**Moderator:** DR. BARBARA BIERER

**Discussants:** DR. VALERIE STONE and MS. SHANNON BELL

DR. BARBARA BIERER: Thank you for listening, and welcome to Dr. Valerie Stone and to Ms. Shannon Bell. Wonderful to see you. Let me spend a minute to introduce my guests. Shannon Bell is the director of the National Cancer Institute National Institutes of Health Workforce Planning and Development program and the co-chair of Promoting an Equitable and Inclusive NCI Community. And Valerie Stone is the vice chair of Diversity, Equity and Inclusion in the Department of Medicine at Brigham and Women's Hospital and the Director of Health Equity in the Department of Medicine, and a Professor of Medicine at Harvard Medical School. I want to thank you both for being here today. I thought we would start with just letting you give a few opening comments to talk about your own experience and what your organizations are doing to promote a more representative workforce. Shannon, would you like to begin? Thank you.

MS. SHANNON BELL: I would be happy to. Thank-you so much for the invitation. It's really fantastic and exciting to be here. I was delighted to hear the presentation and felt like it was very well done and just excellent information that folks are getting. So, that was really interesting to hear.

I'm at the National Cancer Institute (NCI) where I lead the Workforce Development and Planning Office. Broadly, we have three functions. The first is human capital planning, which is closely tied to equity work, because it's really important to understand who our workforce is. We also oversee the employee engagement function, which of course is also tied to equity because this is where we really learn about, and are able to impact, how diverse the staff experience the organization on a day-to-day basis. Finally, the last component is the workforce development component, which most closely aligns with the lecture today.

I wanted to spend a couple of minutes talking about how NCI develops our staff. And it's our staff that work within our four walls, so not the broader workforce out in the field, such as at academic institutions as your own. These are the individuals who - normally I would say "show up to work" but that's not necessarily true these days - work directly for the National Cancer Institute. We have a number of programs specifically focused on leaders because we think that's incredibly pivotal to the culture and organization. Broadly, that includes a number of programs across supervisory training. We
have found, as in many fields where there's a high need for technical expertise, that sometimes people get promoted because they're really good technically. But that might not always mean that they are entirely prepared to be a supervisor. We really want to ensure that supervisors have the skills and tools to manage the workforce.

I love what Dr. Bierer said about proactive retention. We provide guidance on when and how to conduct interviews, so you are talking to people on an ongoing basis about their career goals, how can we support them, what keeps them here, what could potentially make them consider leaving, and how we retain them. I think diversity recruitment is important, but I'll always double down on retention, absolutely.

We also offer leadership development programs to ensure that NCI's current and future leaders have the skills essential to lead from wherever they are in the organization. We view leadership broadly and understand that people can lead from anywhere. But we also have programs that are specifically geared towards supervisors and managers. All our programs at all levels include tools and resources on both inclusion and bias. We think that is critically important and a foundational issue. We also provide actually individual coaching, which I notice you also mentioned. Broadly, the goal of this is to improve effectiveness and working relationships. We do that through executive coaching, which is sort of what people often think of as coaching - you have a one-on-one engagement with a certified coach, and you see them on a regular basis for a period of time.

We build on their strengths and address any weaknesses we think, or they think they may have, and address things that are getting in the way. We also do situational coaching. If a particular problem is just overwhelming, or they need some support, we do situational coaching. We do some group and peer coaching. And we also do some facilitated coaching to help individuals who need to work together, but for whom that might not be coming very simply, or maybe things have gotten in the way, and we help them to figure out how to do it more effectively.

We also have a number of programs focused on developing staff more generally. And these resources are all accessible to staff at all levels of the NCI. So, while they're also available to leadership, they're available across the spectrum of clinical researchers. And this includes a number of individual development courses that we push out from effective communication to your (Cultural Intelligence) CQ, which is a course on vias. We also do inside/out coaching- which is teaching leaders and individual contributors how to coach in the moment, or to come from a coaching perspective and a knowing perspective. And then we also provide career development workshops and resources to enhance people's career performance where they are and help them consider where their future opportunities may be.

