CORE | Commitment to Operationalize Racial Equity

BUMG | EVI

Last updated 10/13/21

This tool is a living document to be revised on an annual basis. Please refer back to the Office of Equity, Vitality, and Inclusion website here for the most updated version. If you would like to adapt or adopt these tools for your own use, please cite us:

Boston University Medical Group Office of Equity, Vitality, and Inclusion | Commitment to Operationalize Racial Equity

For any questions regarding the CORE tool, please contact Cassandra.Pierre@bmc.org or evi@bmc.org

Boston University Medical Group

CENTER BOSTON MEDICAL

BOSTON UNIVERSITY

Table of Contents

EXECUTIVE SUMMARY

Eliminating racism requires acknowledging our role in it. Institutional racism often functions outside of intent. Using a racial equity lens means paying attention to the impact of decisions, big and small, and how they may affect underrepresented racial and ethnic groups[1] (**URG**) and people of color differently compared to their White counterparts. It demands critical thinking, vigilance, and ongoing effort. Without that, our default system produces inequitable outcomes. We need our hands on the wheel at all times to stay the course towards racial equity.

The Commitment to Operationalize Racial Equity (**CORE**) tool provides organizational change tools for departments to create a sustainable culture of racial equity. Specifically, the CORE walks departments through a process of identifying a racial equity goal. The advancement of racial equity is a key aspect of our work as physicians and advanced practice providers, and it is ongoing. Truly achieving diversity, inclusion, and belonging requires an environment that promotes racial equity and vitality at the strategic planning level. This means considering the success and wellbeing of underrepresented groups and faculty of color at all decision-making points.

Everyday people make decisions and implement policies and practices that shape institutional norms. We all have the power, individually and collectively, to reshape these norms, using a racial equity lens and employing antiracist practices. Together, we can foster an environment where our racial equity values are reflected in our everyday practice, where we can dismantle institutional racism.

Historically and currently, unjust systems denied Black, Indigenous, and other people of color basic human rights and adequate resources to live their fullest and healthiest lives. The impact of past and present policies and structures perpetuates inequities despite race neutral policies or good intentions. People of color, particularly Black, Native American, and Latinx populations, still experience consistently poorer health outcomes than their White counterparts.[2] Rather than the result of individual behavior due to inadequate options, these differences are the consequences of policy decisions leading to inequitable access to health promoting resources like livable wages, quality education, and safe neighborhoods. Structural racism and racist policies are also evident in academic medicine.

As a process, we apply racial equity when those most impacted by structural, racial inequity are meaningfully involved in the creation and implementation of the institutional policies and practices that impact their professional lives. In academic medicine, this means URG, specifically individuals who are Black or African American, Hispanic or Latinx, Native American or Alaska Native, Native Hawaiian and natives of U.S. territories in the Pacific, it also broadly includes people of color who may be well represented but do not share equal power and resources nor similar experiences to their White counterparts.

Change requires taking risks and potentially making mistakes. Being antiracist and centering racial equity is about building muscles through continuous practice. It is not about perfection. The more we practice, the more we build our skill to do the work. We all have an important role to play and we all need to start somewhere. No matter where you are on your journey, now is a perfect time to (re)commit to building a culture of racial equity.

[1] According to the NIH, in academic medicine, URG refers to those who are Black or African American, Hispanic or Latinx, Native American or Alaska Native, Native Hawaiian and natives of U.S. territories in the Pacific.
[2] Health of Boston 2016-2017: Boston Public Health Commission Research and Evaluation Office Boston, Massachusetts 2016-2017 https://bphc.org/healthdata/health-of-boston-report/Documents/_HOB_16-17_FINAL_SINGLE%20PAGES.pdf

ACKNOWLEDGEMENTS

We would like to thank BUMG's Diversity and Inclusion Advisory Council members, past and present, for their partnership and input in developing the Commitment to Operationalize Racial Equity (**CORE**) tool.

BUMG Faculty Clinician Members:

Cassandra Pierre, Chair
Rachel Achu
Tejumola Adegoke
Juanita Belton
Vonzella Bryant
Sheila Chapman
Alexis Gallardo Foreman
Nicole Jackson
Shamaila Khan
Lauren Nentwich
Tuhina Neogi
Pieter Noordzij
Perla Macip Rodriguez
Sabrina Sanchez
Carl Streed Jr.
Nadja St. Surin

Ex-Officio Members:

Farrah Belizaire, Graduate Medical Sciences, Associate Director, Diversity & Inclusion, BUSM
Emelia J. Benjamin, Assistant Provost, Faculty Development, BUMC
Tiffany Jadotte, Senior Director & Chief of Staff, Human Resources, BMC
Aviva Lee-Parritz, Director, Office of Equity, Vitality, & Inclusion, BUMG
Mary Beth Molloy, Chief of Finance & Administration, BUMG
John Polk, Associate Dean, Diversity & Inclusion, BUSM

Lead Author: Makaila Manukyan, Senior Project Manager, Office of Equity, Vitality, & Inclusion, BUMG

Additionally, we would like to thank our stakeholders for providing ongoing support and guidance in this work:
William Creevy, Chief Executive Officer, BUMG
Ravin Davidoff, Chief Medical Officer, BMC
Hee-Young Park, Dean of Faculty Affairs, BUSM
Kristen Handricken, Director of Learning & Training, Office of Diversity & Inclusion, BU
Angelique Harris, Director of Faculty Development, BUMC and Director of Faculty Development & Diversity, Department of Medicine

We thank the rest of the Equity, Vitality, & Inclusion team who shape the content and direction of this work:
Megan Bair-Merritt, Chair, Women's Leadership Advisory Council,
Susannah Rowe, Chair, Wellness & Professional Vitality Advisory Council
Meghan Hassinger, Director of Project Management,
Kate Smyth-Hammond, Project Manager

We give special thanks to all the Departmental Racial Equity Champions for their ongoing partnership and input. See **Appendix A** for a full list of names.

We also thank the many leading institutions advancing racial equity, diversity, and inclusion through organizational change, whose work informed and inspired the Commitment to Operationalize Racial Equity tool. Find their specific tools listed in **Sources.**

- AAMC
- Boston Public Health Commission
- Equity in the Center
- Institute for Healthcare Improvement
- Racial Equity Institute
- Race Forward

People often avoid talking about race and racism as it can be uncomfortable, may lead to conflict, and stems from a fear of misspeaking, sounding racist or unintentionally doing harm. Talking about race requires courage. Learning about and addressing structural oppression and inequality such as racism requires courage on all sides. It is normal to feel discomfort as you reflect on your own experiences with racial inequality and deepen your understanding of racism. The more you practice having these difficult conversations, the more you will be able to manage the discomfort. The conversations may not necessarily get easier, but your ability to engage and move towards more meaningful dialogue and action will expand. We hope you will allow yourself to engage in an authentic manner and to provide input towards an important and meaningful growth and learning endeavor. [1]

INTRODUCTION

BUMG's Office of Equity, Vitality, & Inclusion (**EVI**) aims to create and sustain a culture at BU Medical Campus where all students, faculty, trainees, and staff thrive, and their success and wellbeing are not predicted by their race, gender, and other dimensions of identity.[3] BUMG is taking steps towards creating an equitable and safe professional environment to ensure our faculty at all levels is representative of the community we serve and that all faculty feel safe, supported, and professionally fulfilled. As part of this vision, BUMG's Diversity & Inclusion Advisory Council (**DIAC**) is charged with promoting racial equity at BU Medical Campus through programs and initiatives.

