RACIAL EQUITY INTERESTS AND NEEDS ASSESSMENT

The Network for Public Health Law

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INTRODUCTION

By May of 2020, the realities of the inequitable toll of COVID-19 on communities of color became starkly evident, and the murder of George Floyd sparked a renewed movement for racial justice in the United States. During this time, the Network began earnestly exploring how best to respond and be of assistance in a rapidly changing environment. One of the steps we took was to establish an internal Health Equity Work Group (HEWG) to create a space for connection and learning, and to identify ways to collaborate across all our teams to be responsive to what we were observing and experiencing.

As the group started to formalize, we spent time collectively developing a shared vision and agenda and prioritizing actions we wanted to take together. One of those actions was to "evaluate what services and supports Network users are interested in" via tools like an environmental scan, stakeholder interviews, and focus groups. We formalized a work plan in October of 2020, coinciding with the increasing number of declarations of racism as a public health crisis across the nation, which were nearing 200 at that point in time. At the national level there was great interest in the meaning behind these declarations. Like many organizations, the Network started to explore what our constituents – especially state and local health departments – might need to support their racial equity work.

This report explores the process we undertook to answer that question and the key findings and themes relevant to health and racial equity work across a variety of public health practitioners and organizations.

OVERVIEW OF SURVEY

A subcommittee of six HEWG members met to research and develop a plan to conduct an assessment via survey and focus groups.

PURPOSE

To identify constituent interests regarding health and racial equity initiatives and ways the Network can provide support.

Over a period of several months in early 2021, the subcommittee crafted and refined a set of questions and proposed a survey that was submitted to the full HEWG for review and approval. After HEWG approved, the proposed survey was sent to the National Office for review. Once the National Office approved the final survey, we developed a plan for distribution of the survey via the Network report and personalized contacts, as well as a plan for conducting focus groups. The survey was open for five weeks between July and August 2021.

The survey questions assessed the following categories: demographic data, health and racial equity from the respondent's perspective as an employee, respondent's perception of their organization's position and capacity on health and racial equity, data, challenges and barriers, and supports needed.

Among the 384 responses:

- State and local health departments and non-profits were the most common organization types
- Administrator/director/manager, public health practitioner, and attorney were the most common position types (along with "other")
- Nearly half of respondents (48.4%) did not supervise others.

TABLE 1
SURVEY RESPONDENTS BY ORGANIZATIONAL TYPE

Organizational type	Count
State, local, and Tribal health	143
Federal government	20
State & local non-health agencies	17
State & local legal departments and law firm or legal service organizations	24
College or university, and research/policy organizations	45
Healthcare delivery organizations	18
Nonprofits and foundations	81
Other	36
Total	**384**

TABLE 2
SURVEY RESPONDENTS BY PROFESSIONAL ROLE

Professional role	Count
Academic faculty	17
Administrator, director, manager	87
Appointed official	2
Attorney	40
Communications/Journalism professional	2
Consultant/Advisor	24
Elected official	3
Emergency Preparedness, Management or Response Professional	9
Epidemiologist/Statistician	12
Health care professional	21
Health officer	15
Public health practitioner	45
Privacy officer	2
Researcher/Analyst	33
Scientist	2
Student	7
Other (please specify)	63
Total	**384**

Overall, the makeup of respondents reflected both the Network's current constituents and those whom we want to engage with more deeply. The diversity of perspectives also painted a broad picture of both successes and challenges, leading to some clear and actionable next steps.

OVERVIEW OF FOCUS GROUPS

Focus groups were designed to provide a deeper dive into many of the concepts and questions explored in the survey. The primary purposes were to further inform the Network's efforts in the area of racial equity, to develop new partnerships, and to align resource development to the needs of public health and community-based organizations by exploring:

» Key strengths and challenges for organizations engaging in racial equity work

» Strategies for engaging community members and organizations

» Opportunities for external support or technical assistance.

FOCUS GROUP QUESTION TOPICS

» Organizational structure(s) for addressing racial equity

» Resources and trainings needed to engage in racial equity work

» Description of the communities served

» Use of race and ethnicity data within participant organizations

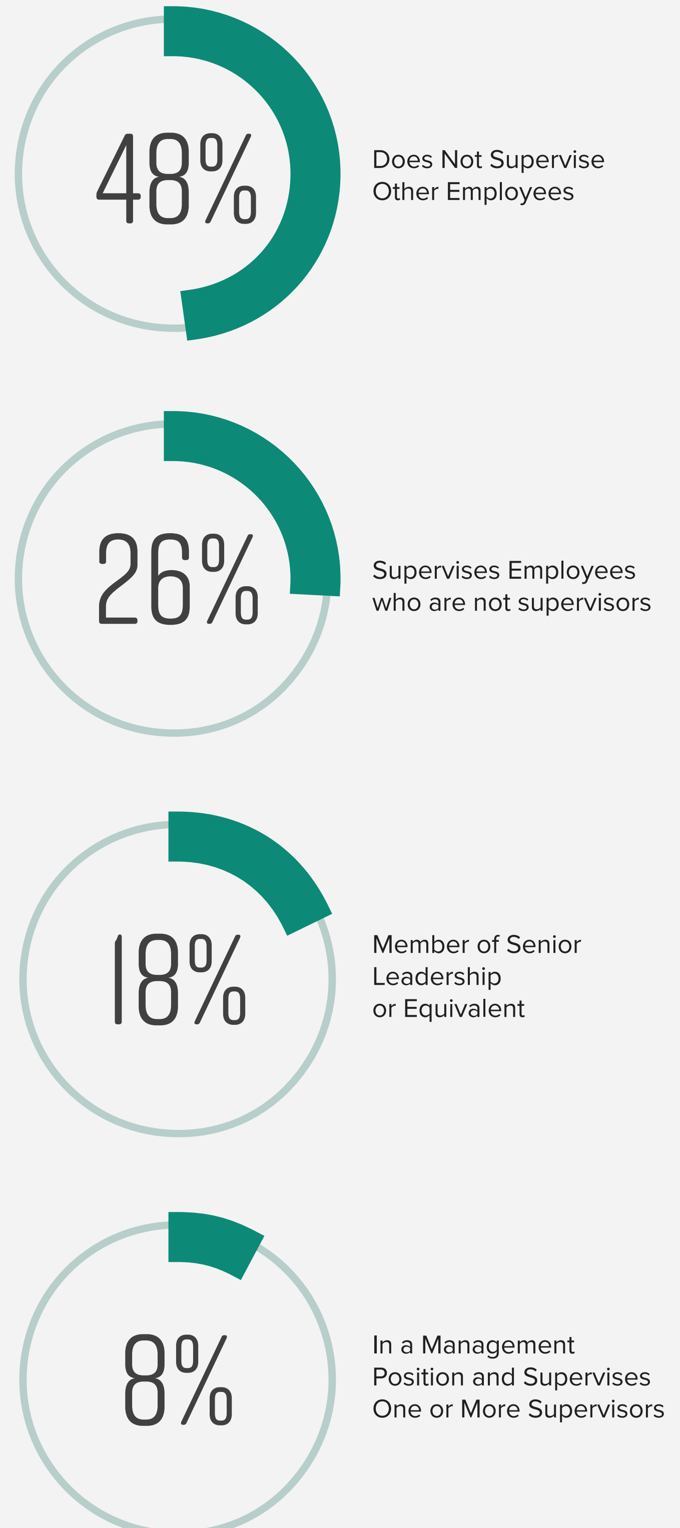
» Community input in strategic planning and decision-making

