White Coats for Black Lives

Racial Justice Report Card 2021-2022

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1. Introduction

The David Geffen School of Medicine (DGSOM) at the University of California, Los Angeles (UCLA) has been actively increasing its commitment to bolstering justice, equity, diversity, and inclusion through research and practice. This includes the development and implementation of a range of structural changes and programmatic initiatives across the domains of research, teaching, clinical care and community engagement. Although Los Angeles is often celebrated as one of the most racially and ethnically diverse cities in the country, it is deeply troubled by health inequities. For example, studies demonstrate that (1) Bel Air residents live, on average, nearly 10 years longer than those from Southeast Los Angeles, (2) infant mortality rates among Black patients are greater than three times higher than that of their white counterparts, and (3) Black/African American men aged 20-24 are four times more likely to have STIs such as chlamydia and gonorrhea than white men of the same age group.

One method through which we can strive for health equity is the diversification of our medical student and physician populations. Dr. Paul Rothman, Chief Executive Officer of Johns Hopkins Medicine, says, “Studies show that students trained at diverse schools are more comfortable treating patients from a wide range of ethnic backgrounds. When the physician is the same race as the patient, patients report higher levels of trust and satisfaction. The visits even last longer—by 2.2 minutes, on average. When patients enter our hospitals, they want to see staff members and physicians who resemble them.” Diversifying the physician population, however, will require medical schools to strengthen their recruitment and retention efforts, including making their campuses, climate, and culture more inclusive, supportive, and affirming of racially diverse students.

One tool to help illuminate gaps between current and desired organizational performance is the Racial Justice Report Card (RJRC). The RJRC, first implemented in 2015, is an important tool to help give medical schools tangible methods through which they may become more anti-racist. Since its inception, over 25 academic medical centers nationally have participated. Unfortunately, while other premier academic medical centers have published Racial Justice Report Cards, DGSOM has not. The UCLA Student WC4BL Chapter is pleased to present its inaugural RJRC and, ultimately, an advancement of anti-racism praxis within the DGSOM community.
The Racial Justice Report Card

The following principles are taken directly from the 2019 national Racial Justice Report Card (RJRC) full report and provide detailed context clarifying the purpose and benefits of the DGSOM utilizing the Racial Justice Report Card to examine areas for growth and change.

White Coats for Black Lives (WC4BL) believes that in addition to promoting diversity and inclusion, academic medical centers (AMCs) must also commit to policies and practices that intentionally promote racial justice. The racial justice report card is a WC4BL initiative with three principal goals:

1. **Articulate specific ways in which AMCs can promote racial justice**
2. **Allow students to express their views on their institution’s policies and practices while advocating for change**
3. **Ensure public accountability for AMCs to advocate for change**

The Report Card consists of metrics that include but are not limited to, evaluations of an institution’s curriculum and climate, student and faculty diversity, policing, racial integration of clinical care sites, treatment of workers, and research protocols. **WC4BL relies heavily on the input of local students for the completion of this report.** We believe that local chapters and groups are best equipped to evaluate their schools and interpret the nuances of these metrics as they relate to their institution’s specific environment. Ultimately, **WC4BL hopes that the Racial Justice Report Card will highlight best practices and encourage academic medical centers to direct their considerable power and resources toward addressing the needs of our patients and colleagues of color.**

**Methods**

The RJRC team included a group of 7 students and 3 faculty overseeing the project. The process began with weekly meetings beginning in Summer 2020 to discuss the reinstating of the WC4BL Chapter within DGSOM. After securing a commitment from faculty and students to help make this chapter a success for many years, we started discussing our goals as an organization. After this commitment, we reached out to the WC4BL national chapter and discussed necessary steps to carry forward the RJRC. A proposal was then submitted to UCLA DGSOM leadership in October 2021 which included petitioning for financial support for student workers. Five student workers were approved for compensation of between $19-25 per hour for their work on the RJRC.
On November 15th, 2021, a town hall meeting with stakeholders from every department including UCLA DGSOM Deans and UCLA Health Department Chairs was held to launch the initiative and receive executive sponsorship and buy-in from leadership. This kickoff event allowed the team the opportunity to ask stakeholders to assist in obtaining the data needed for this report.

Students were divided into three teams: Medical School Team, Residency Team, and Hospital Team. Each team met on a weekly basis, and took charge of their respective section of the report card. Data collection officially began in early December 2021 during which time, each team reached out to various departments via email for the required data. The teams then held meetings with spokespersons from these departments to determine what exactly was needed and how it could best be obtained.

For the medical school team, students primarily connected with Dean leadership at DGSOM. The decision was made to stratify DGSOM/CDU recruitment and admission metrics as students go through separate interview processes for each school.

For the residency team, students connected with residents at Ronald Reagan Medical Center residency programs who spearheaded their data collection. The decision was made to attempt to stratify data collection by residency program given the potential differences between programs, however, not enough data was collected from each department to fully stratify. Notable differences between programs were mentioned in this report.

For the hospital team, data collection relied primarily on communication with UCLA Health’s Health Equity, Diversity and Inclusion (HEDI) office in addition to referencing UCLA hospital policy. Students also made attempts to communicate with workers unions to uplift their voices in this report.

All teams met together for bi-monthly meetings with faculty advisors to determine how to navigate difficulties and to identify necessary data point person(s). All of our data was stored within our Racial Justice Report Card Google Drive.

**Of note, students adjusted some language of national metrics for clarity within the DGSOM report.
Grading

The following grading system was obtained from the WC4BL Racial Justice Report Card website. Metrics for each subsection are summed, and then converted to a letter grade using the following scale:

97-100% = A+
93-96% = A
90-92% = A-
87-89% = B+
83-86% = B
80-82% = B-
77-79% = C+
73-76% = C
70-72% = C-
67-69% = D+
63-66% = D
60-62% = D-
<60% = F

However, for the DGSOM iteration of this report, students intended for the focus to be primarily on the production of DGSOM specific recommendations.
2. RJRC Metrics

MEDICAL SCHOOL METRICS

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.
  - The above metric is not fully met given AMCAS role in medical school application: Per DGSOM Dean of Admissions Dr. Lucero, the AMCAS application includes a question related to disclosure of a felony conviction and a question related to a misdemeanor conviction. This is true for both the DGSOM application and the CDU application.