We also have a formal mentoring program where we actually support folks in identifying mentors around a particular issue that they get to define, and we have developmental courses as a part of that. We are also in the process of developing a mentoring hub to provide sort of resources and best practices for anybody at any role as they think about being a mentor or selecting a mentor. It's really important to understand that and know those differences and then to know what doing it well looks like. As part of our equity work, we're just now starting to collect demographics of participants who access our services. And we're also considering our processes and policies and thinking about where there are systemic barriers to participation so that we might be able to address those. Finally, we also develop organizational or team capacity. We consult with leaders to develop customized interventions, assessments, strategic planning, process improvements, and sort of those kind of things. That can take really any iteration, based on what the organization comes to us with, the individuals in the organization, and what their needs are.
This office has actually been a part of NCI, although in a number of different iterations, since 1999. But more recently, as you mentioned, I’m co-chairing the promoting an inclusive and equitable internal NCI community group. And that is part of NCI’s robust equity and inclusion program that was started in 2020 and really is focused on the cancer research environment and workforce that you defined.

In addition to other components, the program has a workgroup that focuses on increasing and enhancing health disparities research and increasing diversity of thought across the science workforce. Again, defined broadly. And then the one I co-chair is really more narrowly focused and aligns really with the work of my office, and that's diversifying the workforce and creating inclusion and equity across the experience of those folks who work within the NCI. This new program has actually initiated over 30 new activities in this first two years, which have included collecting and analyzing information, so we really understand what we’re calling the current state of NCI. What are the demographics? And what are the experiences, and how do those experiences vary based on how someone sees themselves or others see them? And then also included is information from the extramural community that we find. It's been a variety of things from two RFIs around health disparities research and diversification of the broad cancer research workforce, as well as a couple of RFAs on connecting underrepresented populations to clinical trials. That one was worth a mention here. And we are also working on recruiting more diverse trainees, because we do know we’ve got to have a pipeline in place. And we really want to nurture that from a very young age.

DR. BARBARA BIERER: Thank you so much. A lot to dig into as we unpack the conversation. But let me pivot to Valerie. I know that you've really remodeled how the Brigham and Women's Hospital generally, and the Department of Medicine specifically, have thought about workforce development and a commitment to diversity and inclusion. I wonder if you could discuss how you're thinking about it and approaching it.

DR. VALERIE STONE: First of all, thank-you Barbara for your talk. It really made a large number of critically important and compelling points, particularly concerning the data that I think so many of us are committed to making look different in the future. My position as vice chair for diversity, equity and inclusion really grew out of the department’s recognition that their long-term strategy of recruiting a diverse residency class, so that they would have diverse faculty over time, had not worked over a long period of time. And the bottom line was we had had a diverse residency for a while, and we had a slightly diverse faculty group, but there were a lot of problems with retention and departures. So, the goal of my position was to truly increase the recruitment of minority faculty, and dramatically improve the retention, with the goal of increasing representation in terms of numbers and percents. Of course, the underlying goal was to keep those faculty long enough that they would experience career advancement, academic promotion, and leadership opportunities and positions. And we would do this through a series of different programs to get to those goals. At the same time, we realized that there had been little focus on our fellows. And importantly, we felt that making sure that our underrepresented minority fellows were part of a supportive community and felt part of the entire underrepresented in medicine (URIM) community at the Brigham would make them more likely to stay as faculty since very few people were going directly from residency to faculty positions. So, we understood that this was a group of trainees that we = failed to focus on before. We were focusing on all three levels - residency, fellows and faculty - but with the largest goal being accruing more faculty with more senior positions who advanced in terms of their career and their career satisfaction over time.