Leading with race is not to the exclusion of other identities experiencing inequities; EVI and the DIAC apply intersectional approaches. We understand that systems of oppression work to benefit dominant cultures and identities (White, male, cisgender, non-disabled, etc.) and a racial equity framework can be applied to all our work by focusing on groups who are most disenfranchised and structurally marginalized. However, history and data continuously show that the greatest injustices and inequities exist along racial lines, a result of structural racism. Across nearly all sectors and outcome measures Black, Latinx, Indigenous and other people of color fare worse than their White counterparts.[4] Within academic medicine[5], racial inequities persist in terms of representation (students, trainees, faculty, and leadership) and the degree to which individuals feel valued, safe, and respected in the workplace.

Workforce equity and vitality is not only about our faculty, it has substantive implications to our external outcomes – the health of our patients and the community at large. It is up to us, hospital and faculty leaders, to examine the ways in which our organizational culture has unintentional barriers to vitality for underrepresented and faculty of color, as well as students, trainees, and staff.

The Commitment to Operationalize Racial Equity (**CORE**) tool provides organizational change tools for departments to create a sustainable culture of racial equity. Specifically, the CORE tool walks departments through a process of identifying a racial equity goal. CORE is our work as physicians and advanced practice providers, and it is ongoing. Truly achieving diversity, inclusion, and belonging requires an environment that promotes racial equity and vitality at the strategic planning level. This means considering the success and wellbeing of underrepresented groups and faculty of color at all decision-making points.

To move equity and vitality forward at BUMG, we are required to 1) understand and reconcile the racist history of medicine, healthcare, and the United States as a whole and 2) uproot the ways we are sustaining racist norms through our current institutional policies and practices. For faculty, this means:

- Acknowledging the interlocking systems of oppression, primarily racism, which cause our URG colleagues to face inequities in recruitment, retention, advancement, and vitality
- Acknowledging that when our patients of color have the opportunity to choose URG clinicians, they flourish (e.g., better health outcomes, treatment outcomes, and overall experience)
- Interrupting the roles racism and bias play in recruitment, retention, advancement, and vitality of URG faculty
- Not perpetuating ongoing inequities in the health of our patients and the lives of our colleagues

[3] Other dimensions of identity may include *socio-economic status, sexuality, age, disability, national origin, religious beliefs, culture, cognitive styles, personality, appearance, and more.*
[4] See Racial Equity Institute's The Groundwater Approach for a brief study of racism's deep and lasting impact across society.
[5] According to many resources including the AAMC's Diversity in Medicine: Facts and Figures 2019 https://www.aamc.org/data-reports/workforce/report/diversity-medicine-facts-and-figures-2019

Using the CORE Tool

The CORE tool provides a framework for critical thinking and integration of racial equity in the following four sections:

Section 1: Getting Started: Create your racial equity team and examine your disaggregated workforce data

Section 2: Departmental Racial Equity Assessment: Explore where you are on your racial equity journey and identify growth opportunities

Section 3: Racial Equity Strategic Goal Selection: Commit to an internally focused, departmental racial equity goal

Section 4: Action Plan Creation: Establish specific, measurable practices and reporting structures to achieve your racial equity goal

Across these four sections, there are a total of eight activities for your department to complete. The CORE will walk your team through each activity. See **Submission Form** on page 14**,** your final activity to complete and send to the Office of Equity, Vitality, & Inclusion.

Shared Understanding

Before selecting a racial equity goal, it is important to have a shared understanding of the following central concepts as well as the historical context of racism in the United States. Continue to deepen your understanding by reviewing the **Glossary** on page 15, a more detailed explanation of **Racial Equity Principles & Approaches** in Appendix B, and **Ongoing Learning & Practice Resources** on page 18.

Racial Equity

Racial equity is the state in which race no longer determines one's life outcomes. In terms of the workplace, those outcomes are recruitment, hiring, mentorship, advancement, leadership, retention, salary, overall wellbeing, and more. Racial equity is when everyone has what they need to thrive professionally and are free of racism, race-based harassment, bias, discrimination, and microaggressions.

Racism

Racism is a system of power and oppression, codified into law, policies, and institutions, based on the socially and politically constructed concept of race, that advantages the dominant group (White people) and disadvantages non-dominant groups (people of color). Racism operates in the following interconnected ways: internalized meaning within individuals; interpersonal meaning between individuals and/or groups; institutional meaning within policies and systems; and structural meaning across institutions, society, over generations.

Racial Equity Approaches[6]

Additionally, fostering a culture of racial equity requires the following actions:

- Naming systems of oppression like racism as root drivers of inequities
- Analyzing disaggregated data by race, and the intersections of identity
- Promoting deep understanding of historical context and systemic barriers to equity and vitality
- Engaging the community, particularly those underrepresented and most affected by inequities
- Focusing on impact and systems change
- Grounding the work in our shared fate, i.e., racial equity is good for *everyone*

[6] Adapted from the Boston Public Health Commission's Racial Justice and Health Equity Professional Development Series 2-day Core Training

GETTING STARTED

[Total estimated time: 8 hours]

Complete the following activities to embed racial equity into your department's culture. This work requires a diverse team to make decisions and set your direction. As you move through the CORE tool together, continue to welcome various perspectives and experiences. Pay attention to implicit bias and limit its influence.

Activity 1: Assemble Your Racial Equity Team

- Identify member(s) who are department leaders and decision-makers. These members will facilitate the team in using the CORE tool and will make decisions toward selecting your racial equity goal.
- Gather a diverse team; strive for equitable representation by race, ethnicity, gender, age, rank and role (e.g., frontline staff), and with various perspectives. Size of team will vary.
- Establish roles and responsibilities. Be sure to include staff responsible for implementation and an administrator to record steps, arrange meetings, etc.
- Develop a timeline for your team; set aside enough time to complete the CORE tool and establish a racial equity goal (up to three months). Build the following into your plan:
    - Meeting time to review materials, share tasks, consider findings, and make decisions.
    - Time between meetings to prepare, research, and collect information to answer questions asked in each of the following sections.
    - Time to engage additional stakeholders within (and potentially outside of) your department to promote inclusive engagement, such as looping back to staff on decisions that may result.