- 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.
  - The above metric is fully met: The DGSOM Admissions Website includes a section titled "DACA Applicants," in which the institution reaffirms its commitment to respecting and protecting the civil rights of undocumented applicants. Secondly, advising for undocumented students is regularly provided at weekly Admissions Virtual Office Hours for applicants and pre-applicants. Undocumented students who are AB540 have access to institutional grants and loans to cover the full cost of attendance. Undocumented students classified as non-AB540 receive financial support to cover the full cost of attendance.

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

- **DG SOM/CDU: The above metric is fully met:** For the overall class of 2025, 86 students (49% of total student population) received Pell Grants as undergraduate students.
- **DG SOM-only: The above metric is fully met:** For the DGSOM-only cohort of the class of 2025, 70 students (40% of cohort) received Pell grants as undergraduate students.

- 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.
  - **DG SOM/CDU: The above metric has not been met:** Per DGSOM Dean of Admissions Dr. Lucero, students who participate in recruitment are not compensated.
  - **DG SOM-only: The above metric has not been met:** Per DGSOM Dean of Admissions Dr. Lucero, students who participate in recruitment are not compensated.
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.

- **DGSOM/CDU: The above metric has not been met:** Per DGSOM Dean of Admissions Dr. Lucero, the medical school does not publish a report with this information.
- **DGSOM-only: The above metric has not been met:** Per DGSOM Dean of Admissions Dr. Lucero, the medical school does not publish a report with this information.

**Community Control and Self-Determination**

- Black, Indigenous, or Latinx alumni of local public schools comprise at least 10% of enrolled medical students.
  - **DGSOM/CDU: The above metric has not been met:** For the overall DGSOM enrolled student population, 12 students (7% of overall cohort) identify as Black, Indigenous and Latinx and are alumni of a local (CA) public school. DGSOM further defined this term as the last high school that they attended was a public institution.
  - **DGSOM-only: The above metric has not been met:** For the DGSOM-only student cohort, 10 students (8% of overall cohort) identify as Black, Indigenous, or Latinx and are alumni of local public schools. DGSOM further defined this term as the last high school that they attended was a California public institution.

- As a part of the medical school admissions processes, all applicants participate in interviews with local BIPOC leaders, who are compensated at a rate equal to or greater than the local living wage.
  - **DGSOM/CDU: The above metric has not been met:** Applicants do not participate in interviews with local leaders. All interviews are conducted by DGSOM faculty and Admissions personnel.
  - **DGSOM-only: The above metric has not been met:** Applicants do not participate in interviews with local leaders. All interviews are conducted by DGSOM faculty and Admissions personnel.
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 above metrics are met given POC student involvement with curriculum changes: The Structural Racism and Health Equity (SRHE) curriculum includes education from medical historians and other social scientists on the atrocity of past and present abuse of enslaved and incarcerated peoples for medical research.

- 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.
  - The above metrics are met given POC student involvement with curriculum changes: SRHE curriculum also explicitly has stated that race is a social construct. However, there have been some pre-clinical lecturers who have not made as explicit of a distinction between race and racism as they pertain to risk factors.

- Students in their preclinical years hear from individuals who have been incarcerated and their experiences receiving healthcare.
  - The above metrics are partially met given POC student involvement with curriculum changes: While technically students are not taught by previously incarcerated people, SRHE curriculum has invited abolitionist speakers and family and friends of those previously incarcerated.

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 above metrics are partially met given POC student involvement with curriculum changes: BIPOC faculty alongside students of color lead the SRHE curriculum. However, other aspects of the curriculum do hold sessions in which white faculty lead sessions on community health and health inequities.

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 above metric has not been met:** The medical school does not have a community leadership board.

- 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).
  - **Further student data is needed to determine if this metric can be met:** Though technically, no classes are officially required, students may feel pressured to attend classes despite feeling they’re redundant to their lived experience.

**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.
  - **The above metric has been partially met and with potential to be fully met within the next year given POC student involvement in curriculum changes:** Per Dr. Edward Ha, Assistant Dean for Clinical Education, at present this topic is not explicitly covered in the required clerkship phase.
There are plans to incorporate this type of training into the structural racism/health equity content being planned for the Intercessions course that will start October 2022.

Per Dr. Arthur Gomez, one of the co-chairs of Foundations of Practice for the first year classes: the Systemic Racism Health Equity thread addresses health issues related to incarceration, specifically for patients integrating into life afterwards. It does NOT at this time address patients presenting in police or prison custody. It does however address undocumented patients: this year in FOP they devoted a week of sessions to this topic in collaboration with the Undocumented Student Interest Group. Sessions included required readings to better understand the undocumented patient experience, as well as resources for such patients.

In summary, while steps are being taken to create comprehensive training for all students on this topic, at this time the medical school is still working on this goal.

- 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.
  - The above metric has not been met: Per Dr. Christina Harris of GME leadership: at this time, there is nothing done at the level of the GME office for all trainees that covers this metric. Different departments have the flexibility to incorporate this into their training. For example, per Dr. Areti Tillou, co-head of GME leadership, the surgery and EM residents will be receiving this type of training next year.

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.
  - The above metric is not met given a number of student-run free health care clinics/sites: There is a UCLA mobile clinic run in partnership with the Department of Family Medicine. It is one of the Early Authentic Clinical Experience (EACE) sites for first year medical students. There is
also the yearly Care Harbor Health Fair that offers free medical, dental and optometry services to local community members, run by medical students supervised by faculty volunteers.

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).
  - **The above metric is fully met:** Per Dr. Ha, “The school of medicine has a single policy for clinical supervision for all clinical experiences. Regarding our affiliate institutions, this is a bit more complicated. Each hospital system will undoubtedly have an institutional policy regarding supervision of trainees. That said, all faculty of the medical school must abide by the school of medicine policy no matter their hospital system (and in addition to their institutional policy).”

