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From Words to Action: Equipping the Public Health Workforce to Advance Health Equity

May 2025

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Authors' Note

Over the past five years, hundreds of jurisdictions and organizations — including the Centers for Disease Control and Prevention — have recognized that long-standing disparities in health outcomes are not random but rooted in systemic factors that affect the well-being of millions of Americans. These disparities — between rural and urban communities, across income levels, and among different racial and ethnic groups — continue to hold back individuals, families, and entire regions. Health equity means ensuring that all people have a fair and just opportunity to be as healthy as possible. It is not a partisan issue — it is a national imperative that directly influences the strength of our economy, the productivity of our workforce, the resilience of our communities, and the overall health of our nation.

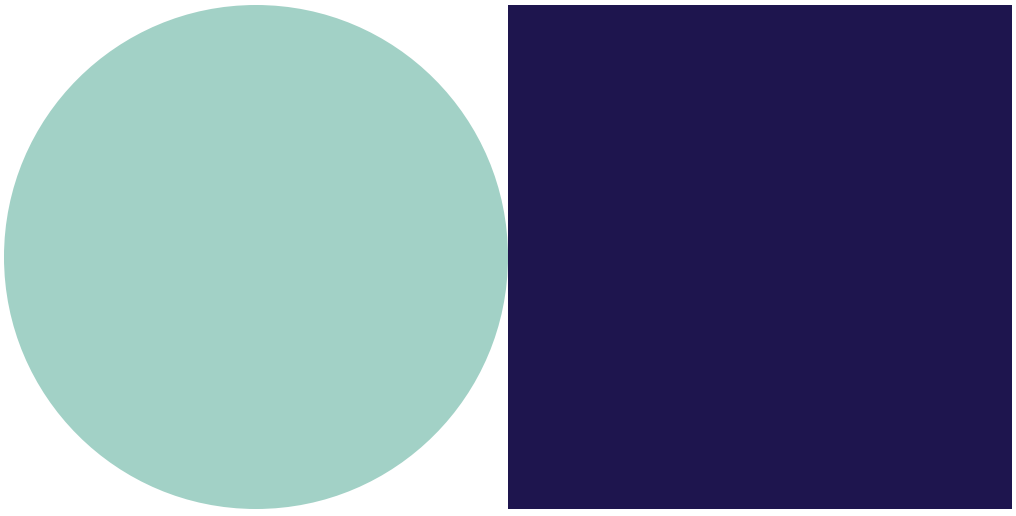
Whether the goal is to lower health care costs, strengthen local economies, or improve quality of life, advancing health equity is essential. Yet too often, discussions about equity have been reduced to polarized political talking points. When policies and programs designed to improve health for all become politically divisive, the consequences are real — for communities, for public institutions, and for the long-term health of the country. This report does not aim to wade into political debate. Rather, it describes the experiences of public health professionals working every day to protect the health of all Americans — and offers practical, evidence-informed insights for how agencies can advance health equity effectively and sustainably.

The insights presented in this report are drawn from interviews with state and local public health professionals across the United States, conducted between December 2023 and February 2024. These conversations provide a timely, ground-level perspective on the extent to which health professionals are embedding equity into their work, as well as the organizational, structural, and resource-related challenges they face in doing so. Since these interviews were conducted, national dialogue around diversity and health equity has intensified, and many of the people and programs driving this work have faced heightened political scrutiny. Amid today's challenges, the urgency of advancing health equity has not diminished, because this work is not political. We must ensure that every community can thrive, together.

The research de Beaumont conducted set out to understand and elevate the voices of the public health workforce — those who are tasked with promoting and protecting health in every corner of the country. These professionals work at the intersection of science, service, and systems, often navigating complex cultural and institutional dynamics to pursue a vision of a healthier and more equitable society. The findings of this report highlight both the barriers that hinder progress and the opportunities that lie ahead. They underscore the urgent need to confront organizational and systemic obstacles to health equity — not just because it is the right thing to do, but because it is a strategic and practical path toward building stronger, more vibrant, and more unified communities nationwide.

Kay Schaffer, Jamila M. Porter, Caryn Bell, and Brian C. Castrucci

May 2025



Executive Summary

Hundreds of organizations, including state and local health departments across the country, have declared racism a public health crisis. In 2021, the Centers for Disease Control and Prevention (CDC) called it a "serious public health threat." But words alone don't inspire action or make change. This study conducted by the de Beaumont Foundation — which is based on a survey of more than 44,000 state and local public employees and interviews with 20 public health employees — investigates the public health workforce's capacity and readiness to address unequal conditions shaping health outcomes. This research provides critical insights into the motivations, challenges, and opportunities that government public health employees face and offers practical recommendations for steps that health departments can take to rectify longstanding gaps in opportunity and access and advance health equity.

Key Findings

Health department employees are aware of the connections between systemic inequities and public health and believe it should be a priority for their organization. But in many state and local health departments, efforts to address these issues are often considered to be "extra work" that a small group of motivated employees take on — not responsibilities infused into their daily jobs.

Key barriers that public health employees identified included:

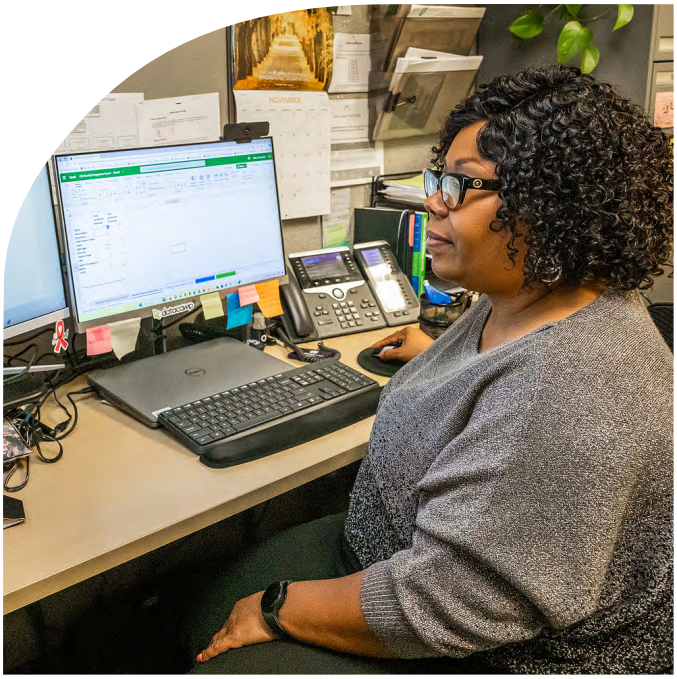
- Unsupportive organizational policies and culture, and a political climate that restricts certain language and policies;
- A lack of action by department leaders; and
- The relegation of efforts to address health equity as "extra" work rather than integrating them into employees' core daily work.

To effectively address systemic inequities within and outside their organizations, health departments leaders will need to:

- Understand and address the challenges their employees face;
- Recognize their own roles in perpetuating barriers to communities achieving equitable health outcomes;
- Integrate equitable approaches into all health department policies and practices;
- Identify practical roles and steps for staff; and
- Partner with community-based organizations and others.

01 Introduction

Given the inextricable link between structural inequities and community health, addressing longstanding gaps in opportunity and access must be central to the work of health departments and the public health workforce.[1] In response to the COVID-19 pandemic, the police murder of George Floyd, subsequent protests against racial injustice, and increased national attention on the ways that policies and systems drive inequities in health, life outcomes, and life expectancy, hundreds of jurisdictions across the country declared racism a "public health crisis." In April 2021, the Centers for Disease Control and Prevention (CDC) took an important step in prioritizing this work by formally declaring racism a "serious public health threat."[2] However, the government public health workforce requires more than words to make progress toward eradicating health inequities at institutional, community, state, and national levels. Government public health agencies and their leaders must understand and address the challenges that their employees face as they aspire to address unequal conditions shaping health within and outside of their organizations, recognize their own roles in perpetuating and dismantling these practices, and take action to advance equity in all aspects of their work.