Activity 2: Build Group Agreements

- Establish agreements for how your team will work together. Group agreements will help to ensure everyone's voice is heard by grounding your team in racial equity and promoting inclusion.
    - See examples of **Group Agreements** used in various parts of the BU Medical Campus in Appendix C.
    - Make them your own. Ask your team to add anything missing and offer any clarification.
    - Check in with your team regularly to make sure these agreements work in practice so that you are "walking your talk." When things get sticky, these agreements can help move the team past the stickiness by holding each other accountable.

Activity 3: Examine Disaggregated Data and Review Organizational Goals

- Gather your data. Refer to supplementary materials from EVI and any department-specific or other data you have that may be helpful. *Understanding the data limitations, please work with what you do have.*
    1. BUMG faculty workforce data, disaggregated by race, ethnicity, and gender
    2. BMC patient population data, disaggregated by race and ethnicity
- Examine the racial and ethnic makeup of your department. Pay attention to the intersections of race, ethnicity, and gender. Begin to consider the following:
    - Are there racial and ethnic differences by leadership? Other roles?
    - How does your workforce reflect the racial and ethnic diversity of the community BMC serves?
- Review your department's Clinician Vitality Survey data from BUMG.
    - Are there differences when disaggregated by race, ethnicity, and gender? *If not available, consider how to incorporate this data in the future.*
- Review the **BUMG Strategic Plan Goals 2019-2022** and **BUSM Diversity and Inclusion Strategic Plan Goals** and **Diversity at BMC**.

DEPARTMENTAL RACIAL EQUITY ASSESSMENT

[Total estimated time: 4 hours]

Trying to change the system to eliminate institutional racism can feel overwhelming. Your own department, where you have the most control, is a great place to start.

An assessment can orient your team and help guide you on your racial equity journey. Understanding where you are is necessary for planning where to go. This work must be data informed – both quantitative and qualitative. The goals and strategies your department selects should build upon past or existing efforts, maximize opportunities and address any urgent gaps to reduce further inequities.

Activity 4. Complete the Racial Equity Assessment Tool

[~ 1 hour]

The assessment tool[7] examines six key areas for building a culture of racial equity.

I. Racial Equity is a Departmental Priority
II. Champions Identified at the Leadership Level
III. Disaggregated Data
IV. Shared Language
V. Ongoing Learning and Dialogue
VI. Institutional Support

Using a 1 through 5 ranking scale, assess how well your department is doing in each key area. Be honest in your answers. Rely on your group agreements from Activity 2 and the Disclaimer below. These scores serve to highlight departmental strengths and gaps which will inform your team's next steps. Organizational change processes are not linear. We may be doing well in some areas and still have lots of room to grow in others. This just verifies that the work of racial equity is ongoing.

Assessment Scale:
1 = no work done in this element
2 = minimal work in this element
3 = some work has been done in this element
4 = the department executes this element most of the time
5 = the department consistently executes this element
Do not know = you do not have enough information to answer or are uncertain

Disclaimer:

- **This tool is not an individual assessment**, but rather an assessment of your department and system as a whole.
- **These scores are not intended to be shared beyond your team**, but to facilitate discussion among your team. It is not about getting a high score or perfection, but about helping your team gauge where to invest your efforts.
- **Be brave**. This content can be new and challenging. Embrace that discomfort and direct it toward taking action. You cannot work towards improvement without taking the first step. Rely on your team for support.

[7] The Assessment Tool is informed by and adapted from Race Forward's *Ready for Equity in Workforce Development: Racial Equity Readiness Assessment Tool*, AAMC's *Diversity + Inclusion Strategic Planning Toolkit*, IHI's *Improving Health Equity: Assessment Tool for Health Care Organizations,* and Equity in the Center's *Awake to Woke to Work: Building a Culture of Race Equity*.

- **It is ok to answer, "Do not know."** You may not have enough information to answer some questions or the data may not exist. Do not let that prevent you from completing as much of the assessment as you can. "We don't know what we don't know" and the benefit of this tool is to find out what we don't know so we can do something about it.

Instructions

1. Individually go through each element in **Worksheet 1** and choose an assessment score (1-5 or "Do not know"). Be prepared to discuss your scores and rationale as a team in Activity 5.
2. After each section, provide brief comments, e.g., relevant examples, anything notable, etc.
3. Complete as much of the assessment as you can.

Worksheet 1: Racial Equity Assessment Tool

Racial Equity is a Departmental Priority

Element	Level of progress Assessment Scale: 1= no work done 5= the department consistently executes this element					
1. Racial equity is explicitly stated as a priority in key strategy documents (e.g., departmental strategic plan, fiscal plan, annual plan) and there is a shared understanding of how racial equity links to the department's mission, vision, and values.	Do not know	1	2	3	4	5
2. The department has a plan to actualize the racial equity strategy, tracking progress over time, and reviewing racial equity data at the leadership and unit levels.	Do not know	1	2	3	4	5
3. Racial equity, diversity, and inclusion are part of everyone's responsibilities.	Do not know	1	2	3	4	5
4. Racial equity priorities are communicated, understood, and aligned within your department.	Do not know	1	2	3	4	5
5. There are policies in place with practical implementation to advance racial equity within your department.	Do not know	1	2	3	4	5
6. There is shared understanding on why inequities need to be addressed in terms of representation among Black and/or African American, Hispanic or Latinx, Native American or Alaska Native, Native Hawaiian and natives of U.S. territories in the Pacific populations in academic medicine (URG).	Do not know	1	2	3	4	5
7. There are policies and practices within your department that support URG faculty and address inequities in recruitment, retention, compensation, and promotion.	Do not know	1	2	3	4	5
8. Your department prioritizes mentorship among URG faculty.	Do not know	1	2	3	4	5
9. Within your department, you have identified champions, i.e., people to advance internal racial equity, diversity, and inclusion efforts.	Do not know	1	2	3	4	5
10. Your department has funded positions or offers protected time for faculty doing racial equity, diversity, and inclusion work.	Do not know	1	2	3	4	5

11. Your department promotes widespread interest and commitment for progressive change and racial equity in your department.	Do not know	1	2	3	4	5
12. Your department is engaged in advancing racial equity improvement work for which they are responsible.	Do not know	1	2	3	4	5
Comments (examples, questions, achievements, challenges, key supporting documents, next steps, etc.)						

Champions at the Leadership Level

Element	**Level of progress** Assessment Scale: 1= no work done 5= the department consistently executes this element					
13. Your department leadership leverages their influence to achieve racial equity.	Do not know	1	2	3	4	5
14. There are departmental resources dedicated to leadership development and management in the areas of racial equity.	Do not know	1	2	3	4	5
15. Racial equity is a consideration in recruitment and promotion decisions.	Do not know	1	2	3	4	5
16. In senior level hiring decisions, your department prioritizes experience in racial equity, diversity, and inclusion work.	Do not know	1	2	3	4	5
17. Experience, skills, understanding and interest in racial equity, diversity, and inclusion are seen as assets among your faculty.	Do not know	1	2	3	4	5
Comments (examples, questions, achievements, challenges, key supporting documents, next steps, etc.)						