- 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.)
  - **The above metric has conflicting thoughts from faculty and students, given students report more procedural experience in county sites:** Per Dr. Ha, “The school of medicine has the same expectations for procedural training across all sites for medical students.” However, from speaking to students anecdotally, many feel that the most hands-on procedural training they receive is at county sites, which serve higher numbers of patients of color than our private hospital sites. Unfortunately, there is no tracking system for racial and ethnic data on patients whom medical students perform procedures on (or assist in procedures on).

**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.

- **The above metric is fully met**: Per Brandon Susselman: There are many options for reporting and several different units that collect student feedback. Reporting options and resources are compiled [here](#).

- Additional options and resources are described in the [Medical Student Mistreatment Policy](#), which includes the Mistreatment Incident Reporting Form and the details about information collected in course and faculty evaluations by the Educational Measurement Unit.

- All reports of student mistreatment are reviewed in real time by the co-chairs of the Committee on Learning Environment Oversight (CLEO) as well as by the larger committee monthly. Students are able to follow their submitted complaints (either anonymously or not) on a live dashboard and the data from the committee is shared regularly with all members of the DGSOM community, including students.

- Other reporting options include the [UCLA Discrimination Prevention Office](#).

- There is also an [Ombuds office](#) available as an additional independent, neutral and confidential resource.

- In January 2021 the “Driving Real Change in the Learning Environment,” initiative was rolled out. The charge of the group included:
  
  - Recommendations for better reporting and accountability measures for learners in all environments, perhaps modeled after and building on the relatively new Committee on Learning Environment Oversight (CLEO) for the MD program
  
  - Recommendations for specific metrics on the quality of the learning environment to use as key performance indicators over time
• Recommendations for specific interventions that improve the culture and quality of experiences in the learning environment in substantive and measurable ways

• Members of the group consisted of faculty members (including affiliates) as well as medical students. The advising group met monthly from January 2021-April 2021 and crafted a list of recommendations.

Redistribution

o 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.

  • The above metric has been met given POC student advocacy for this: The Health Equity Hub exists for students and support staff are available.

o The medical school does not participate in Alpha Omega Alpha (AOA.)

  • The above metric has not been met, but there is a current hold for further evaluation on this: There is a moratorium on new members, but the organization still exists on campus.

o 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.

  • The above metric is fully met: Per Brandon Susselman: DGSOM recently completed a comprehensive review of the core clerkship grades of the previous several years to see if there was bias in the grading system. This study was shared with the community in various forums including the Medical Education Committee and the Medical Student Council, as well as with clerkship leadership and clinical departments. Currently core clerkships are graded credit/no credit due to the ongoing impact of the COVID-19 pandemic on the learning environment, and there will not be a return to grades without a change to the assessment system to mitigate any potential for bias. DGSOM has no grades in the pre-clinical curriculum.
o 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.

- **The above metric is fully met:** Per Brandon Susselman: Since the onset of the pandemic, there has been regular messaging and greater flexibility with student scheduling to accommodate the varying impact of the pandemic on student lives. This has included remote learning, remote exams, taking time off due to illness or family concerns, and more. There has also been an increase in hiring and capacity for mental health services during this time. The Society Deans held regular group and individual check-in meetings throughout the first years of the pandemic to address student concerns. Larger town halls were also held with the student body for all students to share their concerns as well as hear about pandemic-related curricular modifications.

**Community Control and Self-Determination**

o 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.

- **The above metric is fully met as evidenced by DGSOM emails acknowledging such, however further survey data required to determine how supported students feel during times of racialized violence.**

o 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 above metric is partially met. Further survey data required to determine whether students feel as though their concerns are adequately followed.**
**PHYSICAL SPACE**

*Police and Prison Abolition*

- The medical school campus is free from surveillance cameras.
  - **The above metric is not met given school safety regulations:** Per Sharon Younkin, the Chief of Staff of Dean Braddock, the David Geffen School of Medicine indeed has surveillance cameras located at both locations at which medical students spend a majority of their in-person pre-clinical years - specifically, Geffen Hall (GH) and the Center for Health Sciences (CHS).

**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.
  - **The above metric is partially met:** The lobby within the Center for Health Sciences (CHS) on the main campus of UCLA commemorates the contributions of workers of color to healthcare and the institution specifically. However, the primary hospital through which DGSOM students rotate, Ronald Reagan UCLA Medical Center, is named after an individual who has expressed implicit racist beliefs while also enacting explicitly racist policies as the President of the United States. **See Hospital recommendations regarding Physical Space**

**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.
  - **The above metric is not met:** The medical school does not have a process through which community organizations may use locations on campus free of charge during the weekends, evenings, and other times when it is not in use.
**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.
  - *The above metric is not met, UCPD has constant presence around campus and hospital spaces.*

**Redistribution**

- The medical school has divested from private prisons, security forces, prison profiteers and prisons and companies that facilitate related societal injustices.
  - *The above metric is met:* The medical school has no investments in these institutions.

**TREATMENT OF WORKERS**

**Police and Prison Abolition**

- The hiring processes for workers at the medical school do not incorporate inquiries about the person’s history of criminal punishment system involvement.
  - *The above metric is not met given UCLA and governmental policies requiring background checks:* Per Shawn Kang, senior director of Human Resources for UCLA, which oversees both DGSOM and CDU: “UC maintains a policy on background checks – PPSM21. The policy requires us to conduct background checks after the candidate has received a conditional offer of employment.”

**Redistribution**

- All medical school staff are paid a living wage for a family of four with a single wage-earner as defined by local advocacy organizations.
The above metric is not met and more information is needed to specifically determine what/if any percentage of staff are paid a living wage per advocacy organizations: Per Shawn Kang, senior director of Human Resources for UCLA, “Any release of compensation information requires executive leadership approval and legal review.”

- All full-time medical school staff have comprehensive health insurance that is accepted at the health system affiliated with the medical school.
  - The above metric is met: Per Shawn Kang, senior director of Human Resources for UCLA: “Full-time medical school staff have a number of medical plan options, including insurance that is accepted at the affiliated health system.”