Conducted by the de Beaumont Foundation and the Association of State and Territorial Health Officials (ASTHO) in 2014, 2017, 2021, and 2024, the Public Health Workforce Interests and Needs Survey (PH WINS)[3] is the first and only nationally representative survey of state and local government public health agency employees. The survey collects information on the government public health workforce, including self-identified demographics, engagement and satisfaction, training needs, and their ability to

address pressing issues in public health. PH WINS 2021 was distributed to 137,447 state and local government public health employees, representing 47 state health agencies and over 300 local health departments. The survey was completed by 44,732 individuals, for a 35% response rate. More information and details on the issues and needs of this vital workforce can be found in the PH WINS 2021 Methodology Report[4] and in the PH WINS 2021 Special Supplement in the *Journal of Public Health Management and Practice*.

Quantitative data from PH WINS 2021 were previously used to study the public health workforce's ability and willingness to address racism as part of their jobs.[5] This subsequent qualitative research builds on findings from the quantitative study to better understand the context, motivations, and challenges state and local health department employees face in addressing health equity as part of their jobs and provides actionable recommendations for public health agencies hoping to advance this work.

Definitions

Racism as a Public Health Crisis: An increasing number of cities, counties, and states have declared racism to be a public health crisis or emergency. These declarations are driven by a recognition that systemic, institutional, and other forms of racism drive disparities across employment, housing, education, the criminal legal system, health care, and other determinants of health. The declarations also reflect a growing acknowledgment that state and local governments must anchor efforts to eradicate the impacts of racism to achieve the conditions needed to create optimal health for all.[6]

Structural Racism: An entrenched and multifaceted system in which public and organizational policies, institutional practices, cultural representations, norms, and other structures collectively work in various, often reinforcing ways to maintain a racial hierarchy that allows the privileges associated with "whiteness" and the disadvantages associated with "color" to endure and adapt over time.[7]

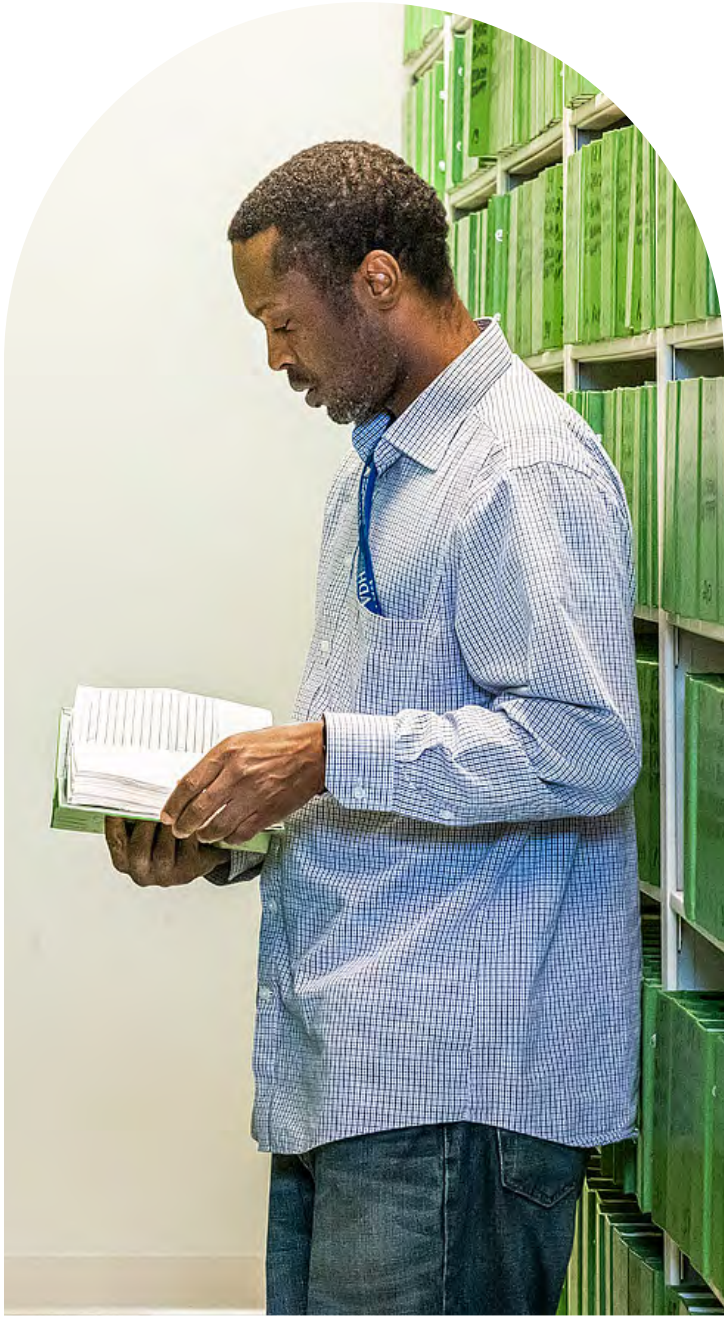
Health Equity: A set of conditions in which all people, regardless of who they are, where they come from, how they identify, where they live, or the color of their skin, have a fair and just opportunity to live their healthiest possible lives – in body, mind, and community. Achieving health equity requires removing social, economic, contextual, and systemic barriers to health; and making a continuous and explicit commitment to prioritize those affected by historical disadvantages.[8]

02 Research Questions

The qualitative study was framed around three research questions:

1. What are the workforce's experiences of addressing racism as a public health crisis before 2020 and presently?[a]
2. What are the strengths, opportunities, and gaps in the workforce's ability to address racism as a public health crisis?
3. How can the workforce operationalize efforts to address racism as a public health crisis and begin to create systems for accountability for this work?

Findings are organized by each research question and are followed by recommendations on how public health agencies can more meaningfully engage in efforts to address conditions that prevent all communities from achieving their optimal health.



[a] Interviews were conducted from December 2023–February 2024.

03 Methods

Research Strategy & Interviewee Recruitment

A qualitative research approach and methodology was used to answer all three research questions. An interview guide was developed and piloted by the research team between July and August 2023. Questions were developed based on results from the 2021 PH WINS findings, which showed that over 70% of government public health employees believed that addressing racism should be part of their daily work. To better understand the public health workforce's needs, strengths, opportunities, and challenges to operationalize efforts to address racism in their work[5], it was determined that a qualitative study could allow for further inquiry to frame and contextualize the 2021 survey findings. The study was approved by the Western Institutional Review Board-Copernicus Group (WCG IRB) in October 2023.

Initially, 2021 PH WINS respondents who indicated that they addressed racism as part of their work at the health department and that they worked in the "Public Health Sciences" were eligible for inclusion in the study. Public Health Sciences job roles often involve interfacing with the public, an avenue through which employees could presumably address racism.[b,4]

Two interviewee recruitment strategies were used. Recruitment Strategy A was a stratified random sampling strategy that began in October 2023. The research team stratified survey respondents by region, setting, and race and ethnicity (Figure 1). A sample of 90 survey respondents were randomly selected based on their U.S. Health and Human Services (HHS) region[9], health department setting – State Health Agency Central Office (SHA-CO), Big Cities Health Coalition (BCHC) health department member, or local health department/regional health department (LHD/RHD) – and race and ethnicity. These variables were selected for stratification to ensure that the demographic characteristics of the sample resembled those of the PH WINS 2021 study, and because analysis of PH WINS 2021 data found that

[b] Employees who selected the following job categories in PH WINS 2021 were considered to work in Public Health Sciences: Animal Control Worker; Disease Intervention Specialist/Contact Tracer; Emergency Preparedness/Management Worker; Engineer; Environmental Science and Protection Specialist; Environmental Science and Protection Technician; Licensure/Regulation/Enforcement Worker; Peer Counselor; Policy Analyst; Population Health Specialist; Sanitarian or Inspector; Student, Professional or Scientific; Other Public Health Science Professional

engagement with and perceptions of addressing racism varied across these variables. Although all 90 survey respondents were invited to participate in an interview, only five interviewees were obtained using this strategy.

