 2020-2021.
- We also host Diversity Recruitment Days.
- We conduct a holistic review of applicants to the Internal Medicine Residency Program and consider "distance traveled" - meaning barriers to becoming a physician - in our review of applications. We do not adhere to a USMLE score cutoff, and applications from people who are underrepresented in medicine are always reviewed by a member of the admissions team.

Planned Actions:

- The Internal Medicine Residency Program is developing an LGBTQ+ recruitment plan for the 2021-2022 interview season.

Underrepresented in Medicine (URiM) Faculty Representation

STANDARD 2: Programs should endeavor to recruit faculty that reflect population parity, meaning that the racial, ethnic, and gender composition should be similar to the population we serve. This data should be published on our website along with transparency in our recruitment efforts and plans to increase URiM representation. A comprehensive approach should be taken to achieve this goal, including active recruitment of URiM faculty, greater transparency in the qualifications for faculty positions, compensation transparency and equity, greater financial and mentorship support for URiM faculty, formal acknowledgement of racial justice-related labor (mentorship, recruitment, committees, etc.), more diverse senior faculty, and a commitment to advocate for more diverse leadership of Emory University School of Medicine.

Current Status:

- The Department of Medicine in collaboration with the School of Medicine hosts an Underrepresented Minority Faculty Development Program. This is a five-month longitudinal program that matches faculty with mentors, provides experiential seminars, and promotes meaningful discussions about navigating academic medicine as URiM faculty.
- The Emory School of Medicine requires bias mitigation training for all GME leaders.
- The Department of Medicine publishes and circulates "Diversity Dashboard" each year that provides the gender and racial breakdown of each department both generally and at different faculty and leadership levels as well as survey-based engagement indicators.

Planned Actions:

- The Department of Medicine will continue to prioritize increasing diversity at all levels of faculty and leadership and continue to gather and share information on these efforts in order to promote ongoing transparency and accountability.

Area 2: Support

Underrepresented in Medicine (URiM) Recognition

STANDARD 3: Resident educational spaces should acknowledge the contributions of diverse alumni and other physicians of color (through plaques, statues, portraits, and building names). Named awards and conferences, presenters chosen to lead "expert" conferences, and processes for selecting chief residents should prioritize diversity.

Current Status:

- In 2021 the Internal Medicine Residency Program modified the plaques and portraits displayed in our main educational areas at Emory University Hospital to represent the diversity of the program.
- The Internal Medicine Residency Houses, which were devised in 2019, were deliberately named for a diverse group of faculty who have had a direct impact on the educational program.
- The School of Medicine has added photos to prior display of the Deans' Teaching Award displayed in the School of Medicine to be more representative of the diversity of awardees
- The Internal Medicine Residency Program has intentionally reviewed and modified our website and social media accounts to represent the diversity of our program.
- The Department of Medicine and School of Medicine have introduced new recognition and awards for diverse clinical and research contributions.

Planned Actions:

- We are evaluating other physical spaces within our department to see if the photographs acknowledge the diversity of our program and leadership.
- We are developing a mechanism to review who leads expert conferences to ensure that diverse clinicians are represented.

Discrimination Reporting

STANDARD 4: Programs should have adequate discrimination reporting systems and ensure that residents feel supported and the environment is as inclusive as possible. There should be a clear plan for follow-up when problems are reported and protection from retaliation.

Current Status:

- The Internal Medicine Residency Program added a confidential bias reporting tool to our end-of-rotation evaluations in July 2021. This includes the GME Compliance Line phone number for anonymous reporting. This information is shared with residents during orientation and periodically throughout the year.

Planned Actions:

- In July of 2021 the Internal Medicine Residency Program leadership began assembling a working group of faculty, staff, and trainees (specifically from historically marginalized groups) to develop and pilot a bias reporting system. We are working to balance anonymity - which may help overcome the fear of reporting and may lead to the most protection for historically marginalized groups - with making the system freely shared, transparent, and easily accessible, which may be better-achieved with confidential reporting.
- The Internal Medicine Residency Program is modifying our evaluation of learners to include an intentional statement to reduce evaluation bias and are also currently writing a grant to support and measure the impact of this intervention.