» Community engagement and outreach in communities of color

» Legal and policy challenges and barriers

» Organizational racial equity priorities

FIGURE 1 SURVEY RESPONDENTS BY SUPERVISORY STATUS



Five focus groups were conducted with a total of 34 participants from August 2021 to September 2021. Themes that emerged from these focus groups are detailed alongside survey results throughout this report, as many of the these aligned with survey responses. However, some specific themes emerged from these discussions that were not addressed in the survey, including an interest in incorporating trauma-informed approaches into public health practice, increasing civic engagement, the economic impact of racial equity (or of racism on the local and state economy), evaluating racial equity, and coordination across state and local government agencies in both health and non-health sectors.

KEY FINDINGS

One high-level takeaway from the survey was the general agreement across organizational type, professional role, and supervisory status that addressing health equity and, to a lesser extent, racial equity, was a priority for their organization. At the same time, there was also agreement that this commitment was not backed up with sufficient resources. There also was an overall sense of a lack of clarity among some parts of the workforce on the distinction between health equity, racial equity, and DEI (diversity, equity, and inclusion). In line with many other assessments of the public health workforce, this assessment also illustrated that the demographics of the workforce still often do not reflect the demographics of the community served, especially at the leadership level. Finally, data questions gave insight into opportunities to build workforce capacity on the collection and use of data, associated policies and practices, and using data for decision-making.

Advancing racial equity is everyone's responsibility, and also something from which everyone benefits. It must be operationalized with intentional action in these key areas, with the understanding that equity is both a process (the way the organization works) and an outcome (what the organization hopes to achieve). The rest of this report highlights key data about the public health workforce and organizations, perceived barriers and support needed, and a specific discussion of data (one of the Network's areas of expertise), as well as findings from focus groups. At the end is a set of recommended actions informed by these findings.

"Equity is both a process and an outcome."

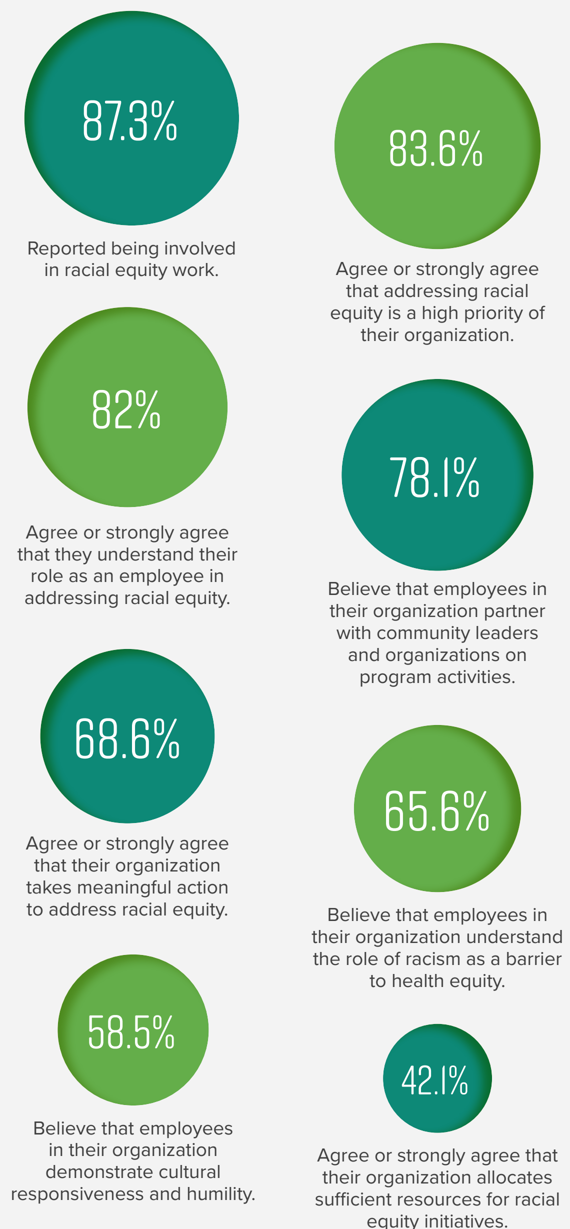
PERCEPTIONS OF THE WORKFORCE

Addressing racial equity is no longer optional in the workplace. An organization's action or inaction around racial equity matters inside and outside its walls. In a workforce that is predominantly women (79%), over the age of 40 (63%), and majority white (54%),[1] it is important to be intentional in taking steps to diversify the workforce, to demonstrate that equity is both understood and valued, and to create paths to recognize and rectify historical injustices both within the organization and in the communities they serve.

In both the survey and focus group discussions we asked for participants' perceptions on how racial equity work is addressed, understood, demonstrated, and acted upon in their organization, by their co-workers, and in their own roles. **One common sentiment was that organizations may create the appearance that equity is important without follow-through demonstrating commitment.** Most of the respondents agreed both that addressing racial equity is a high priority in their organization (82%) and that they understand their own role in helping to advance this work (87.3%). At the same time, there was significantly less agreement that their organizations have taken meaningful action (69.6%) or have allocated sufficient resources (42.1%) toward racial equity work.

In focus group discussions, some participants expressed that their colleagues and organizational leadership were afraid to talk about racism due to it being viewed as a politically charged topic that could trigger internal divisiveness and feelings of hostility. How to deal with political divisiveness was also an area of need, along with a need for ways to communicate to conservative audiences about key concepts, like the social determinants of health, in a way that fosters understanding and helps to build political will. This includes being able translate science, research, and law in a way that is actionable for policymakers.