To be able to include at least 20 interviewees in the study, the research team pivoted to Recruitment Strategy B, a combination of stratified random sampling and snowball sampling that took place between November 2023 and January 2024. Using Recruitment Strategy B, the research team generated a list of PH WINS Workforce Champions[c] — employees who served as points of contact for fielding PH WINS 2021 at their respective health departments. The research team stratified the list by region, setting, and race and ethnicity, then sought additional staff suggestions from the Workforce Champions to support outreach to potential interviewees.[d] To ensure representation across race and ethnicity categories, Asian and Native American Workforce Champions were proactively invited to participate.

Once interviewees were recruited, their agreement to participate was documented and their informed consent was obtained. Interviews were conducted virtually using Google Meet and were 60–90 minutes in length. Interviews were recorded with interviewees' consent, and recordings were transcribed using GoTranscript. A codebook was developed and transcripts were double-coded by the research team to identify specific themes for analysis. Data were analyzed using Dedoose analytical software (Version 9.2).

Interviewee Demographics

More than half of the interviewee sample identified as non-Hispanic white, and approximately one-third identified as non-Hispanic Black/African American (Table 1). Ten percent of the sample identified as Hispanic or Latino. One interviewee identified as Asian. Interviewees primarily identified as women; only four identified as men. All HHS regions were represented. There was also representation across types of health departments: Almost half of interviewees worked at BCHC LHDs, while around one quarter worked at other LHDs/RHDs or SHA-COs.

[c] PH WINS Workforce Champions were self-selected during the administration of PH WINS 2021. The research team did not share the names of interviewees for this study with Workforce Champions.

[d] Some staff suggested by Workforce Champions did not participate in PH WINS 2021. The research team decided to invite them to participate so they could share their perspective. The research team did not share the final list of interviewees with anyone outside of the team.

Interviewees' job titles varied, but their job tasks and functions included workforce development, human resources, health in all policies management, strategic planning, and community health. Job descriptions were used to compare employees whose work focused within their departments (e.g., workforce development, human resources, and strategic planning) to those whose work focused on efforts outside of the health department (e.g., community health). Five interviewees stated that their positions were created to specifically address health equity efforts within their health departments and communities.[e]

[e] During interviews, many interviewees referred to efforts that address "health equity" rather than explicitly using the term "racism." It is important to note that "equity" and "racism" are distinct constructs with different definitions; they are not interchangeable. Some interviewees acknowledged distinctions between the terms "racism," "bias," and "equity," but many interviewees described their work at health departments in terms of addressing "equity" rather than "racism."

04 Findings

Research Question 1

What are the workforce's experiences of addressing racism as a public health crisis before 2020 and presently?[f]

Interviewees discussed how motivations to address racism as a public health crisis were — as one person noted — an "opportunity that the times allowed." Interviewees discussed how, over time, the field of public health had been slowly shifting toward discussing issues of equity and racism:

> "I also think it was becoming more prevalent in public health literature to really call it out and to really think about it specifically. Our professional societies and organizations were really naming it and encouraging public health professionals to think about it.

Several interviewees worked for health departments that either made their own declarations about racism and health or were in municipalities where mayors, county commissioners, and boards of health made such declarations. Although some health departments had begun to address racism and equity prior to 2020, the COVID-19 pandemic and the publicized murders of Black people in 2020 — particularly the murder of George Floyd — were substantial motivators for health departments to address racism:

> "I will say that [the] pandemic was devastating, but [it] accelerated conversations that needed to be had. There's no surprise who was disproportionately impacted as a result of the pandemic because they were always disenfranchised prior to the pandemic. As we've moved through the pandemic, I think the world paused. They saw George Floyd, they saw Black Lives Matter. It was a pause because everybody was not busy with anything, except we were all faced with the same thing. We were watching in real time as something horrible happened that always happened in the Black community. It was just a bringing together of everything.

[f] Interviews were conducted from December 2023–February 2024.

One interviewee in HHS Region 7 discussed how the murder of George Floyd in particular motivated them personally and professionally to address racism in their work:

> The reality is, as a person of color and as a public health practitioner of color, I cannot separate out the realities of what is happening in the world from my work. Really, to be blunt and frank, the killing of George Floyd was a transformative and pivotal moment in my own professional and personal life. It was a point in which I recognized that I had a responsibility to the public health workforce to speak out openly and often about the reality that institutional racism and systemic racism are not just things in books that are gone, but they are very much factors impacting both the communities we serve and the organizations we work in.

Other interviewees expressed a more personal motivation to address racism in their work. Several interviewees described personal experiences that provided a starting point for their interest in addressing racism and saw their professional positions as ways to effect change. One interviewee in HHS Region 4, for instance, said she needed to use her privileged societal position as a white person to address racism:

> As someone who is in such a privileged group, it's my job to be part of changing that because other white people will be more likely to listen to me or talk to me about it. I have possibly more in that way to change people's perspectives or at least open their minds a little bit.

Interviewees also discussed their perceptions of their health departments' motivations to address racism as a public health crisis, as well as their own personal motivations. Several interviewees discussed how addressing racism was core to the mission of public health:

> It's important to me just from the stance that I'm a public health practitioner, I care about health, and I have to address racism first and foremost to be able to do that.

Conversely, most Black interviewees said their motivation to address racism came from the fact that they — along with others who share their racial identity — directly experience the adverse health impacts of racism. They described specific, negative racialized health experiences, such as experiences related to maternal health or personal reflections on the murder of George Floyd. A Black woman in HHS Region 3 elaborated on how it was personally important to her to address racism because people like her are dying prematurely.

> "If I'm being honest, I think it's because I have a personal connection to it. I think just knowing that people who look like me are experiencing worse health outcomes, that could be my sister or anyone in my family that could potentially die due to childbirth. Not because of anything that they did, but because of racism that they're experiencing in the healthcare system. I think that's the main factor.

Research Question 2

What are the strengths, opportunities, and gaps in the workforce's ability to address racism as a public health crisis?

Strengths

Although most interviewees did not mention learning about racism as part of their formal education, several interviewees revealed that **exposure to the construct of racism in their academic studies helped inform them about the need to address racism in their work.**

Several interviewees said they were initially exposed to the construct of racism as part of their academic education. Many of these interviewees reported feeling shock and anger when learning about racism and its impacts on health in graduate school. Some white interviewees described attempts to process their feelings about racism while learning about it in their academic programs:

> "My major was anthropology, and so I feel like I spent a lot of [time in] undergrad being really angry and learning about that was eye-opening. I'm first-gen college, multi-generations in the south, thought we were progressive, but not really, and so I was angry for a long time, but then through [these educational] experiences, I've been able to figure out what is my role in this and how can I help.

One interviewee, who had a public health degree, noted that the public health workforce's knowledge about racism could be improved by educating them on how racism is tied to health:

> "We can improve the way that we are teaching future public health workforce [members] by explaining that racism is incorporated in most health outcomes and most disparities that we're seeing.