Underrepresented in Medicine (URiM) Support and Resources

STANDARD 5: URiM residents should have access to opportunities for affinity group spaces and support staff. The program should routinely (at least annually) survey URiM residents about their satisfaction with this support and create a follow-up plan to address deficiencies.

Current Status:

- The Churchwell Diversity and Inclusion Collective: Started in 2019, this resident-run affinity group works to build an inclusive resident body to better serve the greater Atlanta community and hosts numerous social and networking events over the course of the year.
- CDIC resident board members are also members of the Department of Medicine DEI Council and attend their monthly meetings.

- Our residency program is developing an LGBTQ+ affinity group in 2021.
- The Department of Medicine has a URiM Professional Development Program and a new URiM Small Grant Program. Additionally, the internal medicine residency program hosts multiple stand-alone professional development and social events throughout the year.
- The Internal Medicine Residency Program currently gathers data about resident perceptions of bias and diversity in the following ways:
    - Semi-annual Diversity Engagement Survey
    - Six diversity questions on the Annual Engagement Survey
    - Diversity questions on resident surveys

STANDARD 6: All resident physicians should receive a badge from their program that makes their role as a physician clear to avoid the frequent misidentification of female and URiM residents as non-physician staff. This badge should be legible from several feet away.

Current Status:

- Our Internal Medicine Residency Program has purchased and distributed "Resident Doctor" badge buddies to all residents within our program and plans to continue to do so with each incoming class.

Planned Actions:

- We are planning a study to evaluate whether or not these badge buddies lead to improved identification of our residents as physicians and the extent to which this impacts female and URiM resident physicians.

Resident Compensation and Insurance

STANDARD 7: The program should ensure that resident compensation is sufficient and all residents have access to high-quality medical care. Health insurance coverage should not disproportionately impact pregnant residents or residents with disabilities or chronic medical conditions. The program should also advocate for similar policies for all healthcare and program staff.

Current Status:

- Resident salary: Using the established benchmark of affordable rent, defined as <30% of gross annual income, Emory's PGY-1 salary is competitive: The average 1-bedroom apartment rent in Atlanta is $1559/month, and 30% of the PGY-1 salary is $1537/month, with salary increases annually by PGY level.

- Resident benefits: Emory residents are provided with professional liability, health, life, and disability insurance. Health insurance for dependents is available at low cost. The Emory 403(b) Savings Plan provides a basic contribution of 1% of eligible salary for all current residents, separate from their established compensation. Residents may contribute additional salary towards the retirement savings plan at their discretion.
- Resident health insurance: Emory residents have the option to enroll in the Aetna POS plan. This plan is available to all Emory employees. It includes coverage for infertility including ovulation induction and advanced reproductive therapy. These services are covered at the same rate as coverage for disease or injury.
- Resident access to care: Emory's Internal Medicine Residency Program partnered with leadership at the Emory Clinic and in the Divisions/Departments of General Internal Medicine and Family Medicine to establish a Resident-PCP connection in 2020 to make it easier for residents to schedule primary care appointments. Instead of calling the clinic to schedule an appointment, residents can fill out a form at any time, select possible dates and times and preferred physicians, and choose from multiple clinic locations. Residents then receive a phone call and email within two business days to schedule the appointment.
- Resident time off for routine appointments: In 2020 our program instituted Flex Days, which are ½ days residents may use for any purpose, including attending routine medical appointments.
- Compensating extra duty: In 2020, our program instituted a back-up/Jeopardy pay back system that provides residents with a future day off after completing two long, weekend, or overnight back-up/Jeopardy shifts.

Planned Actions:

- Our program leadership will continue to routinely solicit feedback about affordability and wellness from residents via monthly Class Representative and Program Director meetings and periodic surveys
- Annual trainee salaries are established at the Emory School of Medicine level, and residents have elected GME representatives who can present feedback to the School of Medicine leadership.

Area 3: Education

Health Justice Training & Curriculum

STANDARD 8: As part of core education, residency programs should develop a longitudinal, required, comprehensive educational series about the history of racism and bias in medicine, intersectional oppression, non-biological drivers of disease, comparative health systems, and health justice strategies. This should include historical perspective on race within our own communities, including the history of racial segregation at the hospitals in which we train and current disparities. This curriculum should explicitly address the fact that race is a sociopolitical construct, not biological. This education should exist at all training hospitals. Residents and faculty should receive training on how to acknowledge and address both interpersonal and structural bias within and outside of the healthcare system (bystander/upstander training, data analysis skills for identifying inequities in care, activism/organizing training). This training should start during intern orientation and continue throughout residency with periodic evaluation and feedback.

