STANDARDS THAT REQUIRE INPUT FROM MULTIPLE STAKEHOLDERS

Standard	Report card
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.	Resident salary is determined by the Graduate Medical Education (GME) Office, not the IM residency program. Inflation and a lack of corresponding cost of living increases have meant that Emory's salary has become less competitive over the last two years due to inflation. This problem has plagued many employers nationwide. Residents are working with GME to rectify this, and GME has announced an additional 3% raise in resident salary for 2023-2024 (though this does not match the current inflation rate). We are committed to remaining transparent about how resident salary at Emory compares with similar programs in the region. The IM residency program provides additional benefits for IM residents in an effort to offset/alleviate resident salary concerns by providing food at two-three weekly noon conferences, increasing the amount of food vouchers residents receive, and providing free access to coffee at all sites. This means residents rarely spend their own money on food during the workday. The program also provides some financial support for attending research conferences and for funding research projects. Parking does not incur an additional expense. Step 3 expenses are not reimbursed by the program or the GME office. Regarding time off: residents have three regular vacation weeks and one week over the holidays. Additionally, Residents have four flex half days to utilize for personal needs including doctors' appointments, car maintenance, etc. With appropriate communication with leadership, any resident that requires time off for regular doctors' appointments or mental health appointments can receive accommodations for such. Residents may receive extra flex days if called to cover long jeopardy shifts. **Summary:** • **Major success: access to free/ subsidized food** • **Work in progress: competitive salary**

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.	Through resident and faculty efforts, we have held several noon conferences and grand round talks about the healthcare of incarcerated patients and the connection between the carceral system and healthcare. Several members from the DOM (residents, fellows and faculty) are volunteering with the Medical Justice Alliance and the Georgia Human Rights Coalition to advocate for better healthcare on behalf of incarcerated patients in Georgia. CDIC residents are working closely with emergency medicine faculty at Grady to formalize guidance about the care of incarcerated patients at Grady. To date, Grady has not yet published formal policies specifying the rights of incarcerated patients to receive the same standards of healthcare as non-incarcerated patients. Of note, Grady has appointed its first Chief Health Equity Officer, and the residents are working with them on formalizing this guidance. Grady takes care of most of the incarcerated patients seen in the across the 4 training sites. This is why our efforts have focused on enacting change at Grady. These goals, however, apply to all 4 sites and the remaining hospitals will be the focus of future efforts. **Summary:** • **Major success: multiple lectures and formal discussions about health and incarceration** • **Work in progress: partnering with Grady on policies regarding healthcare of incarcerated patients. This will be followed by partnership with the other three hospitals in which we work towards similar objectives**

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.	Emory and Grady have eliminated race from their eGFR calculation, and the department of medicine held a grand rounds lecture by Dr Nwamaka Eneanya on race and eGFR. Dr Eneanya is now the Chief Transformation Officer at Emory University. There are ongoing discussions with other divisions within the DOM about eliminating race-based corrections in their calculations (e.g., pulmonary function testing). **Summary:** • **Major success: elimination of race based eGFR at Grady and Emory sites** • **Work in progress: elimination of other race-based calculators**

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.	Through advocacy by residents and faculty, the **Emory University Institutional review board (IRB) Implemented the change in January 2022**. The Emory IRB now requires all biomedical study protocols to define racial and ethnic classifications they plan to use, state whether they are describing or explaining differences between groups, and to provide justification for any use of racial or ethnic group variables as covariates. This antiracist IRB intervention, helped by Emory IM residents, is an example of how research institutions can help ensure the scientific validity of studies involving race and ethnicity to avoid unscientific reification of race as an inherent biological concept. (See section 12 of biomedical protocol at this **link**) Additionally, there was an Emory DOM Town Hall on this topic on April 26, 2022, an Emory DOM grand rounds was on this topic on October 4th, 2022, the division conference for Emory Renal Division was on this topic on December 13, 2022. **Summary:** • **Major success: IRB requires protocols to define how they intend to use race and ethnicity within the study** • **Work in progress: continue to work with the IRB and DOM about ongoing research**