Health departments created new positions and task forces to address racism and equity. Interviewees discussed how health departments created new positions to address racism and/or equity. These positions ranged from an executive in the office of the director to teams created to address equity and/or racism. Some interviewees mentioned that their health department had created equity task forces, and several interviewees said they had taken a position on a task force in addition to their full-time job. According to interviewees, most task forces spanned the health department, with representation across divisions. The activities of task forces varied. Some interviewees described task forces that focused on equity through workforce development, while others described task forces that focused on centering equity in the work of health department divisions.

Some interviewees shared that their equity task forces were mandated by city or county leaders rather than by the health department, and some task forces were created to address equity across multiple local government agencies. However, many task forces were funded with grants, which potentially jeopardized their sustainability. An interviewee in HHS Region 7 said their health department had a team dedicated to addressing equity, but the continuity of the team's existence in its current form was contingent on additional grant funding:

> "Most of my team, we are funded off of grants. These people who are in these positions have to worry about their grant funding going away and either losing their jobs or being transitioned into another role. We need to stabilize this team and our work so that we don't have to worry about [if] we will still be around next year or not.

The interviewee also discussed how providing sustainable funding for the team would demonstrate the health department's commitment to the work of addressing racism as a public health crisis. An interviewee in HHS Region 9 went on to describe the relationship between funding and health department priorities:

> "Then [the grant the employee is funded with] ends. Good luck keeping [the employee]. The obvious answer is continued sustained funding. The priorities are only priorities as long as we have the resources to address them. They're important until they're not funded and then they go away.

Opportunities

Government public health workers' understanding of racism can be enhanced by connecting their personal experiences and visible racial inequities in the communities they serve to the concept of structural racism. One opportunity that arose out of the interviews was the potential to build understanding of structural racism by connecting employees' personal experiences to visible racial inequities and the contexts in which these inequities exist. For example, several white interviewees described how their understanding of racism was shaped by the contexts in which they grew up. Many white interviewees shared that they never had to think about racism before working in public health. They described how their race, coupled with having greater socioeconomic status, allowed them the privilege of not having to think about racism

prior to working in the health department. However, observing the magnitude of racial inequities in health and economic mobility over time increased their understanding of racism and its effects.

One interviewee discussed the importance of "painting a picture" at a personal level to help others understand how racial inequities compound economic and social challenges:

> Being able to paint that picture first, you can see how this plays out. Now let's add on this compounding variable of racism. The fact that you are now a single mom of two kids who is underemployed, and you happen to be a woman of color. Can you imagine how much that compounds the challenge and barrier? That has been able to start the conversation in a way that paints a common picture.

Several white interviewees also discussed how their understanding of racism shifted from individual-level discrimination to structural racism. Many interviewees discussed increases in their knowledge about the history of racism in their surrounding communities as well. Some interviewees linked knowledge of specific instances of racism in their communities to their early-career experiences working with residents of low socioeconomic status or in jobs where racial inequities in health and socioeconomic status were particularly evident.

Gaps

Efforts to address racism were not infused into employees' regular job roles and instead became "extra work." Although the creation of new positions to address racism and equity was considered a strength of the public health workforce, it came with a cost: These new positions separated the work of addressing racism and equity from most employees' core, daily work. As a result, many interviewees discussed how efforts to address racism at the health department were perceived as "extra." Although some interviewees described their jobs as specifically addressing equity or racism, other interviewees discussed how the work to address racism as a public health crisis in their health department was done in addition to their regular job responsibilities and tasks. An interviewee in HHS Region 2 discussed how efforts to address racism should be a part of employees' job descriptions rather than an "add-on":

> Often when people have a job description, that's what they do. Is [addressing racism] part of it or not? I think just having the space for people to include that in their work would be really helpful instead of an add-on. It's like, 'Oh, well, this is my work. I would like to do these things [work to address racism], but only if I have time.' No, this should be part of the work.

Several interviewees discussed how work to address racism felt like work that was tacked on to their jobs. This work was often treated as optional, less essential, or "extra," rather than integrated into their jobs:

> A lot of other things that we want to do, we haven't gotten to a point yet where it becomes just part of the way we do our work. It still feels like a separate thing to think about in some cases. That's not how it should be, but that's where we are in our department's maturity on this topic.

Health department leaders often talked about equity but failed to take action. Many health department leaders voiced support for addressing racism or equity in 2020 and beyond. However, oftentimes, their words were not followed by action. Some interviewees discussed how their health department leadership claimed to prioritize equity, but referred to this as "lip service" given the clear disconnect between their words and actions:

> I would say leadership has that perspective in an academic sense, but not necessarily in a felt sense. They know the statistics...and they know that racism certainly has been declared a public health crisis by many agencies across the United States. They know that historically, racism has been a core factor in loss of life and longevity. I don't necessarily think that they are feeling the fire to address it in the way that I would like to see.

Interviewees discussed how racism was a "wicked problem" that public health practitioners can be trained to address, yet **many health department leaders and other members of the public health workforce often undermine the credibility of efforts to address racism as a public health crisis.** Several Black interviewees in particular stated that their credibility related to addressing racism was questioned by health department leaders. Some Black interviewees said that although they were recognized as subject matter experts, their health department leadership did not believe in their expertise. For example, one interviewee shared how their health department leadership negated their suggestions to address racism, as they felt doing so was not "evidence based." Another interviewee discussed how their work to address racism was not recognized as "traditional public health practice."

Many health department employees were not comfortable talking about racism and equity. Interviewees observed a general discomfort among many colleagues when explicitly discussing racism and equity. They described a range of attitudes and perceptions about racism within their health departments, referring to conversations about racism and equity as "messy," "difficult," and "frank." Several interviewees discussed not being able to "change all hearts" and an inability to generate buy-in for equity and anti-racism work from all of their colleagues. One interviewee in HHS Region 4 suggested that some members of the public health workforce may not even identify racism as an important topic for their health department to address:

> There are a lot of people who don't want to talk about racism. It's not a topic that people want to talk about, and a lot of people don't believe that it truly is a factor. Those can be barriers because…it is people who we work with. It's people who make the decisions.

Some Black interviewees discussed having to carefully navigate how their white colleagues understood their own privilege. They discussed the difficulty of determining whether a colleague made a genuine mistake when they said something offensive that had harmful impacts nonetheless, or was knowingly making a racist statement. Black interviewees also described the difficulty of having to explain their racialized experiences to their white colleagues:

> … I learned early on that [white colleagues] don't think about [racism] as much as I do. They don't talk about it, and their philosophy is that if we don't talk about it, it really doesn't exist. They don't understand their privilege. There have been several times I've had to help people see that. I've gotten more comfortable being more upfront with those types of conversations. In order to normalize a conversation, they need to see where I sit.

Interviewees discussed how their health departments' efforts to address racism were limited by the political climates of their communities, and as a result, the language they could use related to equity and racism was restricted. **Several interviewees reported that they had to refrain from using words like "racism," "equity," or "bias" because they received pushback from their health department leadership.** An interviewee in HHS Region 3 described how their word choices in health department presentations and documents were scrutinized:

> If we use the word 'bias,' for example, a lot of times that could get sent back or stricken from the presentation or document. There are multiple follow-up questions like, 'Well, why are we doing this?' or 'Why are we using this word? Are we sure this is evidence?' The trust I think for folks doing this work has decreased.

An interviewee from HHS Region 4 said their ability to apply for specific grants was prohibited if the grant addressed racism or equity:

> I have also found that if there are grants that we would apply for that address equity or include some aspect of racism, we often don't get approved for them. I think right now, things are very political. Not just concerning racism, but things that are against what our current administration stands for.

Another interviewee, who worked in a municipality with both urban and rural populations that were predominantly white, discussed how their use of specific words and phrases depended on their audience. They discussed how they changed their use of words or phrases related to racism or equity when interacting with "rural populations."[g]

Other interviewees shared similar experiences about how their use of language to address racism and equity was policed, oftentimes discouraging them from participating in public-facing presentations or preventing them from addressing racism candidly in public-facing reports.