FIGURE 2
RESPONSES TO QUESTIONS ABOUT RACIAL EQUITY FROM THE EMPLOYEE PERSPECTIVE



A critical first step would be addressing a gap revealed by the survey – ensuring that the workforce understands the role of racism as a barrier to health equity.[2]

Many declarations of racism as a public health crisis include engaging with communities of color and creating paths to community-integrating policies and processes as common goals. In the survey, most respondents (78.1%) reported that their organization has formed partnerships with community leaders and other organizations. In focus groups, participants shared examples of these partnerships, including speaker bureaus, community advisory groups, and outreach teams established to engage with and listen to community members. At the same time, focus group participants shared the need for their organizations (and their colleagues) to be more intentional in establishing relationships and building trust with community leaders, actively engaging them early and throughout any decision-making processes.

Survey responses for these questions were also analyzed by supervisory status. What is clear from these responses is that there is often a disconnect between leadership and the rest of the workforce. This was also a recurring them in focus groups. In the survey, senior leaders had more positive ratings than all other employee types. At the same time, on questions for which “unsure” was an answer choice, the percent unsure was highest for non-supervisors and managers of non-supervisors. More specifically, on the questions of whether racial equity is a high priority and whether the organization takes meaningful action, the percent agreement was lowest for non-supervisors and highest for senior leaders, progressing linearly across supervisory status.

Responses about whether the organization allocates sufficient resources were more mixed. The percent agreement was lowest for senior leadership and highest for managers of non-supervisors, but no group was over 45% agreement (agree or strongly agree), which would suggest some level of awareness at the leadership level that resources for racial equity are lacking. In sum, these findings suggest some areas of opportunity for organizations to establish avenues for communication between senior leadership and the rest of the workforce; to engage the workforce more actively in planning, programs, and policy development; and for senior leaders to take a more active role in connecting with all levels of the workforce and with community members.

FIGURE 3
RESPONSES TO SECTIONS OF QUESTION 3 BY SUPERVISORY STATUS (WEIGHTED AVERAGES)

PERCEPTIONS OF ORGANIZATIONAL BEHAVIOR AND COMMUNITY ENGAGEMENT

In addition to looking at perceptions of the workforce, we also looked at perceptions of organizational behavior. This included assessing whether there were structures and processes in place to support racial equity work, and how equity was integrated into operations. One of the biggest challenges facing today's public health workforce is embedding equity throughout public health policy and practice. This can be done through establishing strategic plans that center equity, using racial equity tools or frameworks, designing policies to facilitate the work, and providing trainings for all employees to meet identified needs. In fact, these steps are a necessary pre-requisite to sustainable changes in law and policy.[3]

Survey results showed that respondents overwhelmingly felt that health equity was incorporated into their organization's mission, vision, or values (75.5%), however answers in the affirmative were significantly lower in relation to racial equity (57.8%). A majority of respondents also agreed that policies were in place to address diversity, equity and inclusion (63.1%) but less agreed that their organizations had policies to address racial equity (41.3%). **Importantly, only 36.7% of respondents indicated that their organization uses racial equity tools or racial equity impact assessments to guide program or policy objectives and outcomes.**

In research conducted by the Network for the ASTHO Eliminating Structural Racism Policy Academy in 2022, one common recommendation for institutionalizing equity was for an organization to make a clear, visible commitment to equity.

One of the biggest challenges facing today's public health workforce is embedding equity throughout public health policy and practice.

IDENTIFIED TRAINING NEEDS

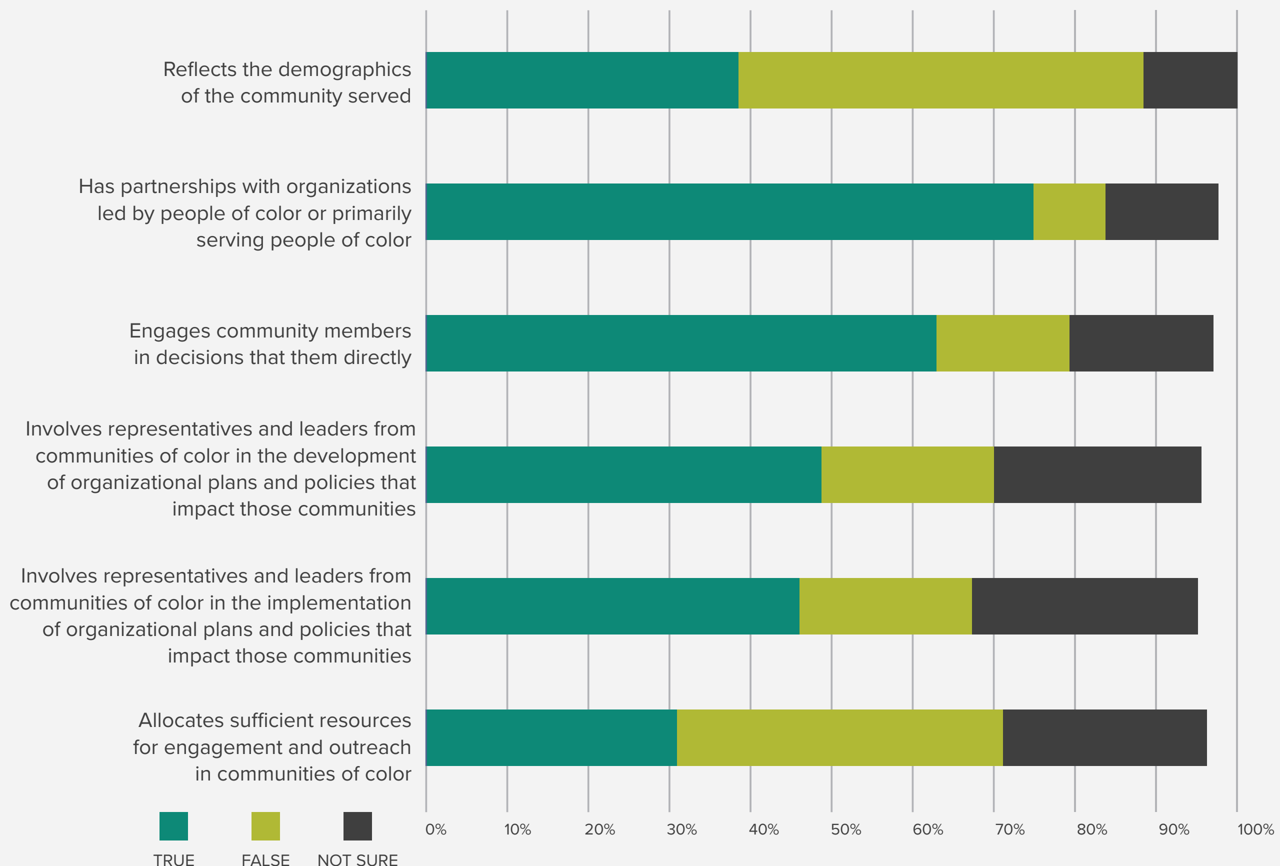
- Implicit bias
- Cultural competency/humility
- Diversity, Equity, and Inclusion (DEI)
- Health Equity 101
- Public Health Law
- Understanding the role of health departments
- Communicating with policymakers
- Racial equity tools and frameworks
- How Human Resources can support operationalizing equity
- Employee rights
- Preemption
- Drafting policies on racism and equity
- Trauma-informed practices and policies