Current Status:

- CDIC's Advocacy Branch started a monthly Health Justice Curriculum in January 2021 as part of our Internal Medicine Residency core curriculum. Our program has reserved one hour per month of core conference time for this curriculum.
- Emory's Department of Medicine held our first Health Equity Day on May 11th 2021.
- The entire School of Medicine is also working on a comprehensive set of "Actionable Educational Initiatives," or AEIs, each of which focuses on a health justice pillar.
- During our Y weeks starting in July 2021, all of our residents receive bystander/upstander and implicit bias training from faculty members of the DEI council.

Planned Actions:

- We are in the process of forming a committee of residents in coordination with CDIC and the Medical Education Distinction to curate a Department of Medicine-based version of our Health Justice Curriculum under the advisement of the DEI Council.

STANDARD 9: Resident evaluations and overall progress reports should include an assessment of the residents' awareness of structural racism as a core competency.

Current Status:

- Starting in July 2021, our program included evaluation of the inclusion of race in patient 1-liners/HPI during our intern History and Physical Audit (this is where a chief resident reviews and provides feedback on a randomly selected H&P for each intern).
- In July 2021 our residency program began to require resident self-evaluations regarding bias and structural racism in conjunction with the education detailed in Standard #8. This self-evaluation will be discussed with the residents' Assistant Program Director during semi-annual meetings.

Planned Actions:

- Over time we will include peer and faculty evaluations in the above process.

STANDARD 10: Trainee evaluations should include questions about whether the trainee experienced or observed any racist, sexist, or biased actions in the learning and clinical environment.

Current Status:

- Our residency program has instituted implicit bias, bystander, and upstander training for all faculty and residents as detailed in Standards #1, #2, and #8.
- Our current faculty evaluations include the option to include a confidential comment that will be sent directly to our Program Director.
- In Academic Year 2021 we added the following statement to our evaluations: "Our residency program strongly values a diverse, equitable and inclusive environment. In our continued journey towards a more equitable and inclusive working climate, please tell us if you have experienced or witnessed any areas of concern in the areas of diversity, equity and inclusion. All answers will be handled confidentially. For a second mechanism of reporting concerns confidentially, please contact your PD or APD Advisor. The GME Compliance Line is available for anonymous reporting of concerns by calling 1-888-594-5874." This is followed by the option to indicate whether you witnessed any areas of concern in the domains of diversity, equity and inclusion and provide details, after which program leadership will contact the resident to ensure the situation is appropriately addressed.

Planned Actions:

- We are in the process of determining transparent, constructive responses to faculty who are flagged through our new system.

STANDARD 11: Lecturers should receive education about the importance of describing racism (rather than race) as a risk factor for disease, a cause of health disparities, or a basis for diagnostic reasoning as well as post-lecture feedback about this content in their lectures.

Current Status:

- We require implicit bias training for all leaders as described in Standard #2.

Planned Actions:

- We plan to ask all faculty and trainee lecturers who present to our residents to review and sign a DEI disclosure stating that they have received implicit bias training, reviewed the content of their lecture for bias prior to presentation, and agree to receive feedback regarding potential areas of the lecture which may threaten the culture of inclusivity in the learning environment. This disclosure will be presented as a slide in their lecture.
- Our program is incorporating articles and studies that have helped lead to the concept of race as a driver of disease in our evidenced-based medicine and journal club curricula to provide protected time for residents to evaluate and discuss this data.

Area 4: Patient Care

Marginalized Patient Protection and Equal Access for All Patients

STANDARD 12: Programs should provide training for all residents and faculty on the rights of the incarcerated patients under their care. Contact information for hospital legal departments should be provided to everyone who cares for incarcerated patients in case there is concern about a violation, and training should be provided on how and when to advocate for compassionate release. Residents and faculty should be able to educate incarcerated patients on their rights based on this training. We should also receive basic education about the history of racism and incarceration rates in the United States, the difference between jail and prison, the impact of cash bail on

incarceration prior to being convicted of a crime, and ways to optimize care coordination for incarcerated patients.