Organizational culture and a lack of support from health department leaders undermined employees' ability to address racism as a public health crisis. Many interviewees discussed needing "time and freedom to explore" solutions to issues related to racism and equity, but stated that an organizational culture of urgency in health departments prevented them from doing so:

> "Sometimes I feel like we don't have the time or the energy to think through it because there's just this fire that has to get put out, and this fire, and this demand. It's only gotten worse since COVID in terms of the expectations for our productivity and our responsiveness.

Another interviewee described their health department as having a "culture of yes" (e.g., health department staff are eager to address racism in many ways); however, many staff are "spread thin" and have "so much to do" that they cannot make good on authentically addressing racism as part of their work, no matter how eager they may be. Some interviewees shared that the public health workforce has too many tasks and cannot put additional attention into developing approaches to address racism as a public health crisis.

Interviewees also discussed how **the political climate in which their health departments functioned influenced their ability to address racism.** One interviewee shared how employees knew "how ridiculous it is that they can't say the word 'equity' or 'racism,'" but if policymakers who were in charge were opposed to addressing racism — in words or in action — it prevented health departments from addressing racism as well. In contrast, another interviewee whose health department was "in an area of the country that would broadly be considered liberal" said that the liberal political climate made it "a bit easier" to prioritize work related to addressing racism and equity.

[g] Some interviewees used the term "rural" as a coded term for "white" when discussing urban-rural differences. This is a common but erroneous practice in the United States. Given that roughly one-fifth of rural residents in the United States identify as people of color, the term "rural" cannot be considered a proxy for the term "white." The research team felt it was important to provide this clarification.

One interviewee described how political climates could also undermine their efforts to share power with communities and engage them in collaborative decision-making:

> Engaging more with community and setting up joint decision-making processes is a big opportunity that we may not have, depending on who's elected.

Research Question 3

How can the workforce operationalize efforts to address racism as a public health crisis and begin to create systems of accountability for this work?

When discussing how the public health workforce has operationalized efforts to address racism as a public health crisis, several themes emerged.

Declarations of racism as a public health crisis facilitated health departments' prioritization of addressing racism in their work. Some interviewees worked in cities or counties where the mayor or other municipal leaders declared racism a public health crisis. These interviewees noted that city- or county-wide declarations made by elected officials bolstered their health departments' work. Interviewees specifically noted the influence of their mayor or board of health in prioritizing efforts to address racism in their municipality, and by extension, their health department. One interviewee stated that municipal leaders who prioritize addressing racism can be particularly effective given that they are elected and have influence that non-elected officials may not have.

Another interviewee noted that their mayor's declaration about racism required their health department leadership to respond:

> When [the mayor] made that declaration, that put pressure on our [health department] leadership as well.

Another interviewee noted that changes to address racism as a public health crisis occurred because pressure was applied from multiple sources in their locality:

> The mayor, the Board [of Commissioners], staff, and leadership have sort of been [pressed] from all sides to buy in, to understand and to attend the trainings and to then say, "Okay, yes, we're going to have this declaration." Sometimes you feel like some people are never going to get this, but you have enough people to tip it.

Another interviewee noted that having a declaration on racism that included action steps – such as equity plans for all agencies, as was the case for some interviewees – was critical to advancing their work:

> That declaration had 22 action steps written into it that are tangible action steps designed to address the impacts of racism from a public health perspective and empowered us as a department to work towards addressing those.

Interviewees shared that having a declaration was a start, but should be accompanied by actions and measures of accountability:

> A declaration is just that; it's just words. The political will that existed motivated and propelled the leadership of this health department to make sure that they actually spelled out measures of accountability and expectations that were attached to it. Then those were communicated very clearly to all of the communities that are served by our health department. Here's what we're committing to, hold us accountable. If we fail, if we drop the ball, call us out on it.

Intentional changes to organizational structures can help health departments more effectively address racism across teams and departments. This helped ensure efforts to address racism did not occur in silos, but were instead addressed across teams. One interviewee discussed how multiple teams were moved under their purview in an effort to make addressing racism part of "the DNA" of their department:

> By moving our vital statistics team under my division...we can make real-time data-driven decisions and corrections to how we are operating as a department based off of our life expectancy or infant mortality data. Then, our strategic plan, community health needs assessment, community health improvement plan – all of those things have been situated under my division as an opportunity to embed our work around addressing racism into everything that we're doing across the entire department and build it into our strategic plan and really just the DNA of our department.

Trainings related to addressing racism and advancing equity have the potential to be useful, but only if they are live, interactive, practical, and action-oriented. When asked what their health department had done to address racism as an organization, most interviewees discussed the trainings they had attended. However, many said that most trainings they had attended focused on raising awareness about the connections between racism and public health rather than how to address these issues. While no interviewee expressed an unwillingness to participate in more trainings about racism, few interviewees felt that their health department necessarily needed more trainings. An interviewee in HHS Region 5 discussed how the trainings they participated in fell short of helping the public health workforce translate standards into implementable practices:

> A lot of the programs and courses that I've gone to have talked about the past practices, but [I want to know] what is still occurring today and [the department should] try to get that out there. For example, the city passed a resolution years ago about equity and fairness in the city and within the city and its hiring practices. [That is] positive standard, but how do you implement that?

According to interviewees, the most effective trainings were synchronous (i.e., live and not recorded), interactive, practical, and action-oriented. An interviewee in HHS Region 3 described a useful training that was designed for employees by employees at their health department. They discussed how the training focused on changing the culture of their health department to address racism, which was essential to implementing changes throughout the organization:

> Well, our vision is to push culture shift as it relates specifically to racism because the system is so ingrained in it that we need to be able to look at the policies and look at the beliefs and perceptions of the people in the health department to determine how best to address it.

Health department employees can put a spotlight on racism by publishing and publicizing data on racial inequities in data reports and disaggregating race and ethnic data. Some interviewees described advocating for addressing racism as a public health crisis by including data on racial and ethnic inequities in reports published by their health departments. Several interviewees shared that their health departments are beginning to incorporate questions about racial discrimination in the surveys that they implement. Most interviewees who discussed the role of data talked about disaggregation by race and ethnicity. One interviewee described how they constantly examine data by race and ethnicity to identify points of intervention:

> When we're looking at our data, whether it's violence, infant mortality, or access to care, and we disaggregate all that and see things are going in the wrong direction for our Black and Brown neighbors — when that happens every day, it is always at the top of your mind of, why is this and how do we make it better?

Interviewees also shared that sharing data on racial disparities during legislative sessions can be an approach to obtain funding to address racism. One interviewee noted that including these types of data was important for effecting change at the policy level. Specifically, they described the importance of using data to communicate with policymakers:

> When general assembly time comes around, we're putting in budget amendments for things that we're hoping can improve the disparities that we're seeing in the data.

Health department staff need to build authentic, trusting, and long-term relationships with community-based organizations and community members. Interviewees discussed the necessity of being honest and trustworthy partners to community members and community-based organizations to effectively address racism and advance equity. One interviewee discussed how building trust required health departments to provide resources to their community partners:

> If we're able to help our community partners meet their needs from a resource perspective, that's us showing up as a good partner. That's us developing a relationship that fosters trust.

Another interviewee said that co-governance between communities and government agencies was important, but bureaucratic barriers created by governments can prevent them from ensuring that communities have decision-making power:

> So many of our county requirements or restrictions…it gets in the way, I think, of us being able to genuinely engage with communities. I also think there's no good internal structure to really have joint community participation where a community is in addition to the government entity, part of the decision-making process and actually saying like, "We're voting on this decision."