I would say that I think there’s a set of core components to this sort of work that I just would like to emphasize. And much of it, Barbara has already said in her slide number 16. But I want to really highlight
it. Many people talk about DEI but in a fluffy way—there's not really a plan, there's not really a feeling of whether it really matters whether they get anywhere or not. They're just kind of doing it. And I think the key is to think about this as I think about things as a physician and taking care of patients. I'm serious about this. I have a plan and I expect an outcome, if everything goes well. Similarly with our research. Similarly with our analyses. So, I would like to have that same approach, where we need a commitment to making a difference. And that commitment needs to not just be on the part of the people in charge of the DEI work, but it has to be on the part of the leadership. The leadership has to have a stated commitment that they say frequently in public, and of course back that up with resources—both financial resources and personnel resources to actually roll out and basically implement the DEI strategy.

First of all, there needs to be a sense of what the outcomes are that one wants to achieve. So obviously I talked about our outcome's increase in percent and numbers of UI and faculty. We also have some outcomes around them doing research and getting promoted and retention and so forth. But you have to have clear outcomes and the ability to track those outcomes. The ability to track the outcomes means you have to have clear data on where you are. For example, the number of minority faculty, what their academic ranks are, how long they stay at those academic ranks and how many are getting promoted per year. We look at how we do in terms of these outcomes on a yearly and semi-yearly basis. Of course, there also need to be a set of clear strategies and tactics for positively affecting these outcomes—funding as well as other sources and other terms to make these outcomes and programs possible.

I would say when it comes to the funding, there need to be funds for programs, and funds for the personnel to carry out the programs. I would also say a recognition that many underrepresented minority faculty may need a different compensation structure than others. Perhaps it’s not salary, but if the average minority faculty member is coming in with a tremendously higher amount of loans, perhaps they would appreciate some loan forgiveness built in. Or perhaps there's a signing bonus to help with the loan repayment. B the bottom line is there needs to be an understanding that our relatively low salaries in academic medicine may be more of a burden to people who have no generational wealth and come in relatively disadvantaged. I also think there can be bonuses for the leadership, such as division chiefs, that are tied to working in the DEI space and also achieving certain metrics.

Finally, there needs to be accountability by the overall leadership, and any leaders such as myself who are working in this domain, for actually achieving the stated outcome. And if they're unable to achieve those outcomes, to look strategically at the tactics that have been used and think about how they might need to be modified to be more effective going forward.

DR. BARBARA BIERER: Great. So let me start with picking up on your last point. When you think about accountability for this, what’s the time course that we should be judging it on? Because I think that's complicated. It's got to be real. I just don't know how to think about that. If we really want to develop people in six years, and we need to stay in it— we need to commit to people. So how do you think about that?

DR. VALERIE STONE: I think that you need to have some outcomes that are reasonable to track over an annual basis. For example, as I said our department was challenged by a lot of departures of minority faculty. So, my first outcome I wanted to influence was increasing retention. And that is not the same as getting to associate professor. It basically is intervening for people who seem like there may be some challenges and doing some things to enhance their retention challenges. To try to create a retention package but also to change the environment such that people say, “Hey, this is a pretty nice place to be. I’m enjoying how people are supporting me. I’m enjoying the community. I don’t see that at maybe the
other places I'm looking at.” So that was an outcome that we were able to effect within a year and could really see a difference within a year.

I also think that while one may not go from having 5% minority faculty to 10% in one year, you know we can measure small increments in between and going to 5.2% percent is much better than going in the wrong direction. I think every step of the way it makes sense to look at the data and see. I don't want to suggest that we've been dramatically successful in every outcome every year. I feel a little hesitant to say this, but I'm going to say it as sort of discretely as I can- the number of promotions of our minority faculty my first full year at the Brigham was shockingly disappointing. I have to say I didn't think that this was something I was going to effect in the first year. But it certainly made me say whatever I was doing that first year sure didn't help and we have to do something more. And in the second year, approximately 10 times as many minority faculty got promoted. Once we started paying attention to it, it made a difference. Some of these things are supporting people's careers, the mentorship and sponsorship, and helping them to get funding. And some of it is helping to understand and navigate the processes because our processes for promotion are so challenging and onerous and time-consuming here at Harvard Medical School. There's those two pieces - the actual outcomes that you have to do to get promoted and then the process of getting promoted.