Disaggregated Data

Element	**Level of progress** Assessment Scale: 1= no work done 5= the department consistently executes this element					
18. Your department reviews its faculty data disaggregated by race, ethnicity, and other identities like gender.	Do not know	1	2	3	4	5
19. Based on the data, your department sets goals for recruitment, promotion and/or retention of URG faculty.	Do not know	1	2	3	4	5
20. Your department transparently shares any gaps or inequities demonstrated in faculty data with its department faculty.	Do not know	1	2	3	4	5
Comments (examples, questions, achievements, challenges, key supporting documents, next steps, etc.)						

Shared Language

Element	Level of progress Assessment Scale: 1= no work done 5= the department consistently executes this element					
21. Your department has a shared language of racial equity, racism, diversity, and inclusion.	Do not know	1	2	3	4	5
22. Your department promotes shared understanding of what racism is, about the root causes of racial and ethnic inequities in health outcomes and representation among the faculty.	Do not know	1	2	3	4	5
23. There is shared understanding of what URG faculty means.	Do not know	1	2	3	4	5
Comments (examples, questions, achievements, challenges, key supporting documents, next steps, etc.)						

Ongoing Learning & Dialogue

Element	Level of progress Assessment Scale: 1= no work done 5= the department consistently executes this element					
24. Your department faculty and staff are trained to build their capability to improve racial equity	Do not know	1	2	3	4	5
25. Your department has established regular opportunities to engage in dialogue on racism and racial equity and participation is encouraged and/or facilitated. E.g., book clubs, affinity groups, lecture series.	Do not know	1	2	3	4	5
26. Your department has invested in ongoing training in the areas of racial equity, diversity, and inclusion.	Do not know	1	2	3	4	5
27. Your department regularly integrates learning about racism and the real impacts on faculty and patients into its policies and practices.	Do not know	1	2	3	4	5
28. In your teaching role with students, ancillary staff, residents, fellows, and other faculty, you have integrated an understanding of racism in experiences of learners.	Do not know	1	2	3	4	5
Comments (examples, questions, achievements, challenges, key supporting documents, next steps, etc.)						

Institutional Support

Element	Level of progress Assessment Scale: 1= no work done 5= the department consistently executes this element					
29. BUMG, BUSM, and BMC's racial equity, diversity and inclusion imperatives are communicated to the broader BUMC community.	Do not know	1	2	3	4	5
30. There is a "charge" from BUMG, BUSM, and BMC senior leadership and their Boards that reflects commitment and clear expectations.	Do not know	1	2	3	4	5
31. There are existing resources through BUMG, BUSM, and BMC that support racial equity and implicit bias training that you may leverage to your department's advantage.	Do not know	1	2	3	4	5
32. BUMG, BUSM, and BMC makes resources available and accessible to help improve racial equity, diversity, and inclusion within your department. E.g., data, administrative support, etc.	Do not know	1	2	3	4	5
Comments (examples, questions, achievements, challenges, key supporting documents, next steps, etc.)						

Activity 5. Identify Key Findings

[~ 1 hour]

Once each team member has completed the Assessment Tool in **Worksheet 1**, discuss the following to identify your key findings together.

Note: Each team member may score the department differently; our various social identities and roles within the department shape our understanding and experiences. Make room for these differences across your team.

1. For each element with a 1 through 5 score, review and discuss the following:
   - Where do your individual scores differ the most? Discuss these differences for shared understanding.
   - Where do you have minimal to no progress (scores of 2 or 1)?
   - What would you need, both at the departmental and institutional level, to rate your department a "5"?

2. For each element labeled "Do not know," discuss the following:
   - Why do you not know how the department scores?
   - How are you able to find out?
   - What is the value in finding out?

3. Build agreement on your next steps. Summarize your assessment findings by discussing the following:
   - What are the top two or three findings that are most important for your team and department to address in the short term?
   - To act on these findings, with whom should your team meet? Who is working in this area already? Who is designated or responsible for this area of work?

For future reference, consider maintaining a copy of your completed assessment tool for ongoing learning and quality improvement.

Activity 6. Prioritize Your Draft Goals

[~ 2 hours]

1. Based on your team's key assessment findings, draft 1-2 goals to advance racial equity. Add those draft goals to **Worksheet 2**. In this activity, you will begin narrowing your potential goals into one that is achievable and impactful.

***Note:** Developing your draft goals **is a good opportunity to engage more stakeholders**, both internal (within your department) and external (stakeholders in the larger organization, other departments, partner institutions, etc.). Consider ways to increase engagement and input.*

2. Use the criteria below to rate each of your **draft goals** in the prioritization grid in **Worksheet 2**.
   - **EQUITY IMPACT:**
     - Will **most likely advance racial equity** in your department, i.e., promote vitality of URG faculty
     - Addresses a racial equity **area that needs the most attention**
   - **FEASIBILITY:**
     - Currently have **resources** or opportunities to take initial action
     - Builds off your department's **strengths**
     - Addresses an area where you have the **greatest opportunities for improvement**

3. Based on the prioritization grid, narrow your list to two draft goals, those that rate the best in both criteria.

Worksheet 2: Draft Goals and Prioritization

Draft up to 2 goals related to your key findings. It is ok to leave some lines blank.		*Prioritize what to work on*	
KEY AREA	**DRAFT GOAL**	**EQUITY IMPACT** (high, moderate, low)	**FEASIBILITY** (high, moderate, low)
Racial Equity is a Departmental Priority			
Champions at the Leadership Level			
Disaggregated Data			
Shared Language			
Ongoing Learning and Dialogue			
Institutional Support			

RACIAL EQUITY STRATEGIC GOAL SELECTION

[Total estimated time: 2 hours]

The principles of racial equity can be applied to any area of work. The purpose here is to identify a strategic goal specific to internal outcomes. This may mean amending, rewriting, or refining an existing goal or creating a new goal entirely. Dream big and start where you can.

Be sure to create opportunities to build consensus. Identify check points for more inclusive participation in the process to ensure you are going in the appropriate direction.

Activity 7. Develop an Actionable Goal

[~ 2 hours]

1. Create one clear goal from your top two priorities. Look for some easy opportunities to start moving things forward. Remember, the best goals are "SMART" — Specific, Measurable, Attainable, Realistic, and Time bound.
    a. What is the desired outcome for your goal?
    b. How will you know if you have succeeded in achieving your goal?

2. What are anticipated barriers to achieving your stated goal? What resources will you need to overcome these barriers? Can you count on departmental support to help make your racial equity plan a reality long-term with regards to both financial and human capital, i.e., protected time, financial compensation, etc.?

ACTION PLAN CREATION

[Total estimated time: 1 hour]

Your action plan should answer how your department will operationalize achieving your set goal - what needs to be done, who will do it, and by when.