- 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.
  - The above metric is not met given lack of current data available on this: Per Shawn Kang, senior director of Human Resources for UCLA: “Compensation analysis by race and gender currently unavailable. Any release of compensation information requires executive leadership approval and legal review.”

Community Control and Self-Determination

- The medical school respects workers’ rights to organize unions and does 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).
  - The above metric is partially met given more information is needed from current staff to confirm their thoughts on this metric: Per Shawn Kang, senior director of Human Resources for UCLA: “UC adheres to and maintains multiple collective bargaining agreements across the workforce, both systemwide and locally, all of which includes provisions regarding fair and respectful treatment of workers. Further, UC does not engage in counter-campaigns against worker organizations.”
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. Plans for the construction of any new facilities include community-designed strategies to prevent displacement of surrounding BIPOC communities.

- **The above metric is not fully met as more information is needed to confirm:** Per Ms. Anja Paardekooper, Sr. Associate Dean, Finance and Administration & Chief Financial Officer: “All plant and other capital assets are owned by the University, not the medical school. Nevertheless, **UCLA Health invests significantly in the community.**

According to this source, in the 2019-2020 fiscal year, UCLA’s community benefit expenses (financial assistance to charities, Medicaid, community health improvement services, health professions education, subsidized health services, research, and cash contributions) was $246,287,909.

**Research**

**Community Control and Self-Determination**

- Any human subjects research studies that recruits from the local community are conducted in partnership with local BIPOC and/or Latinx-led community organizations.
  - **The above metric has not been met:** Through extensive communication with various contacts within the medical school, it is apparent that there is either no institutional guideline requiring these measures, or that it is not enforced in a practical or substantive manner.

- The medical school financially supports the formation of community IRBs at local BIPOC-led community organizations.
  - **The above metric has not been met:** Through extensive communication with various contacts within the medical school, we were unable to obtain information suggesting that the medical school partakes in this initiative. There is no formal platform for data reporting on such community-focused initiatives that is readily available to faculty or third party individuals alike.
The 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.

- **The above metric has been met:** Per staff of the human research protection program within UCLA research administration there is no specific requirement to define race and how race will be used in projects. In lieu of this, the IRB requires justification for race-based assertions that the research is basing its validity on. The IRB will also attempt to work with researchers to ensure research is conducted in an ethical manner. This includes ensuring the researcher has sufficient knowledge and experience to conduct the proposed research.

**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.)
  - **The above metric has not been met:** Andrea Martinez of Committee on Learning Environment Oversight and Deans of JEDI Dr. Brown and Dr. Kozman confirmed no episodes of retaliation reported through Mistreatment Incident Reporting Form (MIRF). This centralized reporting system is used by both DGSOM and CDU.

However, while retaliation against medical student activists has not been documented via MIRF, there are student reports, verified by emails with administration from the time period in question, that are very concerning. One example is a student who on his/her OB-GYN rotation witnessed two attendings joking about sterilizing a multiparous Black woman during her planned C-section later that day. The student reported this incident to the designated individual for issues of bias and racism at the time, an assistant dean. At the end of his/her rotation, the reporting student received an evaluation describing him/her as “too sensitive”, “not
a team player”, with the lowest scores possible assigned for humanism and professionalism. The student approached the assistant dean with concerns of retaliation and was told to request a formal review of the evaluation, which was ultimately deemed fair and a “learning opportunity” by the head of the OB/GYN clerkship, despite this evaluation being at odds with the student’s prior evaluations. The student was later able to redact portions of the evaluation from his/her MSPE only after asking mentors and deans he/she had a close relationship with to advocate on his/her behalf. The student also filed a complaint with UCLA’s Discrimination Prevention Office, under the advisement of above mentors and deans. Approximately two years after the incident, the student was informed that the incident did not meet the burden of proof necessary to be classed as retaliation.

Another area of concern relates to the sharing of information between faculty and medical student leaders, such as in Medical Education Committee and Faculty Executive Committee meetings, and possible intimidation. For example, when DGSOM raised its science GPA and MCAT cutoffs in 2019, student leaders were privy to this decision approximately a year prior to its rollout. The decision was controversial because of its potential to exclude applicants from communities that did not have the resources to produce such high scorers. Student leaders who wanted to share this information with other students and organize peaceful protests of the new cut-offs were repeatedly told by faculty to withhold this information from classmates.

In summary, while DGSOM has many safeguards in place to discourage and prevent retaliation against student activists — including but not limited to the MIRF, the anti-racism roadmap, the establishment of a Justice Equity and Diversity Inclusion (JEDI) body made up of student and faculty leaders — the verified student experiences we collected suggest that these safeguards are not always foolproof.

- 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.
RESIDENCY METRICS

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.

- The above metric is not met given the AAMC involvement in this process: Per the ERAS application that is sent to all residency programs, applicants are asked, “Is there anything in your past history that would limit your ability to be licensed or would limit your ability to receive hospital privileges?”, “Have you ever been convicted of a misdemeanor in the United States?”, “Have you ever been convicted of a felony in the United States?”

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, 17% Latinx).

- The above metric is not fully met: Most residency programs state the rate of Black, Indigenous, and Latinx residents do not correspond to the demographics of the U.S., but for one residency program, “Our residency program is notably one of the most diverse in the country.” And therefore, their program fulfilled this metric. Based on ERAS data from 2019-2020 for incoming residents who matched at UCLA residency programs, 16% were URM. Although the specific percentage breakdowns are unknown, the overall percentage of incoming URM residents does not meet this criteria.

- 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, 17% Latinx).
The above metric is not fully met: There is data from 2019 on the Racial and Ethnic breakdown of faculty at David Geffen School of Medicine. The data shows 51.73% White, 30.62% Asian/Asian American or Pacific Islander, 6.88% Unknown, 4.49% Chican(o)/Latin(o)/Hispanic, 2.79% Black or African American, 0.06% American Indian or Alaskan Native. Programs had varying responses where some were unsure, or felt their programs did not fulfill this criteria. One program acknowledged the diversity in faculty, but also noted that diversity remained lacking in other areas. Therefore, this program ultimately did not meet the criteria for fulfillment.