DR. BARBARA BIERER: And then supporting the process of people.

DR. VALERIE STONE: Right, yes.

DR. BARBARA BIERER: Shannon, let me turn this back to you. How do you create time for mentorship? Is it compensated? Is it rewarded? Is it supported? You mentioned that there's a formal program, but people aren't evaluated on the formal programs or informal programs. So how does that get built in?

MS. SHANNON BELL: I think it's a critical question. At NCI we have the good fortune of training the next generation of scientists. But it's literally a part of the Cancer Act- that is how we came into being. So, it is seen as a fundamental component of everyone's job. And I think that puts us in a better position than perhaps folks in other places. That being said, it does not mean that everybody who works at NCI sees it in a similar light and spends the same amount of time or puts the same effort into it or even defines it the same. I think one of the things that we don't do well, and are actually working on, is acknowledging, rewarding, and really looking at mentorship as a core component of someone's performance as they go through. We are actually starting to look at how to do that as part of a couple of things. We're looking at how do we ensure that anyone who is in a position to mentor, either formally or informally, has gone to some sort of a formal program to learn how to do it well. And I think that's critical. It's insufficient because it doesn't get at the rewarding, and I think it's really important. But I think that's a good starting point.

DR. BARBARA BIERER: Were there repercussions to those who don't participate, or is it incentives to participate that that's an expectation?

MS. SHANNON BELL: Well, I think right now we're in the process of building it. So, that is a yet-to-be answered question. I think, frankly, you should start with the incentive. Incentivize it and create clear expectations. But I think there has to be accountability. Our office is in the process of building data dashboards so that each large organization component can look and see the demographic. The results from our culture survey that happens annually in the federal government should include those things. Here's the percentage of leaders in our organization who completed mentor training. Here are the pieces, you know what I mean?
One of the things that we’re also doing is building in lab culture and leader metrics into lab-review process, to make it clear that we’re not just looking at your science and your publications. All those very individual things are important, but we’re also looking at how you lead and shape the environment as well.

DR. BARBARA BIERER: Valerie, the same question to you. Is mentorship rewarded in some way? Is it compensated? Is there time and expectation? One of the things I’m concerned about as we increase the diversity on recruitment bodies - it’s a tax on the time for people. So how do we address that? How do you think about it?

DR. VALERIE STONE: With regard to mentorship, I think that we have a really robust culture of mentorship for faculty at the Brigham, and particularly faculty who are doing research. My colleague, the Vice Chair for faculty development, Dr. Ellen Seely, has data that shows that of our 1400 faculty - only 42 say they don't have a mentor, but they want a mentor. And so together we have worked to get those individuals mentors over the past year. To those of us leading the DEI space, we thought the more critical point was to make sure that our trainees had mentors who could help them with getting opportunities- including research opportunities and career development that they needed at that very important developmental stage. In fact, we collected data two years ago that showed that our minority residents that were assigned mentors didn't always click. And it was a high percentage of the time that it didn't work out and they didn't do anything about it and then would end up not having supportive mentors.

With the wonderful help of Jennifer Goldsmith and our new junior faculty leader, we developed an intentional program to match our minority incoming interns with mentors based on their stated interest and then their stated type of mentor they wanted, whether it was for career, for life, for work integration, or for same race and gender or race to serve as a guide to the institution. We made these very intentional matches and made sure that the mentors were agreeable to it and said they had the time. To ensure that these really worked out well, we facilitated the first meeting. In addition, we've had two "mentoring across differences" workshops to assist the mentors in understanding how to negotiate any differences between them. Even though we provided the types of mentors that people asked for, there were differences by sexual orientation, by gender, and by race. Sometimes one mentor was Black, and one mentee was Latino, or one was Black, and one was Indigenous. So, I think that's really gotten people talking about how to be extremely effective when the mentee is an underrepresented minority, and they have specific types of challenges in the institution.