- Identify one or more senior leaders *within your department* who will be responsible for your department's racial equity goal.
- Assess the current make up of your racial equity team; determine if you are missing any key stakeholders and potential implementers that should inform the action plan.
- Identify specific resources (e.g., financial, person time) to work on this goal; this is not sustainable on volunteer and unfunded time.
- Arrange informational interviews with colleagues in other departments who have done similar work.
- Determine your plan to track and document your progress and success.
- Engage many people in your department's racial equity work, to not only spread the workload, but also to increase learning, practice, transparency, and investment in your identified goal.
- Be persistent. This work requires long term investment. Celebrate successes along the way and be open to continual improvement and growth.

Activity 8. Develop and Implement a Realistic and Measurable Work Plan.

[~ 1 hour]

RACIAL EQUITY GOAL SUBMISSION FORM

To submit to the Office of Equity, Vitality, & Inclusion at makaila.manukyan@bmc.org by **June 1, 2021**.
If your department needs some support to get started, the BUMG Diversity & Inclusion Advisory Council can provide some consultation.

Topic	Department Agreement	Deadline
A. List of Racial Equity Team members: *Please include names and titles.*		**4/01/2021**
B. Racial Equity Assessment tool completed [Y/N]: *Refer to Activity 4, Worksheet 1*		**5/01/2021**
C. Racial Equity Goal selected:		**6/01/2021**
D. Specific resources you need that you do not have to implement this goal and necessary actions: *Please explain.*		
E. Plan to measure goal progress:		

GLOSSARY

Language shapes our thoughts, attitudes, beliefs, and actions. With shared language, we can form collective understanding through deep connection and commitment to our values of justice, equity, and belonging. Use of the following concepts can help expand awareness, build skills for advancing equity, and create common ground.
Please note: the concepts included here are not all inclusive or exhaustive. They are part of a more comprehensive Glossary for Culture Transformation, a living document for use across BU Medical Campus. Please refer to the Office of Equity, Vitality, & Inclusion website for the full glossary.

Values and Approaches: Frameworks that shape how we do our work and reflect what we are striving toward

RACIAL EQUITY: The state in which race no longer determines one's life outcomes. In terms of the workplace, those outcomes are recruitment, hiring, mentorship, advancement, leadership, retention, salary, overall wellbeing, and more. Racial equity is when everyone has what they need to thrive professionally and are free of racism, race-based harassment, bias, discrimination, and microaggressions. As a process, we apply racial equity when those most affected by structural racial inequity are meaningfully involved in the creation and implementation of the institutional policies and practices that impact their professional lives. In academic medicine, this means underrepresented racial and ethnic groups (URG), specifically individuals who are Black or African American, Hispanic or Latinx, Native American or Alaska Native, Native Hawaiian and Pacific Islander; it also broadly includes people of color who may be well represented but do not share equal power and

resources nor similar experiences to their White counterparts.

ANTI-RACISM: The active and conscious effort to work against the multi-dimensional aspects of racism; undoing racism requires consistently identifying it, describing it and then dismantling it. Note: 'anti-racist' does not mean 'non-racist.' According to The National Museum of African American History and Culture, "No one is born racist or antiracist; these result from the choices we make. Being antiracist results from a conscious decision to make frequent, consistent, equitable choices daily. These choices require ongoing self-awareness and self-reflection as we move through life. In the absence of making antiracist choices, we (un)consciously uphold aspects of white supremacy, White-dominant culture, and unequal institutions and society. Being racist or antiracist is not about who you *are*; it is about what you *do*."

DIVERSITY: Each individual is unique, and groups of individuals reflect multiple dimensions of identity: race, sex and gender, socio-economic status, sexuality, age, ability, national origin, religious beliefs, cognitive styles, personality, appearance, and much more. Valuing diversity means embracing and celebrating the rich dimensions of difference that exist in groups and eliminating interpersonal and institutional biases based on these differences.

INCLUSION: The fundamental and authentic integration of historically and currently excluded individuals and/or groups (e.g., Black, Indigenous, people of color, women, transgender and gender non-binary individuals, and the intersection of structurally marginalized identities) into positions, processes, activities, and decision and policy making in a way that shares power, values input and engenders belonging.

BELONGING: How connected one feels to one's community/communities. Operationalized when individuals are considered part of the constitutional foundation of an organization or institution. Belonging is achieved when individuals have the ability to critique and hold an institution responsible for advancing equity, diversity, and inclusion.

ALLY: Actively making the commitment and effort to recognize one's privilege (based on race, gender, class, sexuality, disability, etc.) and working in solidarity with oppressed groups in the struggle for justice. Allies understand that it is in their own interest to end all forms of oppression, even those from which they may benefit in concrete ways. Allies commit to reducing their own complicity or collusion in oppression of those groups and invest in strengthening their own knowledge and awareness of oppression.

INTERSECTIONALITY: A Feminist theory first highlighted by Kimberlé Crenshaw in 1989. It is the interconnected nature of social categorizations such as race, sex and gender, and other dimensions of identity as they apply to a given individual or group, creating overlapping and interdependent systems of discrimination or disadvantage. Intersectionality recognizes the multiple ways in which people are often disadvantaged by multiple sources of oppression.

PROFESSIONAL VITALITY: A meaningful and productive work life, where people are able to reach their fullest professional potential. Valuing professional vitality means creating a workplace that invests in the emotional, physical, and professional wellbeing of its members, where all are supported so they can do their chosen work with passion, vigor, facility, efficacy, joy, and satisfaction.

Social Identities: Categories society uses to group people, affecting how we interact with the world and how the world interacts with us

RACE: A socially constructed way of grouping people, based on skin color and other apparent physical differences, which has no genetic or scientific basis. This social construct was created and used to justify social, political, and economic oppression of people of color by White people.

ETHNICITY: Classification of human based on shared cultural heritage, such as place of birth, language, customs, etc. *Race* is not a synonym.

GENDER: A social construction that assigns particular characteristics, norms, and roles to sex and genitalia. Refers to the different roles society expects of people. The behavioral, cultural, and psychological traits typically associated with one's gender and often, incorrectly, assumed based on their sex assigned at birth. Usually refers to those aspects of life that are shaped by social forces or to the meaning that society gives to perceived biological differences. Do not use *sex* as a synonym for gender.

URG: An acronym used in academic medicine meaning underrepresented racial and ethnic groups; specifically refers to Black or African American, Hispanic or Latinx, Native American or Alaska Native, Native Hawaiian and Pacific Islander.

Please note: URG is not a permanent or fixed identity because it is based on demographics and representation. The need for URG identification results from systems of oppression, particularly racism, which historically excluded people who are Black and/or African American, Hispanic or Latinx, Native American or Alaska Native, Native Hawaiian and Pacific Islander from careers and within the field of academic medicine.

Although there is some overlap, *URG* is not interchangeable with the term *people of color*, which includes those of broader Asian descent.

Academic medicine made an intentional shift from using the term underrepresented minorities, as "minority" connotes "less than".