- 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.
  - The above metric has not been met: Per resident responses, they have participated in recruitment efforts, but have not received additional compensation for it. These activities were done on a voluntary basis.

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.
  - The above metric has not been met: Many programs stated this was not done in their departments, to their knowledge. One program has students matched up with URM faculty members/community leaders, but they are not compensated for their mentorship.

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.
  - The above metric has not been fully met: 7/12 programs considered this fulfilled, while many others gave partial credit for this work. One program noted improvement in availability of these didactic sessions, while
another stated the variability in exposure to these didactics. Follow up is needed to see what is being done at programs that have partial credit.

- 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.
  - The above metric has not been met: Residents stated this was variable based on the lecturer who was leading the didactic session, and one program stated, “it is definitely not the norm and is more a rare occurrence.”

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.
  - The above metric has not been met: Generally, programs stated there is no compensation for the planning and execution of community health and health inequities sessions with comments like, “so much labor is not being compensated.” In situations where compensation is provided, “There is one Black faculty [who] is very much involved in community health efforts, but the compensation is not equal to what he would be making if engaged in other clinical work.”

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).
  - The above metric has not been met: At most programs, this is not the case, and one program stated, “The BIPOC trainees are often called on to lead these efforts.”
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.
  - The above metric has not been met: Many residency departments noted that no clear training is offered or is known to them. Many Residents quoted the "Guidelines for Releasing Patient Information to Law Enforcement" by the American Hospital Association and the National Association of Police Organizations as a resource for them to know what to do when caring for patients in police custody.

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).
  - The above metric has not been met with strong statements from staff stating different supervision levels at county hospitals: The level of supervision at various hospitals is vastly different. Trainees across different departments have noted that there is attending supervision for all critical parts of patient care within departments at Ronald Reagan and Santa Monica Hospitals. However, at county sites and clinics, there is vastly more autonomy within some departments and noting that at some of these sites there is a significant lack of attending involvement. This has also been seen by Medical Students rotating at these different sites.
**TRAINEE AFFAIRS**

Police and Prison Abolition

- The graduate medical education (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.
  - *The above metric has not been met and further information needed to further analyze this metric:* Through GME Residents have access to reporting: any form of sexual/harassment misconduct through the Title IX Office; and any form of harassment/discrimination based on race, ancestry, national origin, disability, religion, age, and other categories protected by law and University policy brought against academic personnel through the UCLA Equity, Diversity and Inclusion Office. Every incident report made is discussed by the GME Committee on Learning Environment Oversight (CLO) which triages reports and ensures proper response. However, even though there is a clear mechanism on collecting feedback and reporting incidents, there is a consensus among trainees that there is no clear and transparent follow up.

**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.
  - *The above metric has not been met as there is no current data on this:* Historically this has not been the case. There was a consensus among trainees of not knowing if anything like this has been done and if it is done, it is not done publicly.

- 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.
  - *The above metric has not been met:* GME has attempted to help with accommodations for trainees with chronic health conditions, medical leave to care for family members and with child care. However, a number
of trainees across different specialties note that accessing/asking for all of these resources is not encouraged and at times admonished.

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.
  - **The above metric has not been met given the delay on such agreements:**
    With the example of UCLA Housestaff Union, a fair contract was implemented on September 10, 2019 after 10-months of a bargaining process with many building actions including a walk-out. This was followed by a delay in the implementation of the contract until December 2019. Further history of this union victory is documented on [UCLA Housestaff union Website](https://www.uclahousestaff.org/).

**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).
  - **The above metric has been fully met:** The response to this question was unanimous from almost all the residency programs.

**HOSPITAL METRICS**

**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).
  - **The above metric is not met due to safety regulations:** Per hospital representative, video cameras are present for clinical surveillance as well
as for security purposes. There is no current initiative to remove security cameras from the hospital.

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.
  - **The above metric has not been met:** Per hospital representative, There are none at the moment, but there is significant interest in exploring this.  
    **See recommendations regarding Physical Space.**

**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.
  - **The above metric is not met given safety regulations in place:** Per hospital representative, security forces are necessary in the hospital for patient and staff safety. There are alternative structures being explored such as the Law Enforcement Task Force and the Safer U strategy (proactive approach for early response and intervention). There is no public data on whether these forces disproportionately interact with any particular group.

- ICE personnel are not allowed on any of the hospital campuses.
  - **The above metric is met:** Per UC policy, ICE is allowed on hospital campuses as they are public, however they are not allowed to enter hospital buildings.

- 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.

- **The above metric has been met**: Per hospital representative there is policy in place that states law enforcement is not allowed to be present during medical evaluation and assessment. Patient health information is only shared with law enforcement in cases explicitly required by law.

- **Policy**: “Patient health information is shared with law enforcement in the case of a warrant or to identify or locate a suspect. Otherwise, by policy, inquiries should be referred to Health System Information Management, Legal Affairs, or the Privacy office.”

- **Policy**: “[Patients have the right to] Have personal privacy respected. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. You have the right to be told the reason for the presence of any individual. You have the right to have visitors leave prior to an examination and when treatment issues are being discussed. Privacy curtains will be used in semi-private rooms.”

- 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.

  - **The above metric is partially met given more information needed to further analyze if this is actually done by staff**: Per hospital representative, this is included in training.

Redistribution

- The hospital has divested from private prisons, security forces, prison profiteers and prisons and companies that facilitate related societal injustices.

  - **The above metric has been met, but further research is needed to confirm such reports**: Per hospital representative, the hospital had divested.

Community Control and Self-Determination

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

  ▪ **The above metric has been met, but further data is needed to confirm this is actually done by staff:** See policy.

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

  ▪ **The above metric is not met given that access is not granted to immigrant officials on campus:** Per hospital representative, not performed. Likely less relevant for UC campuses.

o Clearly outlined response to requests from ICE or CBP that protects patients’ privacy to the maximum extent allowed by law.