Government leaders inside and outside of health departments need to give initiatives focused on dismantling structural racism more time to demonstrate impact. Interviewees discussed how addressing racism requires a lot of time and a long-term strategy. Many interviewees remarked that it takes a long time to see the impact of public health efforts — particularly those focused on dismantling structural racism and advancing equity — and that this is something that political leaders often do not understand:

> I think the biggest issue that I run into time and time again in my own work, and when I talk to other people, is the issue of time and the understanding of [that by] leadership in our health department. Pressure from our board of supervisors as elected officials to do things quickly is often really deep and forces our hand in terms of how we do things.

Given that it can take a long time to see the impact of public health efforts, particularly those focused on dismantling racism, health department staff and community partners need to strategize together and prepare for the long haul:

> Our overarching goal, our long-term objective, is to eliminate racism. [But] let's be realistic. It is not a goal I'm going to realize within the scope of my career. We had to be intentional about preparing the people in our community for the reality of the impact of long-term outcomes. We're driving towards that. Part of that accountability is setting a reasonable expectation.

05 Recommendations

Advancing health equity is critical to forging a path to a stronger, healthier, and more equitable nation.[1] A 2023 study published by the de Beaumont Foundation found that nearly three-quarters (72%) of state and local government public health employees believe that addressing racism as a public health crisis should be a part of their daily work, but only four in 10 (39%) employees reported being highly engaged in efforts to address racism.[5] This study — which builds on the 2023 study — explores how public health employees have tried to address racism before 2020 and presently, the strengths they bring to these efforts, the opportunities and gaps that exist, and ways they can begin to create systems for accountability.

The study confirmed that health department staff have worked to advance health equity in a variety of ways. While they bring strengths to this work, there are many gaps that must be addressed, primarily within health departments. Conversations with employees revealed concrete ways in which health departments can support their employees' work and hold themselves accountable in the process.

Health department executives directly influence the culture of their organizations. They should not only talk about health equity but take direct and sustained action to operationalize it — both internally and in their communities.

Across all interviews, a clear theme emerged: There is a disconnect between what health department leaders *say* about advancing health equity and what they *do*. Interviewees discussed multiple instances where their leaders spoke about ideals like equity and the importance of addressing racism, but fell short when it became time to identify, implement, and enforce actions to make these ideas a reality, both within and outside of the health department.

Engaging authentically in efforts to dismantle structural inequities requires health department leaders to listen to the needs and experiences of their employees and community members, uplift feedback with acknowledgment and support, and take action — swiftly, concretely, and sustainably — to make their words real. They must acknowledge that taking on unfair systems that affect our health is a critically necessary role for the public health workforce. They should not only speak forcefully and publicly about the adverse impacts of racism

on community health, but immediately follow these words with actions that make their words true. This requires facilitating the creation of new organizational policies, processes, and practices that allow health department employees to actualize and sustain efforts that advance equity. These actions should include (but should not be limited to):

- Listening to, amplifying, and affirming the experiences of colleagues and constituents of color, within and outside of the health department.
- Routinely reviewing, updating, and evaluating policies, processes, job descriptions, and application processes (for job applicants, grants, and contractors) to ensure they are anti-racist and equity-centered.
- Centering under-resourced and marginalized communities — particularly communities of color — in all aspects of the health department's work by prioritizing their needs, preferences, and agendas.
- Allocating resources to communities based on their needs and priorities, with the explicit aim of addressing past and present inequities.
- Financially compensating community members and community-based organizations for their expertise.
- Engaging in continuing education about the innumerable ways structural inequities adversely impact community health.

Health departments should operationalize and infuse principles of health equity into the core, daily job responsibilities of every employee.

In PH WINS 2021, 66% of the government public health workforce reported that they needed more training to address racism as a public health crisis.[5] However, in our interviews nearly two years later, employees' thinking had evolved. While employees provided suggestions for improving trainings and were willing to attend them, they generally did not advocate for more trainings. Instead, they said health department managers and executives should focus on fully infusing efforts to address health equity into all employees' core, daily work.

Given how central health equity is to community health and well-being, addressing these issues should never be treated as "extra work" or only taken on by a few employees in select departments. All health department employees — from epidemiologists to program managers to human resource specialists to procurement coordinators — have a role to play in making equity a normal, fundamental, and integral part of their work and the work of the health department as a whole. To infuse equity, health departments should routinely review, update, and evaluate policies to ensure that they are equal-opportunity for applicants.[10]

To make efforts to advance equity truly "business as usual" within a health department, managers and leaders should work with their staff to prioritize under-resourced and marginalized communities across all of their activities, allocate resources based on communities' needs and priorities to

redress past and present inequities, collaborate with community power-building organizations to implement programs and advocate for policies, and ensure that community members are formally involved in making decisions about the programs and policies that impact them.

Health department employees should measure the health effects of racism and the underlying causes of race-associated differences in health outcomes.

As a field that is grounded in evidence-based practice, public health professionals must understand that "what isn't measured cannot be managed, nor can it be valued."[11] To this end, health departments — and the public health field as a whole — must go beyond merely documenting race-associated differences in health outcomes to actively measuring *the impacts of racism* and the ways that racism drives differences in health outcomes for racial groups. Government public health practitioners, particularly epidemiologists and those who work in public health sciences, should measure these effects and translate findings into action. This requires educating current and future members of the workforce (within schools of public health and through on-the-job training) that "race" is a social and contextual variable that should not be used to measure biological difference; instead, it is a proxy for exposure to structural racism.[12]

Furthermore, health departments should prioritize implementing epidemiological frameworks across their programs that measure the underlying causes of race-associated differences in health outcomes.[13] One example is the state racism index developed by Mesic, et al., a composite measure of Black-white segregation and economic inequity in fatal police shootings nationally, which aggregates the downstream effects of structural racism.[14] Health departments can also use their power to advocate for measures that quantify the impact of structural racism to be included in larger data sets. In 2021, the Tacoma-Pierce County Health Department leveraged their county's declaration of racism as a public health crisis to develop and submit anti-racism questions to be added to the next state Behavioral Risk Factor Surveillance System survey.[15]

Health department leaders and staff should build trust with the communities they serve by using collaborative governance approaches that provide community members with formal opportunities to inform the decisions that affect them.

Health department employees understand that building strong, trusting relationships with the communities that their health department serves is essential to protecting their health. However, like many government agencies, health departments often lack transparent and accountable processes for community collaboration, engagement, and shared decision-making. Without these processes, efforts to build trust will be difficult, if not impossible. Collaborative governance[16] — or "co-governance" — is a style of governing in which public agencies, like health departments, directly engage community members and community-based organizations in collective decision-making

processes that are formal and consensus-oriented. The goal of collaborative governance is for public agencies and community members to make shared decisions about the programs, policies, budgets, and funding allocations that impact them. Collaborative governance "shifts power and builds trust by enabling government officials and advocates to see each other as collaborators with unique capacities and perspectives that support the other's interests and positions."[17]

Ultimately, the primary beneficiaries of any health department's decisions should be the communities themselves. When it comes to collaborative governance, communities are not merely "consulted"; they are central to the decision-making process and the decisions themselves. Health department leaders and staff should build trust with the communities they serve by using collaborative governance processes that are specific to their contexts and ensuring that communities' needs, priorities, and voices are central to the decisions they make.

Health departments should prioritize building strong partnerships with community-based organizations across sectors to collaboratively engage in equity-related work while navigating ever-shifting political environments.

Across interviews, employees discussed how working in challenging political climates often stifled their ability to address racism and health equity through their work at the health department and adversely impacted their ability to pursue external funding opportunities to support health equity-related work. To address these political realities, public health agency leaders should prioritize building their internal capacity to do equity-related work in multiple ways.