Current Status:

- Our March 2021 Health Justice Curriculum session topic was incarceration. During this session, two of our emergency medicine physicians - Dr. Bisan Salhi and Dr. Anwar Osborne - led a discussion of their recent article, "Incarceration and Social Death - Restoring Humanity in the Clinical Encounter."

Planned Actions:

- We are planning a training session in October 2021 for residents and faculty on the rights of incarcerated patients under our care as part of our Health Justice Curriculum.
- We have reached out to hospital leadership to determine the most appropriate course of action for healthcare workers to report violations of these rights while patients are under our care and/or for patients presenting to the hospital from jail/prison with clear evidence that their medical care has been neglected.

STANDARD 13: Programs should clearly document expectations for residents' level of independence, supervision, and patient caps, and these should be consistent across training sites. Specifically, residents should have the same patient caps, time allocation per patient, and rules regarding patients requesting attending-only care for all equivalent inpatient and outpatient services at the hospitals and clinics that they cover. Programs should also survey their residents (or allow resident(s) to develop and circulate a survey during elective time) to elucidate the degree to which residents experience different levels of autonomy at different hospital sites, as much of this occurs at an unofficial level. If equitable caps are not possible or appropriate, programs should clearly document why these standards are different.

Current Status:

- Emory University Hospital and Emory University Hospital Midtown, which are both on drip admitting systems, have a wards cap of 7 patients per intern and 14 patients per team. Grady Memorial Hospital and the VA Medical Center, both of which have staggered long call admitting systems, have a wards cap of 9 patients per intern and 18 patients per team. The differences in caps derive from differences in admitting schedules.
- Continuity Clinic caps for senior residents (PGY-2/-3) at EUH and EUHM are currently 12 patients per resident per day. The Continuity Clinic cap for senior residents at Grady is currently 14 patients per resident per day for in-person

visits and 10 patients per resident per day for virtual visits. The differences in caps derive from site- and visit type-specific no-show rates.

Planned Actions:

- As Grady moves towards a drip admission system, our program plans to decrease the caps to the same 7 per intern/14 per team caps that are currently in place at EUH and EUHM.
- Effective in July 2021, patients at Grady will be able to schedule a follow up appointment before leaving from their current appointment (currently patients have to call to schedule follow up). The aim is to improve continuity of care. If this or any other intervention improves in-person show rates at Grady, the program will reevaluate the Grady in-person Continuity Clinic cap.

STANDARD 14: Programs should prioritize investigating racism, implicit bias, and racial inequalities in healthcare. There should be incentives for residents, fellows, and attendings to investigate and address these inequities. They should investigate the racial breakdown of patients cared for on specialty vs wards teams, or who receives a subspecialty consult, at our hospital sites to determine if there is racial bias regarding where patients of color and/or women receive care. If bias is discovered, programs should work with those teams to institute clear specialty service admission criteria and provide implicit bias training.

Current Status:

- The residency program has a Health Equity, Advocacy, and Policy (HEAP) Track that includes a month-long Social Medicine Elective as well as a capstone project. Internal health disparities/bias research meets the qualification for this capstone project and is encouraged.

Planned Actions:

- Residents on elective blocks will be encouraged to pursue internal health disparities/bias research during this time.

Immigrant Patient Protection

STANDARD 15: Programs should advocate for a demonstrated commitment to immigrant patients at all of our hospital sites by: 1) Ensuring the placement and visibility of multilingual signs stating that patients are welcome regardless of immigration status and expressing their right to receive care in their primary language 2) Enacting a policy of referring immigration authorities to hospital attorneys prior to

any cooperation by hospital staff 3) Training hospital staff at all sites to refuse to speak to immigration authorities until it has been ascertained that they are legally required to do so.

Current Status:

- Our hospital systems have multilingual signs expressing patients' rights to receive care in their preferred language.

Planned Actions:

- We plan to work with our affiliated hospitals to ensure that signage that is welcoming to all patients regardless of immigration status is provided and to improve the visibility of existing signs.
- We are planning a training session in October 2021 for residents and faculty on the rights of undocumented patients under our care as part of our Health Justice Curriculum.