In this assessment, most respondents (76%) agreed that their organizations made a public commitment to addressing racial equity. However, there was less agreement that there were processes or structures in place to support this commitment, such as an office or position, processes to assess the satisfaction of the community served or to share concerns about discrimination in programs or services, or equity-based requirements for contractors and vendors.

Moreover, three-quarters of respondents indicated that either their organization did not have or that they were not sure if their organization had a racial equity plan with clear actions, timelines, indicators of progress, or a monitoring and evaluation process. Across this set of questions about organizational behavior, significant percentages of respondents selected "not sure." These responses suggest that not only is racial equity not being included and operationalized, but even if it is, employees may be unaware. It is not possible to operate efficiently and effectively without clear plans and without the workforce being clear what those plans are.

In the last set of questions regarding community engagement, one key finding was that organizations do not reflect the demographic of communities served. Despite this, there was strong agreement that respondents' organizations partner with organizations led by or primarily serving people of color. However, there was also the perception that organizations may not engage these partners in meaningful ways, like including community members in the development of plans that impact them. Connecting back to an earlier finding, when we have a workforce that doesn't reflect our communities, it is challenging to establish partnerships that break down power dynamics to collectively advance a vision of health and racial equity.

FIGURE 4
PERCEPTIONS REGARDING COMMUNITY ENGAGEMENT



ORGANIZATIONAL BARRIERS

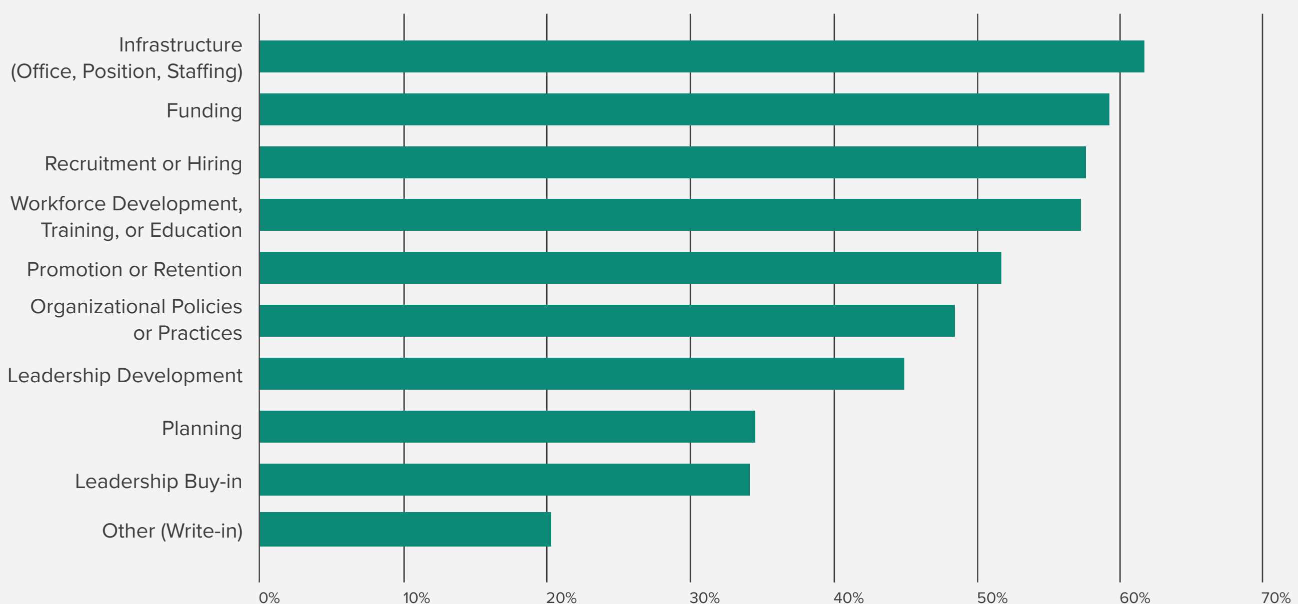
For organizations to further their work with racial equity, it is important to first identify the barriers that currently exist so that strategies can be implemented to address and eliminate those barriers. To assess current barriers among stakeholders, focus group participants and survey respondents were asked “What barriers to addressing racial equity exist within your organization?” Respondents cited infrastructure (i.e., office, position, staffing) as a key barrier. Having a solid infrastructure is key to any successful organization or program not only for the role it plays in supporting programmatic activities and advancing the organization’s mission, visions, and values but also because it demonstrates organizational commitment. This means that organizations must bolster and improve the protocols, systems, and processes they have in place to support the work of their organization.

Funding and human resources (recruitment, hiring, promotion, retention, and workforce development) were also top barriers to addressing racial equity, and a key theme explored in the focus groups. Whether or not a program or activity is funded and to what level is an indication of its value to the organization. Organizations must have dedicated and sustainable funding sources that fully cover operational needs to achieve both near- and long-term impact. Funding is also needed to build and support a diverse workforce, as it aids in bolstering the retention and career development of employees, which goes toward creating a work culture that encourages and supports employees to do their best work without experiencing burnout or dissatisfaction.[4]

FIGURE 5

ORGANIZATIONAL BARRIERS IN ORDER BY PERCENTAGE OF RESPONDENTS SELECTING A PARTICULAR BARRIER

RESPONDENTS COULD SELECT ALL THAT APPLIED.



Leadership buy-in was a recurring theme throughout this assessment. While it was identified as a barrier to racial equity work, it is also a key aspect of successful organizations. Leadership buy-in reflects the priorities of the organization and the investments that leaders are making both in their employees and the goals they are trying to achieve. It also helps to engender a sense of a collective vision and reassures employees that the can and should dedicate time to racial equity priorities.