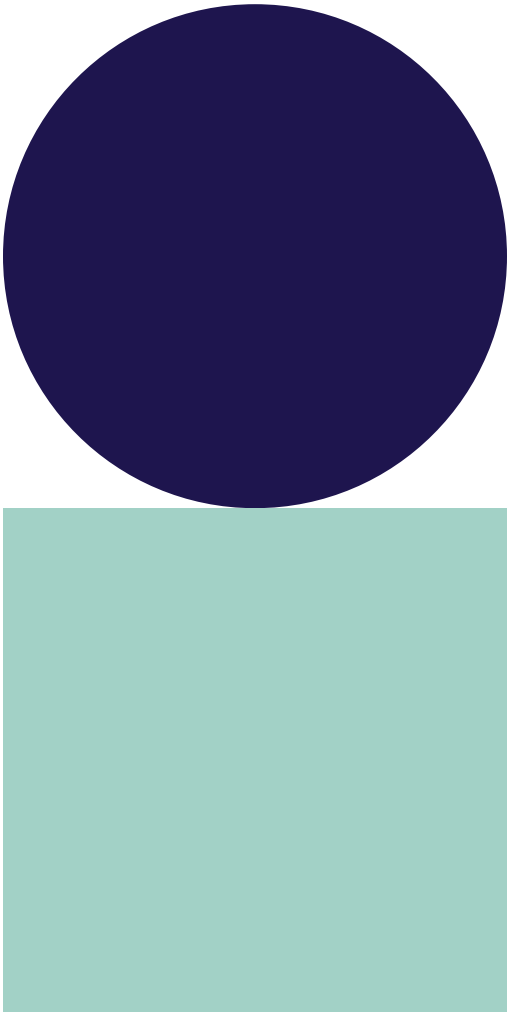
In the short term, to ensure that work can move forward despite systemic barriers, team leaders, directors, and executives can develop values-based messaging using resources such as those from the FrameWorks Institute.[18] Simultaneously — and as part of a longer-term strategy — public health agency leaders must go beyond the walls of their health departments to partner with community-based advocacy organizations and power-building organizations whose missions are focused on shifting political power in the jurisdictions they serve. This will require health departments to collaborate with and fund community organizations, organizers, and advocates to bolster their influence and ability to do this critical work. The Human Impact Partners (HIP) "Power-building Partnerships for Health" initiative[19] has resources for health department staff to initiate deep and trusting relationships with community power-building organizations whose advocacy expertise and authentic relationships are critical to advance racial justice. A strategic partnership between a government agency like a health department and community power-building organizations — described by HIP as an "inside-outside" strategy — can be mutually beneficial. It can help health departments build their knowledge and abilities to address racism, classism, sexism, and other forms of oppression while serving as an ally and resource to community-based

organizations and other external partners across the social determinants of health to advance equity in ways and spaces that the health department often cannot.[20]

Health department employees should be storytellers who can describe how structural inequities are connected to community health and their work at the health department as a whole.

Employees discussed how declarations of racism as a public health crisis were strategically useful narrative tools that helped health department employees draw connections between the importance of addressing systems that make it harder for some people to be healthy, and the role of the health department to protect the public's health. These narrative connections helped health department staff explain their role in these efforts to elected officials and other decision-makers, while simultaneously enhancing their ability to advance health equity in their daily work.

Although the development of these narrative connections were a start, health departments should go further. People are more likely to remember authentic stories over data or facts. Stories that are "designed to evoke empathy, compassion, or indignation can inspire action, influence opinions, and drive positive change."[21] To effectively advocate for much-needed policy changes and sustainable funding to address health equity, health department employees cannot rely on topical expertise or data reports. They should connect with and persuade a variety of audiences to support these efforts, including their own colleagues within the health department, their external partners, and their elected officials. Resources from those conducting and applying narrative research, like the FrameWorks Institute[18] and the Public Health Reaching Across Sectors (PHRASES) initiative[22], can provide useful and practical guidance to help health department staff create compelling narratives that convey how advancing equity can improve health for everyone.




DEPARTMENT
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06 Appendix

Recommendations for the Field: Actions Health Department Leaders Can Take to Achieve Health Equity

What You Can Do	Sample Actions You Can Take	Resources to Get Started
Infuse equity into all organizational policies, practices, and roles so it is not "extra work" but is "business as usual."	■ Engage with, listen to, and amplify the experiences of colleagues and constituents of color, within and outside of the health department. ■ Routinely review, update, and evaluate policies, processes, job descriptions, and application processes (for job applicants, grants, and contractors) to ensure that they are equal-opportunity and equity-infused. ■ Increase your knowledge about the numerous ways systemic barriers adversely impact community health. ■ Center and prioritize under-resourced and marginalized communities in all aspects of the health department's work. ■ Allocate resources to communities based on their needs and priorities, with the explicit aim of addressing past and present inequities. ■ Financially compensate community members and community-based organizations for their expertise.	■ New York City Department of Health and Mental Hygiene, 2016. Race to Justice Tool Kit ■ Lett E et al., 2022. Conceptualizing, Contextualizing, and Operationalizing Race in Quantitative Health Sciences Research ■ Jones C, 2014. Systems of Power, Axes of Inequity: Parallels, Intersections, Braiding the Strands. ■ McGhee H, 2022. *The Sum of Us: What Racism Costs Everyone and How We Can Prosper Together* ■ USC Dornsife Equity Research Institute, 2020. A Primer on Community Power, Place, and Structural Change ■ Travis A, 2023. Infusing Equity Into Organizational Culture at Governmental Public Health Agencies ■ Hussein S et al., 2024. Infusing Diversity, Equity, and Inclusion Into State Public Health Agencies: Perspectives from Connecticut, New York, and Tennessee

What You Can Do	Sample Actions You Can Take	Resources to Get Started
Create and use collaborative governance (or "co-governance") processes to ensure community members are full and formal partners in decision-making and resource allocation in ways that center their needs, priorities, and voices.	Build and use collaborative governance processes that are formal, sustainable, and informed by local contexts in ways that authentically shift power to communities, build trust, and allow government officials, community members, and advocates to collaboratively make decisions and allocate resources.	■ Ansell C & Gash A, 2008. Collaborative Governance in Theory and Practice ■ Gilman HR & Schmitt M, 2022. Building Public Trust Through Collaborative Governance
Strengthen internal and external capacity for engaging in health equity-related work to combat challenging political realities.	Use an "inside-outside" strategy to ensure that work can move forward internally despite systemic barriers by strengthening internal understanding of equity, including racism, classism, sexism, and other forms of oppression while allying with community-based organizations and other external partners that address the social determinants of health to advance equity in a lasting and sustainable manner.	■ Human Impact Partners, 2015. Using an Inside-Outside Strategy to Build Power and Advance Equity - Human Impact Partners ■ FrameWorks Institute, 2023. Talking about Health Equity
Commit to measuring the impact of *racism* rather than *race* on health outcomes across departmental programs.	Implement epidemiological frameworks that measure the underlying causes of race-associated differences in health outcomes and advocate for measures that quantify the impact of structural racism to be included in larger data sets.	■ Jones C, 2021. Invited Commentary: "Race," Racism, and the Practice of Epidemiology ■ Coalition of Communities of Color, 2024. Introducing Community Data ■ Lett E et al., 2022. Conceptualizing, Contextualizing, and Operationalizing Race in Quantitative Health Sciences Research ■ Mesic A, et al., 2018. The Relationship Between Structural Racism and Black-White Disparities in Fatal Police Shootings at the State Level ■ Kresge Foundation, 2021. Moving beyond equity to become an anti-racist health department: lessons from Tacoma-Pierce County