PEOPLE OF COLOR: A self-defined, asset-based term for people who do not identify as White, often abbreviated POC; used in place of *minority*, which connotes "less than" and in place of non-White, which is deficit-based. According to Loretta J. Ross, the term was started by women of color in solidarity with each other. Note: Can be applied to groups and places, e.g. communities of color, faculty of color, students of color.

MARGINALIZED COMMUNITIES: Groups that are and have been confined to a lower status in society due to the unfair structures created by society. Such a group is denied involvement in mainstream economic, political, cultural, and social activities, resulting in inequitable outcomes. Use *structurally marginalized* communities and/or populations to be very clear that this a result of unfair and unjust systems. Instead of using terms like *disadvantaged*, *underprivileged*, and/or *vulnerable* to describe communities that have been structurally marginalized, consider using *disinvested* and/or *under-resourced.*

Drivers and Barriers: Systemic drivers of inequities and barriers to vitality we must understand in order to eliminate

OPPRESSION: Systematic mistreatment of particular individuals. Oppression is not just an isolated incident. Rather, it is a complex system of power, sustained and pervasive beliefs, laws or policies, behaviors, and feelings. In the U.S., there are many forms of often interlocking oppressions: racism, sexism, classism, heterosexism, anti-Semitism, ableism, etc. Because we possess many layers to our identities, we may experience oppression in one or some of our identities, and privilege in others.

PRIVILEGE: Power and advantage derived from historical oppression and exploitation of other groups. An unearned right or immunity granted as a benefit, regardless of an individual's personal effort

and often invisible to those who have it because we are taught not to see it. The power structure of organizations and government through their infrastructure, policies, and practices reinforces the privileged group by advantaging them and disadvantaging others by creating barriers to attaining equal status. For example, White people in America are privileged in that their race will not limit their economic or educational prospects. Because we possess many layers to our identities (e.g., race, gender, class, sexuality, disability, etc.), we may hold privilege in one or some of our identities, and less privilege in others.

WHITE SUPREMACY: A historically based, institutionally perpetuated system of exploitation and oppression of continents, nations, and peoples of color by White peoples and nations of the European continent; for the purpose of maintaining and defending a system of wealth, power and privilege.

SEXISM: Systemic oppression based on sex and/or gender. Gendered prejudice + power = sexism.

RACISM: A system of power and oppression, codified into laws, policies, and institutions, based on the socially and politically constructed concept of race, that advantages the dominant group (White people) and disadvantages non-dominant groups (people of color). Racism operates in the following ways:

- **Internalized Racism:** The set of private beliefs, prejudices, and ideas that individuals have about the superiority of White people and the inferiority of people of color. Among people of color, it manifests as internalized racial oppression. Among White people, it manifests as internalized racial superiority.
- **Interpersonal Racism:** The expression of racism between individuals. These are interactions occurring between individuals that often take place in the form of harassing, racial slurs, or telling of racial jokes. Interpersonal racism also includes doing nothing and/or being silent when harassing, racial slurs, or telling of racial jokes occur.
- **Institutional Racism:** Discriminatory treatment, unfair policies and practices, and inequitable opportunities and impacts within organizations and institutions, based on race that routinely produce racially inequitable outcomes for people of color and advantages for White people. Individuals within institutions take on the power of the institution when they reinforce racial inequities.
- **Structural Racism:** Racial bias across institutions and society over time. It's the cumulative and compounded effects of an array of factors such as public policies, institutional practices, cultural representations, and other norms that work in various, often reinforcing, ways to perpetuate racial inequity.

ONGOING LEARNING + PRACTICE RESOURCES

Racial equity and anti-racism take continual practice and exploration. It requires an active role to prevent harms caused by racism, from the internalized all the way through the structural. Please find the following resources to support your individual, team, and department's development.

COMPILATION OF MULTI-MEDIA TOOLS

- *21-Day Racial Equity Habit Building Challenge*
  By America & Moore: Diversity, Education & Research Consulting (2014)
  https://www.eddiemoorejr.com/21daychallenge
- *Anti-Racism Toolkit*
  By Stanford IDEAL Engage (2020)
  https://stanford.app.box.com/s/ul37cqj2a7j4umef10o8042pb5k3pidj

VIDEO

- *Why we must confront the painful parts of US history*
  By Hasan Kwame Jeffries (2020, February)
  https://www.ted.com/talks/hasan_kwame_jeffries_why_we_must_confront_the_painful_parts_of_us_history/up-next#t-27160

ARTICLES + REPORTS

- *10 C's: A Model Of Diversity Awareness And Social Change*
  By Patti DeRosa and Ulric Johnson (2002)
  https://www.changeworksconsulting.org/The%2010%20Cs-2002.pdf
- *The Groundwater Approach: Building a Practical Understanding of Structural Racism*
  By Hayes-Green, D and Bay Love. The Racial Equity Institute (2018)
  https://www.racialequityinstitute.com/groundwaterapproach
- *Moving Beyond Diversity Toward Racial Equity*
  By Ben Hecht. Harvard Business Review (2020)
  https://hbr.org/2020/06/moving-beyond-diversity-toward-racial-equity
- *Reckoning with histories of medical racism and violence in the USA*
  By A. Nuriddin, G. Mooney, AIR White. *The Lancet*, *396*(10256), 949-951. (2020)
  https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)32032-8/fulltext
- *Restructure Your Organization To Actually Advance Racial Justice*
  By Carter, E.R. Harvard Business Review (2020)
  https://hbr.org/2020/06/restructure-your-organization-to-actually-advance-racial-justice

BOOKS

- *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present*
  By Harriet A. Washington (2007)
- *The Color of Law: A Forgotten History of How Our Government Segregated America First edition*
  By Richard Rothstein (2017)
- *White by Law 10th Anniversary Edition: The Legal Construction of Race*
  By Ian Haney-Lopez (2006)
- *"Why are all the Black kids sitting together in the cafeteria?" And other conversations about race*
  By Dr. Beverly Daniel Tatum (2003)

BUMG + PARTNER DEVELOPED TOOLS

Please refer to the Office of Equity, Vitality, & Inclusion's website for more information on the following:

- *Glossary for Culture Transformation*
  BMC, BUSM, and BUMG
- *Inclusive Language Practices*
  BUMG Women's Leadership Advisory Council
- *Review-Based Guidelines (RBG) for Equitable Appointment of Leadership Roles*
  BUMG Women's Leadership Advisory Council

SOURCES

The following resources are those from which we particularly adapted the CORE tool. Many thanks, again, to these leaders.