Organizational leaders have a strong influence on organizational culture. Visible demonstration of support for equity activities, clear expectations for all levels of management, and tackling processes and programs using an equity framework all inform a culture that embeds and values equity throughout.

These findings were reinforced by write-in comments on the survey, with just a sampling included below: It is also important to address the role that law and policy play in stalling racial equity work within organizations. They provide the framework or legal infrastructure to support such operations. As noted, a review of organizational policies, practices, and collective norms is a critical first step before change can be effected in the communities served and systems within the organization operates. Some barriers mentioned by survey takers and focus group participants include bureaucracy, politics, lack of collaboration, disconnect between stated values and substantive work, ignorance, and lack of accountability. Structural barriers were also explored, along with the role of law and policy in creating and sustaining those barriers.

"There is a disconnect between expressed values and supported activities."

"Constraints placed upon our work through grant requirements and reporting, especially timelines that need to be met."

"Just need more time; lot on everyone's plate."

"No diversity in leadership."

"Workforce buy-in; local governing bodies buy-in."

"Culture."

LEGAL AND POLICY BARRIERS

Law includes statutes, regulations, organizational policy, budgets, case law, political processes, and enforcement in any of these areas, and it is deeply intertwined with the systems that determine health and well-being (also known as the social determinants of health). Law has long been a tool of structural discrimination, but it can also be leveraged to remedy historical injustices and remove barriers to access, resources, and opportunity, resulting in more equitable outcomes. Survey respondents were specifically asked "what policies or laws do you see as challenges or barriers to the work your organization is doing to address racial equity." This was a write-in question that received 141 responses.

Notably, one survey taker said they were unable to single out an individual law or government policy that served as a barrier to health equity and instead pointed to the sum inheritance of a historically embedded system of laws, policies, practices, and attitudes that create and reinforce inequities. Health equity can be advanced by removing these systemic barriers through the strategic use of law and policy.

Perceived legal and policy barriers identified across the survey and focus groups included challenges to public health authority, data sharing, housing (habitability, protections, affordability, and lending), education (affirmative action, school discipline, segregation), employment, urban planning, access to health care, civil rights laws, and financial systems (banking, taxes, wealth access, and wealth protection). Respondents also noted specific policies resulting in historical race-based discrimination, such as pre-existing housing and school segregation, furthered by school assignment policies. In addition, some survey respondents mentioned the negative impact of the war on drugs and discrimination based on citizenship status on housing and employment.

Importantly, multiple survey takers highlighted the need for legal training. Specifically, there are training needs regarding preemption, employee rights, and how to write policies on racism, equity, and other trauma-informed work. Multiple survey takers noted the inconsistent enforcement of existing policies with some respondents remarking that additional enforcement guidance from federal agencies could be helpful. One respondent observed that their organization provided training on health equity for two years, but then never put any supporting policies into place.

There are two ways to think about this question:

1. Looking at specific laws and policies that might prevent us from doing something we want to do to address racial equity, the main issue is the fact that race is a protected class, which prevents us from intentionally recruiting staff who are Native American for the work that we do with Native American people and communities.

2. More broadly, there are, of course, countless local, state, and federal laws and policies that create and perpetuate racial inequities, and these present myriad challenges and barriers to actually achieving racial equity.

-Survey Respondent

FIGURE 6
AREAS OF PERCEIVED LEGAL AND POLICY BARRIERS

- PUBLIC HEALTH AUTHORITY
- DATA SHARING
- EDUCATION
- EMPLOYMENT
- URBAN PLANNING
- ACCESS TO HEALTH CARE
- HOUSING
- CIVIL RIGHTS
- FINANCIAL SYSTEMS

Training must be supported by the development and implementation of policies that require or incentivize employee participation and that meet identified workforce needs.

One recurring opinion centered around a lack of equity-focused policies and community involvement during policy development. First, policymakers and community members must acknowledge that these barriers exist. Declarations of Racism as Public Health Crisis are policy tools that acknowledge structural racism and make a commitment to addressing racism as a root cause of health inequities. While the vast majority of declarations of racism as a public health crisis were issued in 2020, the past two years have seen a slow but steady stream of additional declarations accompanied by efforts to engage and partner with communities in implementing them.[5]

Policy and decision-makers should empower their local communities to engage in policy development to appropriately tackle community-identified priorities and leverage community expertise and perspectives in addressing areas like urban planning, education, and data sharing. In addition, resources such as the Equity Assessment Framework for Public Health Laws and Policies can aid policymakers in identifying issues in the drafting, design, or implementation of a law or policy that could have a disproportionate impact on different population groups, a common area of confusion mentioned by respondents.

Multiple respondents noted a need for policies regarding incorporating racial equity in hiring practices. Student loans, outdated job descriptions and job requirements, lack of diversity during the hiring process, and lack of affirmative action policies were all cited as contributing to the existing racial inequities in the workforce.

Employers may want to consider hiring a racial equity officer to implement strategies to change workplace cultures and work with legal counsel and human resources leaders to develop appropriate strategies.

In sum, write-in comments identified the following areas of opportunity for further research and technical assistance:

- Race-conscious vs. race-neutral laws
- Affirmative action policies and barriers to increasing diversity in hiring
- Workforce policies that impact retention of employees from diverse backgrounds
- Procurement
- Data collection and use
- Diversity in leadership
- Lack of trust in government, other institutions, and the workplace
- School policies related to discipline, funding, affirmative action, and loan forgiveness
- Lack of funding or funding restrictions

Of particular note, anti-Critical Race Theory (CRT) legislation was identified by multiple respondents as an area of opportunity for further research and technical assistance. This is still relevant and perhaps even more timely today, since, according to CRT Forward Tracking Project, there have been 699 anti-CRT efforts introduced at the local, state, and federal levels as of June 2023.[6] Other specific laws identified include Prop 209 in California,[7] which prohibits state agencies from considering race, sex, or ethnicity in public employment, public contracting, and public education; Arizona House Bill 2906 (2021), prohibiting blame or judgment on the basis of race, ethnicity, or sex in training, orientation or therapy;[8] and Washington Initiative 200 prohibiting consideration of race, sex, color, ethnicity, or national origin in public education, public employment, and public contracting.[9]

Finally, the following specific write-in comments are being shared because they capture the challenges that many partners across the public health workforce are facing:

"Our healthcare system is so fractured and underfunded for low-income families. Also, healthcare access is challenging due to our patchwork safety net systems. Implementing and sustaining a healthcare neighborhood model would allow families to access high quality health services, such a primary care and vaccinations anywhere, including schools, pharmacies, community centers, faith organizations etc. We need out of the box thinking to ensure easy, seamless access, data sharing and service delivery of healthcare."