What You Can Do	Sample Actions You Can Take	Resources to Get Started
Embrace the role of storyteller and develop compelling narratives for constituents and policymakers that convey connections between community health and the necessity of advancing equity.	Create and share narratives that strategically combine compelling personal stories with relevant data to show the impact of systemic inequities on communities and opportunities to advance equity.	■ FrameWorks Institute, 2024. Widening the Lens on Health (Explain the Frame: Ep. 2) ■ de Beaumont Foundation & Aspen Institute, 2020. PHRASES Strategic Storytelling For Public Health Messengers: A Research-Based Toolkit ■ Bejtullahu J, 2023. How Storytelling Can Impact Public Policy ■ Miller M, et al, 2022. *Talking Health: A New Way to Communicate About Public Health*

Figure 1

Recruitment Strategy for Interviews with State and Local Government Public Health Employees from December 2023–February 2024

Table 1

Demographic and Other Key Characteristics of State and Local Government Public Health Employee Interview Participants, 2024 (N=20)

	N (%)
Race and ethnicity	
Asian	1 (5)
Black	6 (30)
Hispanic or Latino	2 (10)
White	11 (55)
U.S. Health and Human Services (HHS) Region	
Region 1 (CT, ME, MA, NH, RI, VT)	2 (10)
Region 2 (NJ, NY, Puerto Rico, U.S. Virgin Islands)	2 (10)
Region 3 (DE, DC, MS, PA, VA, WV)	5 (25)
Region 4 (AL, FL, GA, KY, MS, NC, SC, TN)	2 (10)
Region 5 (IL, IN, MI, MN, OH, WI)	2 (10)
Region 6 (AR, LA, NM, OK, TX)	1 (5)
Region 7 (IA, KS, MO, NE)	2 (10)
Region 8 (CO, MT, ND, SD, UT, WY)	2 (10)
Region 9 (AZ, CA, HI, NV, American Samoa, Northern Mariana Islands, Guam, Trust Territories)	1 (5)
Region 10 (AK, ID, OR, WA)	1 (5)

	N (%)
Gender	
Man	4 (20)
Woman	16 (80)
Setting	
BCHC LHD	9 (45)
Other LHD/RHD	6 (30)
SHA-CO	5 (25)
PH degree	
Yes	11 (55)
No	9 (45)
Supervisory status*	
Non-supervisor	5 (25)
Supervisor	6 (30)
Manager	3 (15)
Executive	6 (30)

* Employees were asked to self-identify their supervisory status on PH WINS

07 References

1. Clark EC, Cranston E, Polin T, et al. Structural interventions that affect racial inequities and their impact on population health outcomes: a systematic review. *BMC Public Health*. 2022;22(1). doi:10.1186/s12889-022-14603-w
2. Centers for Disease Control and Prevention. Media Statement from CDC Director Rochelle P. Walensky, MD, MPH, on Racism and Health. Centers for Disease Control and Prevention News Room. Accessed October 18, 2024, https://www.cdc.gov/media/releases/2021/s0408-racism-health.html
3. de Beaumont Foundation and Association of State and Territorial Health Officials. Public Health Workforce Interests and Needs Survey: 2021 Dashboard. de Beaumont Foundation. Accessed October 18, 2024, https://www.phwins.org/nationalph-wins/explore
4. Robins M, Leider JP, Schaffer K, Gambatese M, Allen E, Hare Bork R. PH WINS 2021 Methodology Report. *Journal of Public Health Management and Practice*. 2023;29(Supplement 1)
5. Schaffer K, Porter, J, Castrucci, BC. *Survey: Public Health Employees Eager to Address Racism as A Public Health Crisis*. October 2023. Accessed October 18, 2024, https://debeaumont.org/phwins/2021-findings/ph-wins-2021-addressing-racism-as-a-public-health-crisis
6. National Network for Public Health Law. Declarations of Racism as a Public Health Crisis: Utilizing Declarations to Address Health Inequities. Accessed October 18, 2024, https://www.networkforphl.org/resources/declarations-of-racism-as-a-public-health-crisis-utilizing-declarations-to-address-health-inequities
7. Lawrence K SS, Kubisch A, Susi G, Fulbright-Anderson K., The Aspen Institute Roundtable on Community Change. Structural Racism and Community Building. The Aspen Institute. Accessed October 18, 2024, https://www.aspeninstitute.org/wp-content/uploads/files/content/docs/rcc/aspen_structural_racism2.pdf
8. CityHealth. About Us-Equity. CityHealth. Accessed October 18, 2024, https://www.cityhealth.org/about-us/equity-statement
9. U.S. Department of Health and Human Services. HHS Regional Offices. Accessed October 18, 2024, https://www.hhs.gov/about/agencies/iea/regional-offices/index.html
10. Travis A. Infusing Equity Into Organizational Culture at Governmental Public Health Agencies. *J Public Health Manag Pract*. Jan-Feb 01 2023;29(Suppl 1):S12-s13. doi:10.1097/phh.0000000000001670
11. Coalition of Communities of Color. Introduction to Community Data. Accessed May 7, 2025, https://www.coalitioncommunitiescolor.org/research-and-publications/introducing-community-data
12. Lett E, Asabor E, Beltrán S, Cannon AM, Arah OA. Conceptualizing, Contextualizing, and Operationalizing Race in Quantitative Health Sciences Research. *Ann Fam Med*. Mar-Apr 2022;20(2):157-163. doi:10.1370/afm.2792
13. Jones CP. Invited commentary: "race," racism, and the practice of epidemiology. *Am J Epidemiol*. Aug 15 2001;154(4):299-304; discussion 305-6. doi:10.1093/aje/154.4.299
14. Mesic A, Franklin L, Cansever A, et al. The Relationship Between Structural Racism and Black-White Disparities in Fatal Police Shootings at the State Level. *Journal of the National Medical Association*. 2018/04/01/ 2018;110(2):106-116. doi:10.1016/j.jnma.2017.12.002
15. The Kresge Foundation. Moving beyond equity to become an anti-racist health department: lessons from Tacoma-Pierce County. Accessed October 30, 2024, https://kresge.org/news-views/moving-beyond-equity-to-become-an-anti-racist-health-department-lessons-from-tacoma-pierce-county
16. Ansell C, Gash A. Collaborative Governance in Theory and Practice. *Journal of Public Administration Research and Theory*. 2007;18(4):543-571. doi:10.1093/jopart/mum032
17. Russon Gilman H, Schmitt, M. Building Public Trust Through Collaborative Governance. Stanford Social Innovation Review. Accessed November 5, 2024, https://ssir.org/articles/entry/building_public_trust_through_collaborative_governance
18. Frameworks Institute. Talking about Health Equity. Accessed October 30, 2024, https://www.frameworksinstitute.org/publication/talking-about-health-equity
19. Human Impact Partners. Power-building Partnerships for Health. Human Impact Partners. Accessed October 18, 2024, https://humanimpact.org/about-us/key-initiatives/bridging-partnerships-strategies/power-building-partnerships-for-health
20. Heller J. Using an Inside-Outside Strategy to Build Power and Advance Equity. Human Impact Partners. Accessed November 5, 2024, https://humanimpact.org/using-an-inside-outside-strategy-to-build-power-and-advance-equity
21. Bejtullahu J. How storytelling can impact public policy. October 18, 2023. https://www.linkedin.com/pulse/how-storytelling-can-impact-public-policy-jeta-bejtullahu
22. de Beaumont Foundation & The Aspen Institute. Strategic Storytelling For Public Health Messengers: A Research-Based Toolkit. Accessed January 23, 2025, https://www.phrases.org/wp-content/uploads/2020/07/Storytelling-Toolkit-Final_.pdf

de Beaumont