- AAMC *Diversity + Inclusion Strategic Planning Toolkit.* https://www.aamc.org/services/member-capacity-building/diversity-and-inclusion-strategic-planning-toolkit

- The Boston Public Health Commission (2018) *The Guide to Advance Racial Justice and Health Equity* https://www.bphc.org/whatwedo/racialjusticeandhealthequity/Documents/BPHC%20The%20Guide%20To%20Advance%20Racial%20Justice%20and%20Health%20Equity.pdf
- Equity in the Center (2019) *Awake to Woke at Work.* https://www.equityinthecenter.org/wp-content/uploads/2019/04/Equity-in-Center-Awake-Woke-Work-2019-final-1.pdf
- Government Alliance for Race and Equity (2015) *Racial Equity Toolkit* https://www.racialequityalliance.org/wp-content/uploads/2015/10/GARE-Racial_Equity_Toolkit.pdf
- Institute for Healthcare Improvement (2019) *Improving Health Equity: Assessment Tool for Health Care Organizations.* http://www.ihi.org/resources/Pages/Publications/Improving-Health-Equity-Guidance-for-Health-Care-Organizations.aspx
- Race Forward (2018) *Ready for Equity in Workforce Development: Racial Equity Readiness Assessment Tool* https://act.colorlines.com/acton/attachment/1069/f-02a7/1/-/-/-/-/RaceForward_WFD_ReadyForEquity_Tool_2018.pdf

APPENDICES

Appendix A. Departmental Racial Equity Champions

DEPARTMENT	CHAMPION
ANESTHESIA	Rachel Achu*
DERMATOLOGY	Allison Larson
EMERGENCY MEDICINE	Vonzella Bryant* Emily Cleveland Thea James Kerry McCabe
FAMILY MEDICINE	Lizzeth Alarcon Marielle Baldwin Jacklyn Cheng Nikki Jackson* Afi Semenya
MEDICINE	Sheila Chapman*
NEUROLOGY	Anna Cervantes
NEUROSURGERY	James Holsapple
OBSTETRICS & GYNECOLOGY	Teju Adegoke* Ebonie Woolcock
OPHTHALMOLOGY	Manju Subramanian
ORTHOPEDIC SURGERY	David Freccero
OTOLARYNGOLOGY	Heather Edwards Pieter Noordzij*
PATHOLOGY	Chris Andry Reggie Thomasson
PEDIATRICS	Neena McConnico
PSYCHIATRY	Shamaila Khan*
RADIATION ONCOLOGY	Ariel Hirsch
RADIOLOGY	Ilse Castro-Aragon
SURGERY	Tracey Dechert
UROLOGY	Shaun Wason

MEDICINE SECTION	CHAMPION
CARDIOLOGY	Emelia Benjamin* Rick Ruberg
ENDOCRINOLOGY	Shirin Haddady
GASTROENTEROLOGY	Juanita Belton*
GENERAL INTERNAL MEDICINE	Sheila Chapman*
GERIATRICS	Megan Young
HEMATOLOGY-ONCOLOGY	Laura Lowery
INFECTIOUS DISEASE	Rachel Epstein
NEPHROLOGY	Afolarin Amodu
PULMONARY	Michael Ieong Elizabeth Klings Hector Marquez
RHEUMATOLOGY	Kathy Bacon Monica Crespo-Bosque

(*) = Member of the Diversity & Inclusion Advisory Council

Appendix B. Racial Equity Principles & Approaches used by the Office of Equity, Vitality, & Inclusion

RACIAL EQUITY PRINCIPLES & APPROACHES	
NAME RACISM	We state clearly that racism is a significant root cause of differences we see in life outcomes, such as professional fulfillment.
ANALYZE THE DATA	We analyze the data by race and other identities (e.g., gender). We place special emphasis on racial inequities because data show us that injustice needs explicit attention, not to the exclusion of other injustices/inequities.
DEEPLY UNDERSTAND HISTORICAL CONTEXT	We acknowledge the ways in which systemic racism has and continues to shape cultural and professional norms, broadly in society and within institutions like academic medicine - outside of intention.
FOCUS ON IMPACT & SYSTEMS CHANGE	We acknowledge the need to actively work to eliminate racism and dismantle the ways in which these systems of oppression shape our institutional processes, procedures, decision-making, and outcomes - outside of intention.
ENGAGE THOSE MOST AFFECTED	We must meaningfully engage those most affected by racial inequities to develop solutions.
BE ROOTED IN OUR SHARED FATE	We understand that racial equity and workforce diversity create a more effective and healthier workforce, contributing to overall health equity. I = We[8]. Racial equity is good for everyone.

Adapted from the Boston Public Health Commission's Racial Justice and Health Equity Professional Development Series 2-day Core Training

[8] I=We is a framework from the *10 C's A Model Of Diversity Awareness And Social Change* by Patti DeRosa and Ulrich Johnson. https://www.changeworksconsulting.org/The%2010%20Cs-2002.pdf

Appendix C. Group Agreements

Establishing rules for working together is a great opportunity to shift culture by promoting equity and inclusion in group decision-making processes and general meeting spaces. Group agreements are a tool for shared accountability. Please find three example sets below. Feel free to edit and adapt for your own use.

Example 1. Racial Justice Tenets for Equitable Participation used by the Office of Equity, Vitality, & Inclusion