We also created mentorship communities led by two minority faculty and have four different ones with four different themes and every minority resident was assigned to one of these mentorship communities. The goal was to give them a safe space to talk about all the things going on with them and also to build community- particularly in this time of COVID. I'm about to launch a similar thing for our women new faculty in the coming year, because we've gotten a lot of requests for that sort of thing, and it really makes a difference because it creates almost a co-mentorship model when you have this group that has these two senior people talking to a younger group of trainees or faculty about a wide range of topics.

DR. BARBARA BIERER: Interesting. And let me ask, at the NCI do you do anything intentionally for mentoring across differences? Do you have different programs or efforts or views in terms of how you approach minority individuals than the general group?

MS. SHANNON BELL: We have not done that at all and that's not something we've explored yet. I think it's incredibly important. And I love the co-mentoring model. I think that's really fantastic. We found that
as part of the mentoring program that we have a really broad of levels from very entry level to relatively senior. We have a broad range of ethnicities/races/genders as well. What we found is that the amount of support that folks are finding within those groups is critical. But it's also a fairly large group. You've got 35 to 40 people every time, which then allows people to find their niche. We're talking about a model, but we're way early in the process for looking at new hires who come in and are from underrepresented groups. And what we might be able to do in terms of either creating cohorts and/or mentoring. So, we're exploring that.

DR. BARBARA BIERER: Do either of you have data on the most successful methods to hire underrepresented minority individuals? Does the hiring cohorts concept make a difference? Does it matter? Is there data that is saying from now on this is what we should be doing?

DR. VALERIE STONE: It seems like the first grant announcement from the NIH cited a lot of data saying that was the case. Previous to reading the RFP, I wasn't aware of that data. And we were not successfully getting one here at Harvard Medical School, despite applying. My view was, we have our own cohort here. I had worked with our division chiefs to hire a number of new faculty over the last year. And so, we created a new and early career faculty group and we do events for them on things like how to get promoted, understanding how our institution is organized, more information about grant opportunities, and other things to help them connect and share information with each other that they may know. If one mentor has shared something with one of them and they can share it with each other. My goal was to create a cohort. And I think it really has made a difference. Similar to the last concept I mentioned, I think doing something like this extremely intentionally during the time of COVID was very important. It's really made a difference for some of these faculty who were recruited from out of town with big goals here but knowing virtually no one except for their mentor. I think it makes them feel like they learn. They connect to people. They get more information. They feel a part of a network. And that makes them more likely to stay and I hope more likely to succeed as well.

DR. BARBARA BIERER: And Shannon.

MS. SHANNON BELL: I mean, there is a lot of research out there that indicates that cohorts really help that very initial stage of folks coming in, particularly if they're from underrepresented groups. We have done a lot of that and find it to be incredibly helpful. That is very much like Valerie was saying- we have built developmental and community pieces into our cohort program so that they're not just coming in in a cohort, but they're learning together, and they're doing together. It does make a difference. I also will say that this, in and of itself, is not sufficient. Not surprisingly. So, I think it's a great tool. It's absolutely one that should be maximized. Ultimately at the end of the day, the vast majority of people who leave a job say they leave their supervisor. So, it really is about who you are reporting to, whatever that looks like in your environment, and the relationship you have with them. That is probably the single most important thing. Focusing on leadership, leadership knowledge, and leadership behaviors is critically important as another piece to building that initial cohort.

DR. BARBARA BIERER: I think that's particularly important in research. And frankly when you're on the clinical floors, you've got a much larger environment than when you're living in a lab. You're literally reporting to one person. And they're setting the culture. They're setting the climate. Lots of issues there. So, that's a very good point. And as we think about research, one of the things that I've known is that in order to increase the proportion of diverse participants in clinical trials and clinical research, it is helpful to have investigators that look like, or that are the same race or ethnicity, as the participants. But we can't really wait for that group to come along and be senior PIs. Therefore, it's very important to think about the research staff that are actually interacting with the participants and that we should be
much more intentional about recruiting, training, and retaining that group of people, which has not been a particular focus to date.
I wonder if you want to comment on that, either of you.