"I also feel that more could be done to engage the community we serve and give them a voice in our policy development that affects them."

"I work in a state that has deliberately cut full time public health positions and replaced them with OPS and contract positions. The result of this is that there is high turnover among young, and diverse hires. Further, a system of cronyism, and yes-man leadership has led to incompetent leadership on various levels. As top positions in the agency are susceptible to the whims of the governor, the agency frequently has its hands tied, and makes slow progress based on feedback from gubernatorial directives with no basis in public health theory. Limiting the power of appointed officials, and generally democratizing the bureaucracy will allow for the agility and infusion of new perspectives needed to achieve health equity. The biggest issue with health equity in a state agency, is that whether work is done to addresses it is decided by one or two people at the top of the hierarchy."

"Declarations by communities/states that racism is a public health crisis. While a positive move in the right direction, a year later we see that not much has changed except for in a handful of the 200+ declarations, many of which in their original state were simply proclamations with no action. Encouraging movement and accountability here would be of use to those advancing this work."

"Court-imposed limitations on affirmative action programs, limitations on ability to know the racial, ethnic and other identities of job applicants, court-imposed restrictions on race-based or race-informed governmental programs (e.g., economic relief programs for Black farmers)."

"HR policies and practices regarding the value of 'lived experience' along with educational or professional experience; policies and practices regarding background checks and the types of 'hits' that come back OR the number of years that have passed without an offense. These are 'strikes' against people of color and culture who need to be part of our workforce... leadership...and future. We are working with HR to change these rules, but it is not easy.

"We would like to be able to consider race when hiring, promoting, retaining, etc as well as in designing services, programs, interventions or activities to address the needs of specific communities."

"Our Board of Commissioners think equity is a 'liberal' agenda item to take away their freedoms and way of life."

"The challenges I see are: - a lack of political will to be brave and pass bold regulations and create bold programs - 'old school' and technocratic thinking; 'this is the way it's always been done', 'Planners know best,' and honestly fear of change and of how challenging the status quo will impact public favorability (even though the public already does not trust the government)"

"At times procurement, bidding requirements and other operating rules that may have been created to promote fairness and transparency work against contracting with community level organizations. Also, policies are in place that make it very difficult to offer meaningful stipends to community members to compensate them for their time on advisory and other groups."

"Equal does not mean equitable."

DATA

The Network's Mid-States Region specializes in health information data sharing, so the Network had a particular interest in understanding respondents' need in this area. The interest was informed by a heightened focus on equitable data practices and systems spurred by the pandemic. Three hundred and five (305) people answered questions about their organizations' data collection practices around race, ethnicity, and other demographics. Most respondents (83%) reported that their organization does collect data on race, ethnicity, and other demographics. Of those, 76% also say that race and ethnicity data are *collected for health indicators or related measures;* with 24% reporting either that the information is not collected, or they are not sure. However, a significant number of respondents in senior leadership responded that their organization does not collect data on race or ethnicity.

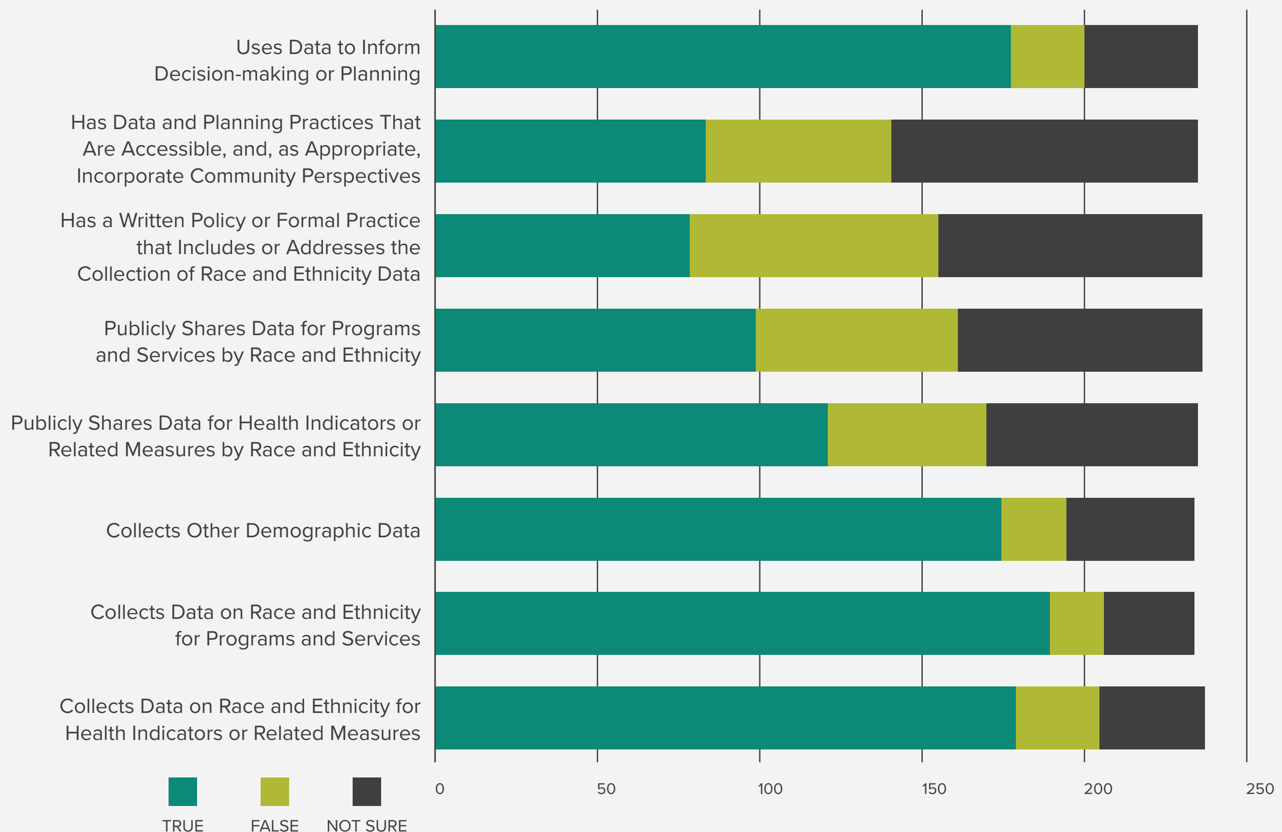
Among the total respondents who answered that they were not sure what purpose race and ethnicity data was collected for, the large majority were non-management respondents. This suggests that even among organizations that do collect race and ethnicity data, most non-management staff do not know what this data is for.