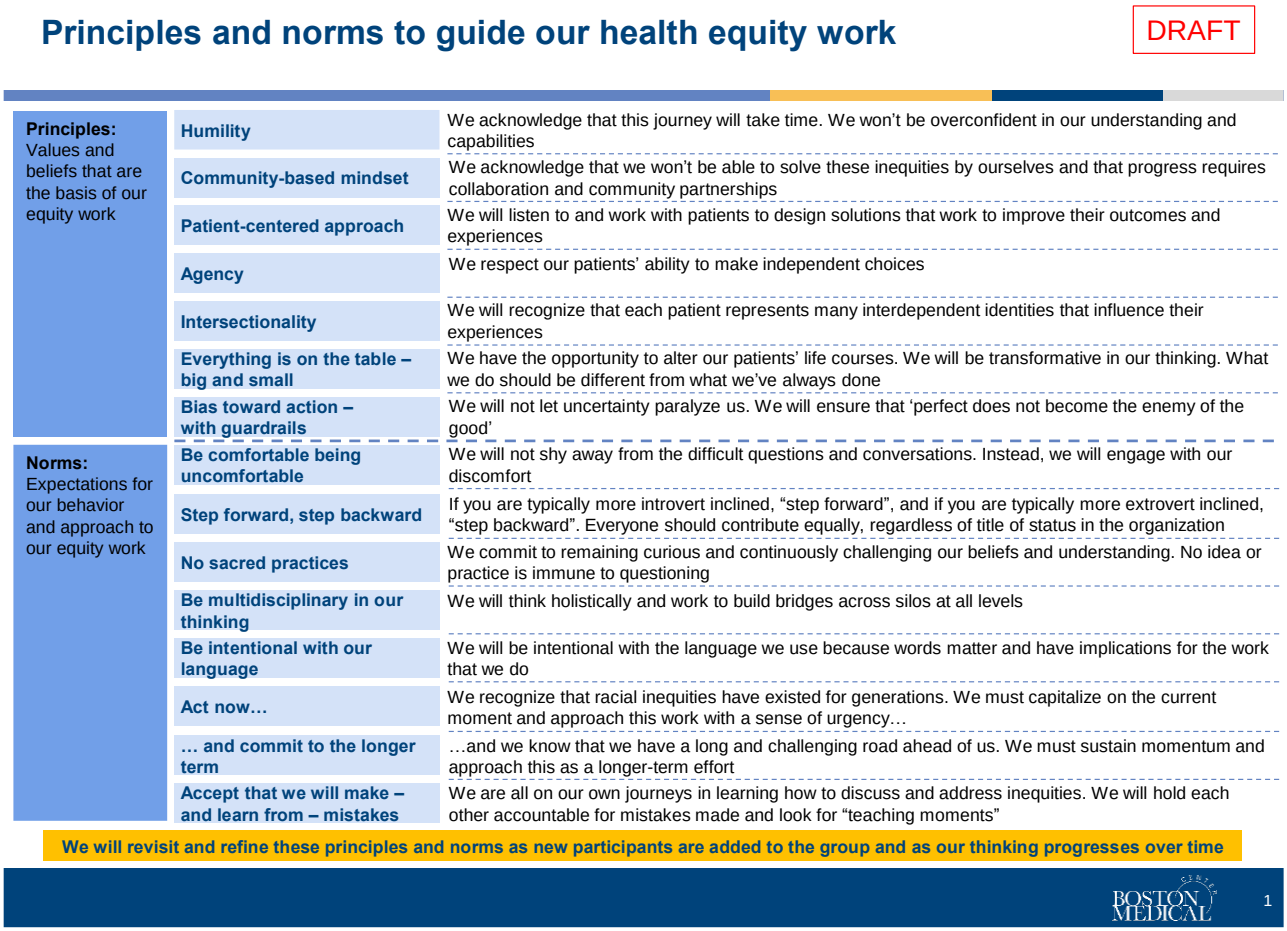
TENET	PRACTICE
Strive for Equitable & Diverse Membership & Representation	We strive ALWAYS for **equitable and diverse membership and representation** across race, gender, culture, and levels of power at every table and every meeting. We acknowledge that **inviting new and different voices to the table requires space, time, and flexibility**. This work is not easy or quick. It is as much about the process as it is about the outcome. Time and space will bring new participants up to speed and help veteran participants slow down, all along the way, so that we may reap the benefits of full and diverse participation.
Value Everyone's Voice & Unique Contribution	We **value everyone's voice and unique contribution** by expecting participation from all members and actively welcoming those who are new, those who hold less institutional power or authority, and those who are traditionally and currently structurally marginalized.
Share the Air	We **engage in new dialogue practices**. If we typically are quiet, we practice speaking more. If we typically fill silence with our voice, we practice speaking less. If we are uncomfortable with silence, we practice sitting with it. If we are uncomfortable speaking, we push ourselves to share. In the words of Peggy McIntosh, we may rely on the "autocratic administration of time in the service of democratic distribution of time" particularly so voices of those at the margins are centered and heard.
Listen for Understanding	We **listen earnestly to others for greater understanding of different and shared perspectives**. We assume best intentions when others speak. We listen to truly understand why someone might think differently than we do.
Intention Does Not Negate Impact	We **actively practice the norm of making it okay to call attention to wrongs, mistakes, or slip-ups** that may occur. We are human and our behavior is the result of years of conditioning in systems of power, privilege, and oppression. We respond according to that conditioning. *Naming without blaming or shaming* is critical to overcoming that conditioning. Practice with "Oops and Ouch". In this way we hold each other accountable, we accept responsibility, and we move on. If repair of harm is needed, we pause long enough to decide when and where that will happen.
Challenge Dominant Cultural Norms	We **challenge the cultural norms for convening and facilitating meetings** by considering broader definitions of "acceptable" behavior or participation (interruption/silence, coming late/leaving early, defining what participation looks like, etc.). We acknowledge that "professionalism" and "institutional norms" have been defined according to a standard of White, patriarchal euro-centrism. We strive to create spaces where people of color, women, and gender diverse individuals lead.

Adapted from Kristen Linda Handricken's Racial Justice Tenets for Equitable Participation used at the Boston Public Health Commission's Anti-Racism Advisory Committee and Racial Justice and Health Equity Professional Development Series.

Example 2. Group Agreements used by BUMG Diversity & Inclusion Advisory Council

Group Agreements	Practice
Share the air	We encourage full participation from everyone, so be mindful to make room for others as well
Assume best intentions	Try not to make negative assumptions about what someone shares or why they are sharing it. Respect the experience/perspective shared, even if it's not yours.
Intention does not negate impact	We need to be accountable for our words and promote a space where we can all be honest. E.g., oops/ouch is an option when a participant shares something that comes out wrong (oops) or when a participant feels hurt by something someone else said (ouch).
What's learned here leaves here, what's said here stays here	Creating space for honesty means creating trust among the team, so as much as possible, particularly when something personal is shared, please do not repeat outside the group.

Example 3. Principles & Norms used by BMC Health Equity Work Group #2



Principles and norms to guide our health equity work

DRAFT

Principles: Values and beliefs that are the basis of our equity work	**Humility**	We acknowledge that this journey will take time. We won't be overconfident in our understanding and capabilities
	Community-based mindset	We acknowledge that we won't be able to solve these inequities by ourselves and that progress requires collaboration and community partnerships
	Patient-centered approach	We will listen to and work with patients to design solutions that work to improve their outcomes and experiences
	Agency	We respect our patients' ability to make independent choices
	Intersectionality	We will recognize that each patient represents many interdependent identities that influence their experiences
	Everything is on the table – big and small	We have the opportunity to alter our patients' life courses. We will be transformative in our thinking. What we do should be different from what we've always done
	Bias toward action – with guardrails	We will not let uncertainty paralyze us. We will ensure that 'perfect does not become the enemy of the good'
Norms: Expectations for our behavior and approach to our equity work	**Be comfortable being uncomfortable**	We will not shy away from the difficult questions and conversations. Instead, we will engage with our discomfort
	Step forward, step backward	If you are typically more introvert inclined, "step forward", and if you are typically more extrovert inclined, "step backward". Everyone should contribute equally, regardless of title of status in the organization
	No sacred practices	We commit to remaining curious and continuously challenging our beliefs and understanding. No idea or practice is immune to questioning
	Be multidisciplinary in our thinking	We will think holistically and work to build bridges across silos at all levels
	Be intentional with our language	We will be intentional with the language we use because words matter and have implications for the work that we do
	Act now…	We recognize that racial inequities have existed for generations. We must capitalize on the current moment and approach this work with a sense of urgency…
	… and commit to the longer term	…and we know that we have a long and challenging road ahead of us. We must sustain momentum and approach this as a longer-term effort
	Accept that we will make – and learn from – mistakes	We are all on our own journeys in learning how to discuss and address inequities. We will hold each other accountable for mistakes made and look for "teaching moments"

We will revisit and refine these principles and norms as new participants are added to the group and as our thinking progresses over time

BOSTON MEDICAL

1