MS. SHANNON BELL: I would absolutely agree with you 100%. I think it is being intentional about how you're recruiting to increase your numbers. And we know that professionals in all levels in these fields are underrepresented. I think you have to recruit and train the surrounding staff beyond the PI to be as reflective of the community you're serving as possible. You also have to make it an absolute priority to do cultural humility and have the folks who aren't necessarily representative of the communities you're serving really understand that no matter how much they do, no matter how much they may learn, no matter how much exposure they get, their lens is going to be different and limited. They need to come from a place of inquiry and openness of how this is working, what this means to you, and how you want this to look. If you do those two things, it's best-case scenario in the absence of the other piece.

DR. VALERIE STONE: Yeah, I think it's so much like clinical care- that we have the front desk problem, which you described incredibly clearly. And then you have every staff person along the way that the trial participant interacts with who going to have an impact on them. Sometimes they don't even know who the senior PI is. Hopefully they do. But it's all the people that the participant interacts with who either need to be culturally competent or need to share some part of their culture or their identity. Most of my research has been in HIV/AIDS and doing disparities and community participatory research. So, this is something I did from the very beginning. I think AIDS research actually prioritized this very highly at a time that other types of trials weren't. And I think cancer trials have done a great job of following suit. It's really important to think about reflecting the community that we want to recruit by recruiting that sort of staff. Luckily, it has not been that difficult to find nurses and research assistants and other types of personnel of color who are very excited about being in these diverse roles.

DR. BARBARA BIERER: I agree. I want to ask one sensitive question before the end, which is: Have you done a salary equity review? And that's a pretty complicated process because everybody's a little bit different. But in general, as the data shows, overall, even if you account for all the messiness and all the differences, there's an inequity. And how do you address that?

DR. VALERIE STONE: In our department, about two years before I arrived, they began doing a salary equity evaluation within every division. And it is reported back to the division chief each year. If there are any people who are too high or too low from the standard range for a given type of role, faculty rank and years in the position, they have to explain why. In general, there's been a lot of corrections. And now there isn't that much variability. This salary equity analysis is both by gender and by race ethnicity. Unfortunately, I would say the salaries are more equitable but they're too low. I mean, we're glad they're equitable but I think they're challenging for many people. So, equity doesn't solve everything.

Dr. BARBARA BIERER: Yeah, I agree. Shannon.

MS. SHANNON BELL: We just started in the last year to do pay equity when people onboard. Government has its own special rules around, well, everything. So, we have to do it up front. Now we're doing it with all of what are called "Title 42 hires", which are not people in the GS scale, but tend to be more the medical professionals - the MDs, PhDs, and scientists. We're starting it there because there's more latitude in what you can pay. Often in the GS scales, there's very limited latitude. And so, the system itself is a barrier which we have not figured out how to address. But we are doing pay equity as we on board staff. And we've actually hired a contractor to help us with that. We're looking at developing a standard process and figuring out if we have the capacity internally to do it broadly with
every Title 42 hire, or if we don't, what would the economic burden be to have a contractor to do that analysis for us on an ongoing basis, because we think it's pivotally important.

DR. BARBARA BIERER: Thank-you. here's an interesting comment in the Q&A which says, “Are other institutions creating research RVUs to allow clinicians to obtain credit for research?”

DR. VALERIE STONE: No. I think we are trying to provide some funding for junior minority faculty who join us who may have a research interest, but no funding at the outset. There's not an ability to do the RVU concept. That would be incredibly effective.

DR. BARBARA BIERER: And if that's the case, then there should be sort of an RVU equivalent for mentoring and for all the other things people are asked to do. It's an interesting concept. I can tell you that at least in our refined ivory tower, in research we get to also find our own salary support. It's not supportive of any institution. So, it's a double whammy. And for that we thank the NCI for helping us to at least get on the path of doing research. It's 6:00. The time has flown. Thank-you so much for spending the hour with us and thank-you for your leadership in this domain and for really making us think seriously about how, as Valerie says, to have a future that's different than it is today. Thank-you, Shannon. Thank-you, Valerie. Everyone, have a nice evening.