  ▪ **The above metric is met by UC guidelines:** Per UCLA campus wide policy, there are protective measures against ICE. These are not specific to the UCLA hospital system.

**TREATMENT OF WORKERS**

*Police and Prison Abolition*

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

  ▪ **The above metric is not met per safety regulations:** Per hospital representative “Inquiry about a person’s history of criminal punishment system involvement is necessary for patient safety.”

**Redistribution**

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

  ▪ **Further information is needed to further analyze this:** Per hospital representative, this metric has been met. Unable to discuss with workers unions.

o All full-time hospital staff have comprehensive health insurance that is accepted at the health system where they work.
The above metric is met but further communication with workers unions needed to confirm the statement: Per hospital representative, this metric has been met. “Everyone is offered comprehensive health insurance that is accepted by our health system.” Unable to discuss with workers unions. **See recommendations regarding communication with workers unions.

- 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.
  - The above metric has not been met: Per hospital representative, The data is publicly available, but unaware of any additional analysis to demonstrate equitable compensation by race and gender.

Community Control and Self-Determination

- The hospital respects workers’ rights to organize unions and does 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).
  - Further information and discussions with unions is needed to further analyze this metric: Per hospital representative, this metric is met. Unable to achieve follow up with workers unions.

- 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. Plans for the construction of any new facilities include community-designed strategies to prevent displacement of surrounding BIPOC communities.
  - The above metric has not been met: Per hospital representative, there is currently no formal structure or process, but the hospital is developing strategies and outlining criteria to prevent displacement of surrounding BIPOC communities.
**PATIENT CARE**

Police and Prison Abolition

- Publicly available data demonstrates that chemical and physical restraints are used sparingly in patient care and are not used disproportionately in the care of BIPOC patients.
  
  **The above metric is partially met as further discussion and analysis is needed to confirm this is not done by staff:** The hospital has a fairly comprehensive policy regarding patients and restraints, however, per hospital representative, the hospital does not currently do not track this data by demographic. There is work underway to try to track this information by patient demographics.

- Policy: “Restraints are used in a manner that protects the patient’s safety, rights, dignity and well being. Patients have the right to be free from restraints or seclusion, of any form, imposed as a means of coercion, discipline, convenience or retaliation by staff. Restraints or seclusion may only be used in clinically justified situations or to ensure the immediate physical safety of the patient, staff member, or others. Restraints are used so they do not cause unnecessary physical discomfort, harm or pain and are easily removable in the event of fire or other emergencies. Before restraints are used, less restrictive alternatives are considered. The minimum level of restraint necessary to accomplish the desired purpose is used. Restraints are used for the shortest period of time possible. Physicians, Nurse Practitioners (NP), Physician Assistants (PA), and registered nurses are qualified to assess and determine the need for the application and removal of restraints, in accordance with their scope of practice and education/training”

**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.
  
  **The above metric has not been met:** Per hospital representative, BIPOC patients are represented in all hospital service lines, but not
representative of the local population. **See recommendations regarding UCLA's relationship with Medi-Cal.

- 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.
  - **The above metric has not been met due to the need for additional information:** Per hospital representative, patients are not disproportionately cared for by trainees, however, this data is not publicly available.

- 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.
  - **The above metric has not been met:** Per hospital representative, there are not currently any lobbying efforts. **See recommendations regarding UCLA’s relationship with Medi-Cal.

**Community Control and Self-Determination**

- The hospital and affiliated clinics have posted multilingual public signs stating that patients are welcome regardless of immigration status.
  - **The above metric has not been met:** Not performed although it would be in accordance with hospital policy: “UCLA Hospital System will inform the patient, or when appropriate the patient's representative, of its patient rights policy in advance of furnishing or discontinuing patient care whenever possible. It may inform the patient using the following methods, as appropriate: Posting of signs in lobbies and waiting areas…”
    “...[Patients of UCLA Health system may] exercise these rights without regard to sex, economic status, educational background, race, color, age, religion, ancestry, national origin, sexual orientation, gender identity or expression, marital status, registered domestic partner status, disability, medical condition, genetic information, citizenship, primary language, immigration status (except as required by federal law) or source of payment.”
Bilingual members of local immigrant communities are preferentially hired for patient-facing roles including nurses, physicians, and aides.

- **The above metric has not been met:** Per hospital representative it is illegal to hire preferentially based on a bilingual background. However, this may be a strongly recommended or preferred skill set.

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 above metric has not been met:** The primary, front-facing leaders of UCLA Health, John Mazziotta, UCLA Health CEO, Johnese Spisso, UCLA Health President, and Steven Dubinett, Interim Dean of DGSOM are non-BIPOC individuals.

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

- **The above metric has been met:** Data was reported to agencies through the standard public reporting portals of CDPH and LA County.

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

- **The above metric has been met:** Per hospital representative, this is directly done with BIPOC leadership and the Office of Health Equity, Diversity and Inclusion.

**RESEARCH**

**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.
  - **The above metric is met but further information needed to confirm the statement:** Per hospital representative, all research studies are conducted
with community leaders that serve on the IRB procedures. There is a
community representative on IRB and research studies are conducted
directly with community-based organizations.

- The hospital financially supports the formation of community IRBs at local BIPOC-led
  community organizations.
  - **The above metric has been met:** Per hospital representative, this metric
    is met. The [CARE center](#) for HIV and AIDS research has monthly
    community advisory board meetings as well as supports the research of
    AIDS project Los Angeles, Black AIDS institute and Black Treatment
    Advocates Network.