While 75% of respondents believe their organization uses data to inform decision-making or planning, the survey results suggest that organizations are not clearly communicating to staff the existence of formal policies or practices around the collection of race and ethnicity data. At least one-third of respondents in each question were **not sure** if their organization *a) has a written/formal policy that addresses the collection of race and ethnicity data* (32%), *b) publicly shares data by race and ethnicity for its programs and services* (34%), or *c) has data and planning practices that are accessible and, as appropriate, incorporate community perspectives* (40%).

On the sole question of whether their *organization has a written policy or formal practice that addresses the collection of race and ethnicity data,* the responses were equally split between "true," "false," and "not sure." When survey responses were categorized by job, a higher number of senior leadership (40%) responded that they did not have such a policy. On the sole question of whether their organization *has data and planning practices that are accessible and, as appropriate, incorporate community perspectives,* almost 70% of non-supervisory staff, the employees who are the most likely to have regular contact with clients/community members, either do not know whether their organization has relevant data and planning practices or think their organization does not.

When identified by organization type, Tribes and Tribal organizations had some noticeable variances from the local and state health department responses, the entities most similar in function to Tribes and Tribal organizations for purposes of this survey. For example, 20-25% fewer Tribes or Tribal organization respondents said their entity publicly shares data for programs and services by race and ethnicity or said their entity has a written policy or formal practice that includes the collection of race and ethnicity data. Similarly, 25% fewer Tribes or Tribal organizations reported that their organization uses data to inform decision-making or planning. Due to the small number of Tribe or Tribal organization respondents, this data is only suggestive. More information is needed to identify the cause(s) of these notable differences to learn, for example, if data is not being used due to limited (or non-existent) data analytics staff or whether cultural practices influence data collection or policy making.

FIGURE 8
RESPONSES TO QUESTIONS ABOUT THE COLLECTION AND USE OF DATA. RESPONSES INDICATE THE NUMBER OF RESPONDENTS INDICATING THE STATEMENTS BELOW WERE TRUE, FALSE, OR THEY WERE NOT SURE (N =305)



DATA THEMES

Survey respondents and focus group members noted many issues related to the collection or use of racial and ethnic data. General themes of those comments are:

COMMUNITIES LEFT OUT

Data is not being shared with communities to make sense of it. When data is shared, it must be translated in a way that is accessible (language and literacy levels).

LIMITED DATA FROM AGENCIES

The data is either not provided at all or is provided at levels that are not meaningful (e.g. 20,000 is a minimum data set)

NO DATA STANDARDS

Data for race and ethnicity do not have standards. Data collection across systems (HUD; Family and Youth Services Bureau) differ in requirements and categories.

DATA COLLECTION BARRIERS

Data is either not collected or participants do not provide their race and ethnicity information.

UNRELIABILITY OF COLLECTED DATA

There are not enough race and ethnicity categories to reflect the reality of who we are. The categories of “multiracial” and “other” need improvements. Example: combining American Indian/Alaskan Native and Pacific Islanders together obscures what is unique about those communities.

SYSTEM LIMITATIONS

Organizations lack data analytics capacity or data is collected on paper and not captured electronically.

DATA RECOMMENDATIONS

The Network has identified three key actions that are responsive to these data findings.

The first is to advocate for the creation of national data standards for race and ethnicity that more accurately capture who we are and that will result in more accurate and usable data. *The second is to re-evaluate the Methods for De-identification of Protected Health Information under HIPAA* and its standards that are often the basis for an agency’s inability to provide smaller data sets that include race or ethnicity data. The third is to provide trainings for IT/business analyst staff who create the data fields and logic behind data requests to ensure what is collected is usable, accurate, and on target to support equity efforts.

We have barriers in the data we are provided by DHS. Data is too high level; we need disaggregation within racial groups.

-Survey Respondent

NEEDS AND SUPPORTS

It was important to the subcommittee developing this assessment not just to identify barriers, but also to explore potential solutions. Survey respondents were asked what would best support their organizations to engage or better engage in racial equity work. The two areas that rose to the top were improved workforce understanding of racial equity and health and communicating about health and racial equity. Since this assessment was conducted, these continue to be high priority areas for the public health workforce, with organizations like the Robert Wood Johnson Foundation, Berkeley Media Studies Group, the deBeaumont Foundation, and the National Network of Public Health Institutes (NNPHI) issuing guidance, resources, and frameworks that address these needs.[10]

While having a public health degree is not a pre-requisite for success in a public health organization, a whopping 86% of the public health workforce **does not** have a public health degree (PH WINS 2022). It therefore makes sense that among the top training needs identified in this assessment are in foundational public health concepts like the social determinants of health and an introduction to public health law.

These findings are also consistent with reports like NNPHI's report referenced above.

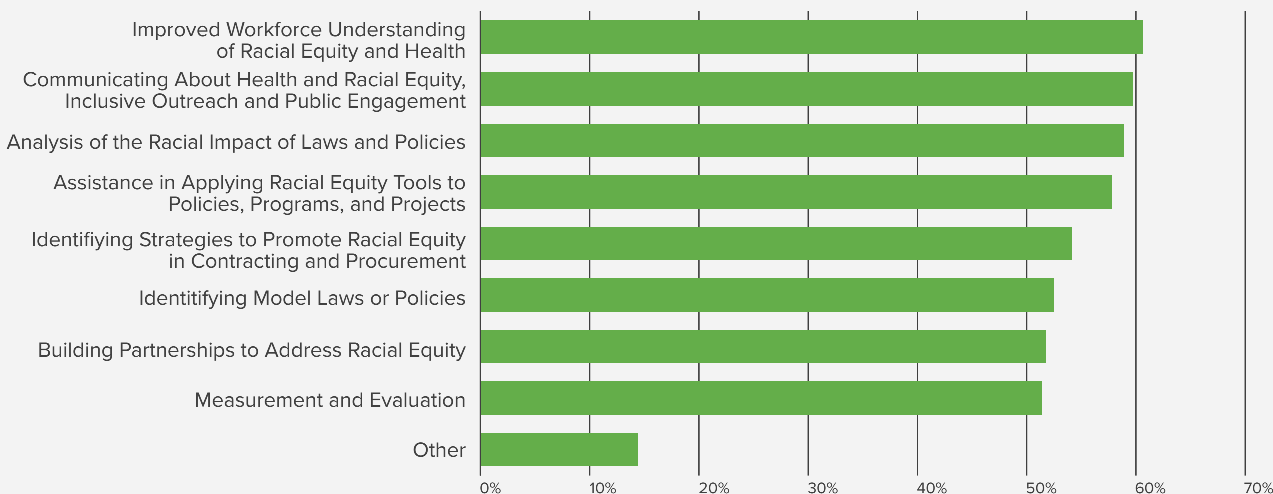
Some noteworthy comments on the kinds of resources and support needed include:

» Historical perspectives of law and policy and their resultant inequity; How facially neutral law/policy can be implemented in a way that is discriminatory (we spend so much time on the analysis of the law itself that we miss the impacts of regulation/sub-regulatory guidance/program implementation).

