Section 1: Setting the context
Best Practice: Create a learning environment that welcomes engagement of people from diverse backgrounds and promotes inclusion and representation.

Q1.1: Do I anticipate, appreciate and acknowledge that learners may have a personal experience with the content?
Probing question: Might the content be upsetting or offensive to someone with personal experience?
Example: “As we discuss this topic I recognize that some of you may have personal experience that impacts your comfort, response, and discussions with classmates and others.”

Q1.2: Have I anticipated challenging questions related to the intersection of sex, gender, race, cultural and other biases with my content area?
Probing question: Am I aware of recent scholarship or advocacy addressing these topics?
Example: A learner asks you to explain the reason for race-based differences in frequency of disease.

Q1.3: Am I prepared to recognize and address microaggressions that arise in the learning space?
Probing question: Do I have a plan for interrupting or responding to verbalized microaggressions that includes supporting the target and resetting the learning environment?
Example: A small group member addresses a peer using the wrong pronouns despite clarification.

Section 2: Language and terminology
Best Practice: Words matter, terminology changes -- Look for updates in your field before presenting, welcome learner input and respond respectfully to feedback.

Q2.1: Do I use people-first language and terminology when appropriate in my written materials and discussions, and remain open to change based on expressed preferences?
Probing question: Am I considering the impact of terms used in my workspaces or daily practice?
Example: Person with diabetes rather than diabetic, person experiencing homelessness

Q2.2: Do I use appropriate and inclusive language and terminology?
Probing question: Do the words I use carry assumptions that may not apply? Am I asking patients how they prefer to be addressed and modeling the sharing of pronouns as a welcome practice?
Example: Partner instead of husband/wife; living with diabetes instead of suffering from; volunteers instead of human subjects
Section 3: Images & Media
Drive Best Practice: Utilize images and videos that invite connection, promote recognition, increase representation and improve diagnosis across physical features and abilities.

Q3.1: Do the images or media in my materials represent a range of characteristics?
Probing question: Have I illustrated the ways in which the condition may present differently in patients with a variety of characteristics such as skin tone, body habitus, hair?
Example: Provide more than one illustrative image.

Q3.2: Could the images or media that I am using be perceived as promoting a stereotype?
Probing question: Do I ensure that tables, graphs, and images do not reinforce unintended bias?
Example: Using multiple images when discussing specific conditions may reduce stereotypes.

Section 4: Research and References
Drive Best Practice: Incorporate research that reflects a wide range of populations and individuals in all levels of study design and acknowledge existing limitations in representation.

Q4.1: Is race defined in the paper appropriately as a social construct?
Probing question: Am I able to describe the role of genetics versus socioeconomic factors?
Example: Recognition of race as a surrogate for socio/politics and not differences in biology has many rethinking the use of race in clinical calculators and the role it should play when we share demographic data.

Q4.2: Who are the researchers whose work I am citing?
Probing question: Am I including a variety of perspectives, research traditions and the full international literature on the topic? How are the people being studied represented in the research design process and authorship?
Example: Citing literature from global journals advances the state of the science, while use of local data can advance understanding.

Section 5: Population and Patient Cases
DRIVE Best Practice: Ensure that cases lead the learner to question rather than reinforce bias and assumptions.

Q5.1: Am I intentional in my inclusion of demographic characteristics (like race or ethnicity) for social context instead of as biological factors or physical findings? Am I clear on how inclusion of relevant social variables supports my learning objectives?
Probing question: Do my teaching examples encompass and normalize a range of patient characteristics similar to the mix in a diverse community like ours in Worcester?
Example: Including demographic or social data only when medically relevant may lead to over-association.

Q5.2: Do I include relative impact of cultural or socioeconomic determinants of health on case pathology?
Probing question: If I connect a demographic with a medical outcome, am I explaining the causal pathway?
Example: When presenting a case associating asthma rates with racial categories, do we explain the social and environmental factors contributing to this association? A woman of color with high blood pressure may be suffering from chronic stress from structural racism.

SECTION 6: CLOSING THE LOOP
DRIVE Best Practice: Recognize that change is iterative; utilize evaluation data and feedback to drive continuous quality improvement.

Q6.1: Am I gathering and examining evaluation data from all sources for evidence of improvement?
Probing question: Am I aware of all the sources of feedback available to me? Reach out to DRIVE if you don’t know how to address the feedback. Content experts are available to help.
Example: Contact course or program leaders to request formal evaluation data and informal feedback relevant to diversity and inclusion; incorporate feedback in ongoing development and improvement.