- 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.
  - **The above metric has been met:** Per staff of the human research
    protection program within UCLA research administration there is no
    specific requirement to define race and how race will be used in projects.
    In lieu of this, the IRB requires justification for race-based assertions that
    the research is basing its validity on. The IRB will also attempt to work
    with researchers to ensure research is conducted in an ethical manner.
    This includes ensuring the researcher has sufficient knowledge and
    experience to conduct the proposed research.
## WC4BL Grading Breakdown per Category

### Medical School Metrics Summary

<table>
<thead>
<tr>
<th>Category</th>
<th>Total Score</th>
<th>Letter Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruitment and admissions</td>
<td>DGSOM/CDU: 2/8 = 25%</td>
<td>F</td>
</tr>
<tr>
<td></td>
<td>DGSOM-only: 2/8 = 25%</td>
<td></td>
</tr>
<tr>
<td>Curriculum</td>
<td>4/6 = 66%</td>
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</tr>
<tr>
<td>Clinical Education</td>
<td>1/5 = 20%</td>
<td>F</td>
</tr>
<tr>
<td>Student Affairs</td>
<td>6/7 = 86%</td>
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</tr>
<tr>
<td>Physical Space</td>
<td>0/3 = 0%</td>
<td>F</td>
</tr>
<tr>
<td>Relationship to the Carceral State</td>
<td>1/2 = 50%</td>
<td>F</td>
</tr>
<tr>
<td>Treatment of Workers</td>
<td>2/6 = 33%</td>
<td>F</td>
</tr>
<tr>
<td>Research</td>
<td>1/3 = 33%</td>
<td>F</td>
</tr>
<tr>
<td>Institutional Response to Student Activism</td>
<td>1/2 = 50%</td>
<td>F</td>
</tr>
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### Residency Metrics Summary

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</thead>
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<tr>
<td>Recruitment and admissions</td>
<td>0/5 = 0%</td>
<td>F</td>
</tr>
<tr>
<td>Curriculum</td>
<td>1/4 = 25%</td>
<td>F</td>
</tr>
<tr>
<td>Clinical Education</td>
<td>0/2 = 0%</td>
<td>F</td>
</tr>
<tr>
<td>Trainee Affairs</td>
<td>0/4 = 0%</td>
<td>F</td>
</tr>
<tr>
<td>Treatment of Workers</td>
<td>1/1 = 100%</td>
<td>A</td>
</tr>
</tbody>
</table>
Hospital Metrics Summary

<table>
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<tr>
<th></th>
<th>Total Score</th>
<th>Letter Grade</th>
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<tbody>
<tr>
<td>Physical Space</td>
<td>0/2 = 0%</td>
<td>F</td>
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<tr>
<td>Relationship to the Carceral State</td>
<td>7/8 = 87%</td>
<td>B+</td>
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<tr>
<td>Treatment of Workers</td>
<td>3/6 = 50%</td>
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</tr>
<tr>
<td>Patient Care</td>
<td>3/9 = 33%</td>
<td>F</td>
</tr>
<tr>
<td>Research</td>
<td>3/3 = 100%</td>
<td>A</td>
</tr>
</tbody>
</table>

3. **Recommendations**

**Medical School**

- **Recruitment and Admissions**
  - Publish an annual report detailing the race, gender, and socioeconomic distribution of the recipients of merit-based financial aid. This is in line with student activist recommendations and meetings with administration in the Fall of 2020.
  - Incorporate a panel consisting of BIPOC leaders from the greater Los Angeles community during Interview Day that allows prospective students the opportunity to inquire about the current state of healthcare within their communities as well as UCLA’s successes and/or failures in the delivery of that healthcare.

- **Curriculum**
  - Pilot a lecture series for 1st year medical students through which individuals who are currently or have previously been incarcerated in Southern California correctional facilities (Los Angeles Men’s Central Jail, Los Angeles North County Correctional Facility, Los Angeles Twin Towers Correctional Facility) may speak to their experiences receiving healthcare.
  - Establish a Community Leadership Board of no less than ten members from regions within Los Angeles that have historically
been underserved by the UCLA Health system that work directly with the medical student body to coordinate

Clinical Education

- Actively develop techniques for protecting the privacy and safety of undocumented patients and patients presenting in police or prison custody. Consider using the resources invested in the Mobile Clinic and other student-run care organizations to ensure that all members of the local community have full access to the healthcare they require at the primary teaching hospital and its affiliated clinics.

- There is concern that medical students perform a disproportionate amount of their procedural training at county hospitals, where more patients of color and other vulnerable populations seek care. Consider whether there is any infrastructure that can be put in place to hold the school accountable to its goal to standardize clinical care across sites.

Student affairs

- Continue to compensate students and faculty for their work in SRHE.

Physical Space

- Please see: Hospital Metrics; Physical Space

Relationship to the carceral system

- None at the moment as further discussion is needed with greater DGSOM community.

Treatment of workers

- Consider not incorporating inquiries about a person’s history of criminal punishment system involvement in hiring processes for workers at the medical school.

- There is a need for more transparency with respect to workers’ wages, and to taxes the medical school pays to the local government.

Research

- Please see: Hospital Metrics; Research

Institutional response to student activism

- There is concern about the speed with which the school addresses complaints of injustice/mistreatment. Consider ways to ensure
follow up of issues presented in a timely manner. This effort should be student led in regards to how they would feel best supported by administration re: follow up (ex. Meeting with unaffiliated individual, message indicating receipt, timeline for follow up).

**Residency**

- **Recruitment and Admissions**
  - Compensate residents and faculty for their time and effort to recruit new trainees. To increase the percentage of URM residents, recruitment is a necessary tool, but is an extra time commitment. Residents have busy schedules, so additional pay for time spent outreaching and recruiting residents is a fair way to compensate them for their time.
  - Include racial and other demographic breakdowns of residency programs easily accessible on the residency website. Currently, this information is not easily accessible, especially if you are only utilizing the residency website to find the racial breakdown of residency programs.

- **Curriculum**
  - Incorporate more of a Structural Racism and Health Equity curriculum component to the didactics given to residents. Consider inviting community leaders, social justice advocates, and speakers with lived experiences to diversify the topics and viewpoints shared.
  - Have a standardized curriculum for didactics given to all the residency programs so there is uniformity in the topics. Developing a standardized curriculum for all residency programs ensures a baseline understanding for all residents. One barrier to ensuring a standardized curriculum is the varying resident schedules. If most of these are lunchtime didactics, residents working overnight may be unable to attend. One way to mitigate this is by recording these didactic sessions and making them available to all residents.