» Actual resources, commitment, investment and policies to build equitable structures in our community and society (housing, food, water, energy, transportation, income, health, education). We know what to do and how to do it. There are simply systemic barriers protected by political and economic interests that prevent real transformative actions and redistribution of power.

» Identification of any laws, regulations and sub-regulatory guidance that prohibit or create barriers to the collection of race, ethnicity, gender, SOGI and disability data for the purposes of health quality measurement and improvement.

FIGURE 7
SUPPORTS NEEDED ORGANIZED BY PERCENTAGE OF RESPONDENTS SELECTING A SPECIFIC BARRIER



CONCLUSIONS

While this assessment was conducted in 2021, the findings are just as relevant today. During the past two years, attacks on public health authority have escalated. States have increasingly introduced restrictions on diversity, equity, and inclusion in the workforce and in the education system. The Supreme Court has undermined affirmative action, protections for LGBTQ+ individuals, and voting rights (among other things). Yet, against this backdrop, states are also working to innovate their public health infrastructure, creating safe spaces to discuss and strategize around equity, and taking actions to ensure that people can actively engage in democratic processes.

To advance a vision of racial equity in these circumstances, the workforce must apply health and racial equity principles in every aspect of public health practice, work with people outside of traditional public health roles to advance sound public health policy, and understand how law is a social determinant of health. **The Network can provide technical assistance and support to partners in applying the findings of this assessment within their organizations and communities.**

SIX KEY TAKEAWAYS

ONE // LEADERSHIP

Senior leaders and executives should facilitate the equitable distribution of power in program planning and policy development, support power building in the communities they serve, and demonstrate their own buy-in to health and racial equity initiatives, which includes taking on responsibilities for this work as leaders.

TWO // GUIDANCE

There is a clear need for practical guidance and examples as well as training on strategies to operationalize equity in the workplace.

THREE // WORKFORCE DEVELOPMENT

It is necessary to build a foundational understanding of the social determinants of health and the role of law and policy in shaping these systems, to provide and encourage professional development, and to meet specifically identified training needs.

FOUR // RESOURCES

More money, people, and infrastructure are necessary to ensure success. The workforce should reflect the demographics of the community served, and the community should be recognized as a resource.

FIVE // COMMUNICATION

Public health needs a common language as well as communication strategies to talk about health and racial equity to different audiences across the political divide.

SIX // COMMUNITY

Organizations must adopt ways to meaningfully engage, co-create, and share power with communities and ensure that community members have a role in policy and decision-making processes.

METHODS AND LIMITATIONS

The Racial Equity Interests and Needs Assessment survey was distributed through multiple electronic channels, including the Network Report, social media channels, and professional platforms like LinkedIn. It was also shared via personalized email contacts from Regional Offices. There were no restrictions on who could take the survey. It was open for 5 weeks and completed by 384 respondents. Analysis of results was completed using Microsoft Excel.

Five focus groups were conducted between August 5, 2021 and September 2, 2021 with 34 participants. Each focus group was scheduled for 90 minutes and explored a series of questions related to organizational structure, community engagement and outreach, resources and supports needed, challenges or barriers, and successes. The same set of questions were used for each focus group. At least two Network staff facilitated or served as notetakers in each focus group. To analyze themes, notes from each session were analyzed by at least two staff and compared.

Please note that respondents for the survey and participants for the focus groups were all people who self-selected for participation. The data have not been weighted to reflect demographic characteristics, and because this is not a probability sample, no estimates of sampling error can be calculated. All sample surveys and polls may be subject to multiple sources of error, including but not limited to sampling error, coverage error, and measurement error.

Specific gaps in this data set include lack of questions related to evaluation of racial equity efforts, power dynamics, and workforce buy-in or commitment. We also chose not to collect race and ethnicity data as the purpose of this analysis was not to make comparisons in responses across these groups. However, that would be a valuable area for further assessment.

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Contributors to this report among current and past Network staff include Chris Alibrandi O'Connor, Dawn Hunter, Morgan Jones-Axtell, Mosalewa Ani, Phyllis Jeden, and Sara Rogers.

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ENDNOTES

1 PH WINS 2022. de Beaumont Foundation and Association of State and Territorial Health Officials, Public Health Workforce Interests and Needs Survey: 2021 Dashboard. August 3, 2022.

2 Many of these same themes are supported by the findings from *Fighting For Public Health: Findings, Opportunities, and Next Steps from a Feasibility Study to Strengthen Public Health Advocacy*, Network for Public Health Law, September 2022. This report involved interviews with public health advocates and leaders from 45 organizations.

3 See Ruqaiijah Yearby et al., *Governmental Use of Racial Equity Tools to Address Systemic Racism and the Social Determinants of Health*, Institute for Healing Justice and Equity, November 2021, p. 31. "Additionally, there is evidence from our interviews and surveys showing that using GARE and/or PolicyLink's racial equity tools has directly influenced changes to internal governmental policies and practices, which ultimately needs to happen before sustainable changes in law and policies can be adopted."

4 According to PH WINS 2022, there were high levels of stress, burnout, and intent to leave among the governmental public health workforce during the pandemic.

5 For examples of what communities across the United States have done since issuing a declaration, see *Racism as a Public Health Crisis: From Declaration to Action*, American Public Health Association, endingracism.apha.org

6 CRT Forward Tracking Project, crtforward.law.ucla.edu.

7 California Constitution, Art. 1, Sec. 31.

8 Arizona Revised Statutes § 41-1494 (2022).

9 Revised Code of Washington 49.60.400

10 Some examples include the March 2023 RWJF report on *Structural racism and health: Messages to inspire broader understanding and action*; the May 2021 NNPHI report on *Challenges and Opportunities for Strengthening the Public Health Infrastructure: Findings form the Scan of the Literature* (the Network served on the Technical Expert Panel for this report); and the PH WINS training dashboard for 2022, showing justice, equity, diversity & inclusion (34%), systems and strategic thinking (47%), and effective communication (19%) among top training needs.