Ending the Use of Race Correction in Clinical Algorithms

STANDARD 16: Programs should advocate to our subspecialty colleagues to eliminate racial bias via the use of race correction in clinical algorithms. The four most relevant to internal medicine are the race-corrected AHA HF Risk Score, eGFR, PFTs, and Kidney Donor Risk Index. Programs should establish a standard that race should not be included in a patient's 1-liner or HPI on rounds or in educational conferences.

Current Status:

- In February of 2021 the Clinical Practice Council at Emory University voted to remove the eGFR race-based correction for non-Hispanic Black people in the electronic medical record. This decision was based on careful consideration of evidence that the use of race-based correction of eGFR creates structural bias with potential adverse health consequences. Moving forward, the eGFR will be calculated without a race-based correction. This change was reflected in all Emory Electronic Medical Records in June 2021.
- As mentioned under Standard #9, starting in July 2021, our program included evaluation of the inclusion of race in patient 1-liners/HPI during our intern History and Physical Audit (this is where a chief resident reviews and provides feedback on a randomly selected H&P for each intern).

Planned Actions:

- Our DEI Council is currently discussing the removal of race-based clinical algorithms with Grady Memorial Hospital.
- The Department of Medicine DEI council is working with the larger School of Medicine to examine the use of race in clinical calculations that affect our daily practice.

Area 5: Research

DEI in Research Policies

STANDARD 17: Researchers that operate within our universities and hospitals should aspire to a framework where studies that evaluate race include its consideration as a sociopolitical construct and examine observed differences as a product of racism, whether through differential health access, economic inequality, etc. If scientists aim to study the effects of geography or other demographic variables on health and disease, they should clearly state these intentions and carefully gather their data in a scientific manner. There is a long history of racist ideology perpetrated under the guise of research/science. Given the history of abuse of people of color in scientific research, institutional review boards (IRBs) and all research governance should specifically delineate protections for research subjects of color and prioritize diversity and representation in human subject studies.

Current Status:

- All researchers within the Emory system must complete basic trainings on research ethics and vulnerable populations
- It is our program's expectation that residents report concerns and bring attention to lapses in this Standard within their own mentored research projects. We will provide contact information to facilitate residents reporting these concerns.

Planned Actions:

- We are funding a resident to complete an advanced IRB training, "Race in Clinical Research: Ethics and IRB Decision Making," to evaluate the extent to which it promotes the above Standard. If our team subsequently agrees that this would be a valuable addition to our required IRB training, we will advocate for this to the Emory IRB.

- We are meeting with Emory's IRB in the Fall of 2021 to learn more about how they approach the use of race in research and potentially to advocate for improvements. We will advocate for: 1) BIPOC (Black, Indigenous and People of Color) to be included as "vulnerable populations," which would mean that research that specifically recruits from this category would be required to undergo additional scrutiny 2) All research submissions involving race to have a written definition of race and a description of how race will be used in the research study 3) The rejection of any proposed study that will explicitly or tacitly reinforce biological definitions of race.
- We are communicating with our current IRB leadership to determine who within their staff can serve as a resource on the use of race in research and related questions.

Resources

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7. Hardeman, Rachel, Medina, Eduardo, and Kozhimannil, Katy. "Structural Racism and Supporting Black Lives - the Role of Health Professionals." *The New England Journal of Medicine,* vol. 375, pp. 2113-2115. DOI: 10.1056/NEJMp1609535. Accessed 1 August 2020.
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9. Egede, Leonard and Walker, Rebekah. "Structural Racism, Social Risk Factors, and COVID-19 - A Dangerous Convergence for Black Americans." *The New England Journal of Medicine,* vol 383. DOI: 10.1056/NEJMp2023616. Accessed 1 August 2020.
10. Chung, Grace, Hamm, Daeja, Hijab, Eman, and Kim, Amy. "Addressing Racism in Medicine Proposal for Emory School of Medicine." 26 August 2020. This proposal was accepted by the Emory University School of Medicine Executive Curriculum Committee and resulted in a new Curricular Thread to span the four years of medical school education at Emory University School of Medicine.

LEADERSHIP TEAM

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