- **Clinical Education**
  - There should be protected time off for Residents to attend training on how to properly care for patients from different backgrounds with empathy and cultural compassion. These trainings should be taken seriously and a standard evaluation of their comprehension for the subject should be done on an on-going basis.
Trainee Affairs

- Create standard practice of oversight over trainees that applies to all training sites. Within county hospital sites and clinics, there should be a standard practice that the attending should see the patient at least once before deciding what the patient care plan should be, and the attending should remain adequately present for support throughout provision of all care and procedures.

Treatment of Workers

- This metric has been met by all programs, so therefore, we do not have recommendations at this time

Hospital

Physical Space

- The UCLA health system does not specifically acknowledge the contributions of alumni and health care workers of color in physical spaces. The Ronald Reagan UCLA Medical Center is titled after the 40th US president of the United States, who alongside being known to have implicitly racist beliefs, was known to partake in explicitly racist policy measures such as the expansion of The War on Drugs (which disproportionately incarcerated Black and Brown individuals) and Reaganomics (which eliminated many publicly funded programs supporting minority communities). These actions had crippling repercussions for communities of color. Some students and faculty of color therefore refuse to refer to the hospital as Reagan, but rather refer to the hospital as UCLA Medical Center. Communication took place between student leaders and BIPOC hospital administration regarding the possibility of renaming and unfortunately, this has been a longitudinal goal of many with significant barriers. Though the naming of Ronald Reagan is rooted in an immense financial transaction, consider encouraging students and faculty to refer to the hospital and affiliated structures as UCLA medical center if the hospital is unable to be renamed at this time. The fight for the longitudinal goal of renaming the hospital entirely should remain under consideration.

- Consider a vetting process for future naming and an analysis of other honorific building names at DGSOM and UCLA Health.
Consider land grant acknowledgment of Native Peoples for naming of UCLA Health spaces (such as UCLA main campus renaming of Tongva Steps)

Relationship to the Carceral State

The patients of the hospital are protected from ICE by the same measures that cover the entire UC system. However, this information was not easily accessible through a google search. Notably, even some UCLA staff and faculty were not aware of where the information regarding protective measures and procedures afforded against ICE was housed. It therefore is recommended to more publically inform the patient populations of UCLA aware that the hospital buildings and rooms have protection against ICE. This could potentially encourage patients to seek healthcare prior to an emergent crisis. This could be through posted placards, an official, searchable statement, such as one made by UC San Francisco, or through public advertisement of UC policy VIA QR code on public transportation.

Treatment of Workers

Police and Prison Abolition

- Bearing in mind that “inquiry about persons’ history criminal punishment system involvement is necessary for patient safety”, certain measures could be put in place to uphold this priority while also addressing concerns of potential employment discrimination. The recommendation is to ensure that the process for conducting background checks is fully transparent and in compliance with the California Fair Chance Act (AB 1008). Furthermore, establishing a procedure for potential hires to challenge “failed” background checks would ensure that eligible individuals are not passed over for employment.

Redistribution

- In addition to providing hospital staff with living wages, it is recommended to support equitable access to their place of employment. Ways that this could be achieved include:
  - The provision of free transportation access, via Los Angeles Metropolitan Transportation, to employees residing in communities outside of Westwood.
- Regular contribution to housing assistance funds to enable employees to reside closer to their place of employment.

- **Community Control and Self-Determination**
  - Workers unions remained hesitant to speak to student representatives and cited concerns that “nothing would be done” after voicing concerns for this report. This could potentially be indicative of a larger issue regarding workers' concerns being dismissed. More information will be required for future reports including whether workers feel their concerns are adequately addressed.

- **Patient care**
  - Around a third of Los Angeles County residents are enrolled in Medi-Cal, and Black and Latino populations represent a large percentage of these patients (7% and 49% respectively). Through collateral information gathered from faculty and staff, UCLA Health in a technical sense accepts Medi-Cal FFS in all departments. However, in practice, many Medi-Cal FFS patients are transitioned to Medi-Cal Managed Care plans with which UCLA Health is contracted to enroll a limited number of patients for primary care. This becomes even more complex for specialty care which is often limited to one time insurance authorizations with limited and often poor follow-up for complex conditions. Unfortunately, this means many patients representative of the Los Angeles community go unseen. Approximately 2-3% of UCLA's outpatient clinic patients and 20-25% of hospitalized patients are enrolled in a Medi-Cal plan. Many students, trainees, staff and faculty alike have been advocating for an increase in these numbers. UCLA Health should continue initiatives to increase the number of Medi-Cal patients meaningfully cared for by our healthcare system.

  - Continue work to track patient restraint data by demographic to ensure there are no gross differences between populations being restrained.
• Recommend signs welcoming patients regardless of immigration status (in addition to race, religion, culture, sexuality, gender, etc.) as per UCLA Health Policy. Additionally, this could take place as an online campaign. This would increase visibility of UCLA HEDI values to patients and encourage them to seek care at UCLA facilities.

○ Research

○ Students on multiple fronts attempted to acquire information regarding BIPOC communities in the UCLA research spaces. Unfortunately, either this information is not housed or it is not easily accessible to students. Research is one of the main progressors of healthcare, however historically, it has been misused to the detriment of disenfranchised groups. In other ways, research studies have historically been less accessible to underrepresented groups who might depend on innovative care or who are not accounted for in studies. Though UCLA Health met the required research metrics, without publicly available information regarding how race is used or accounted for in research projects, it is difficult to prevent misuse. Information regarding race and research at UCLA should be housed and accessible for accountability. This could be accomplished through a Social Justice Research Hub.

  ▪ Such an undertaking could include different projects throughout the UCLA health system that have a focus on social determinants of health, health justice, race, gender, sexuality, immigration, or health disparities. This would not only allow for UCLA Health system to publicly demonstrate the work that is being done, but also allows for accountability within the UCLA community.

  ▪ This could additionally serve as a recruitment hub for underrepresented patient groups to studies who may not otherwise know how to access these health impacting studies. In turn, this increases the diversity of UCLA Health studies and recruitment.

○ Educate research investigators on race as being a social construct rather than an innate biological trait as a part of mandated training.
4. References


