Center for
Urban and Racial
Equity

Racial Equity Organizational Assessment
Health Care for the Homeless

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www.urbanandracialequity.org

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Executive Summary

Racial equity requires a commitment to naming and confronting racism, shifting power, targeted and equitable distribution of resources to address historical and contemporary causes of inequities, and accountability and transparency. As part of Health Care for the Homeless' efforts to strengthen its commitment to racial equity, the Center for Urban and Racial Equity (CURE) was selected to facilitate a change process that includes creation of a Racial Equity Working Group, a racial equity assessment to identify strengths and opportunities for improvement, growth and systemic change, and action planning guided by the assessment findings.

Racial equity organizational assessments provide data for action and a roadmap for informed dialogue, goal-setting and transformational change to take place. Benchmarking current organizational practices, culture, systems, and norms is a critical first step in ensuring the accountability and transparency necessary for meaningful change. The assessment process is like holding up a mirror, allowing organizations to engage in critical self-reflection.

CURE uses an intentional and systemic framework for racial equity organizational change (REOC) based on four key competency areas including 1) Organizational Commitment to Racial Equity, 2) Shared Language and Analysis, 3) Empowered People, and 4) Equitable Policies and Practices. Our assessment process and strategic planning support services are all designed to strengthen and embed racial equity across an organization across these domains.

For Health Care for the Homeless, the organizational assessment included a document review, staff-wide survey, and focus groups with employees who represent a cross-section of Health Care for the Homeless, former staff, and clients. To protect anonymity and confidence in the assessment process, CURE managed administration of the survey and has not provided access to raw survey or qualitative data to members of Health Care for the Homeless' leadership team.

The following outlines key findings from Health Care for the Homeless' 2021 racial equity organizational assessment. For more context, explanation of these findings, and recommendations, we encourage review of the complete organizational assessment report.

Organizational Culture and Commitment to Racial Equity

- Staff report a strong culture of belonging at Health Care for the Homeless, with some describing the agency as "positive," "supportive," and "homey." At the same time, some describe the agency's culture as becoming "more corporate."
- Health Care for the Homeless has begun to add race explicit key performance indicators in strategic planning. This however is still a new concept for some staff members and may require additional learning especially for leadership.
- Health Care for the Homeless' leadership is understood to be "approachable" and committed to racial equity, though some areas of improvement were identified through both quantitative and qualitative responses. Specifically, two areas - 1) the Executive Team's approach to issues relating to gender and sexuality and 2) the Executive Team's make-up of a mostly white team - have been identified as sources of equity concerns for staff and clients of color.
- Overall, there is room for growth and improvement in Health Care for the Homeless' focus and commitment to racial equity. Staff members do not perceive the mission statement as one that fully reflects a commitment to addressing racial equity and tend to disagree that there is a strong focus on racial equity within their departments and in the organization's engagement with clients and other stakeholders. Additionally, Health Care for the Homeless is seen as being "reactive" to issues of race instead of having a substantive, "genuine", and long-lasting commitment.

Shared Language and Analysis

- More institutional transperancy and support for learning about racial equity, bias, discrimination, or exclusion in the workplace is desired. Knowledge around intersectionality is a particular area needing growth, as well as training on ableism, ageism, multiracial and Latinx identity, and anti-racist clinical practices.
- Some respondents named a desire to incorporate trauma-informed approaches, an understanding of adverse childhood experiences, and harm reduction within external, client-facing work (such as services and care, outreach, and other activities).
- There is an opportunity to support the application of racial equity concepts and principles through decision-making tools and resources. Although 63% of respondents have received training on racial equity, diversity and inclusion while employed at Health Care for the Homeless, less than 15% of respondents have used a racial equity tool for policy, program, services or budget decisions.
- In the past, staff have received pushback from leadership after suggesting that Health Care for the Homeless honor and engage in annual socio-historical and cultural reflective

periods, such as Black History Month, Pride Month, and Asian American Pacific Islander Heritage Month.

Empowered People

- A high percentage (27%) of staff indicated that they have felt some level of discomfort because of their race or ethnicity. This includes 15% of white staff and 35% of staff of color. Health Care for the Homeless could do more to ensure that all employees, regardless of position or identity, are treated with respect and feel just as valuable as others. For example, Black staff have reported unfair treatment compared to their non-Black colleagues, women have experienced misogynoir, and as a whole, staff have been impacted by ableism, toxic masculinity, transphobia, and homophobia.
- Staff of color and white staff perceive little organizational support for staff who share their experiences with incidents where race is a factor.
- Staff identified inequities in the tuition reimbursement policy with medical providers, for example, receiving more tuition reimbursement than peer advocates.

Equitable Policies and Procedures

Hiring, Retention, and Advancement

- Both qualitative and quantitative data suggests that Health Care for the Homeless needs to build equitable hiring strategies, policies, and practices. Staff noted that much of the Management team, Executive team, and clinical staff are white, while frontline staff are predominantly of color.
- Staff, especially staff of color, expressed concern about current retention and advancement opportunities at Health Care for the Homeless and were less likely to agree that their compensation is fair and equitable when compared to others with similar jobs and performance reviews.
- There are concerns about salary especially as it relates to inequities between men and women in similar positions, percentage-based merit raises, and the lack of a cost of living adjustment in the past year.

Inclusive Communications and Decision-Making

- There is a need to improve inclusive communication and decision-making at Health Care for the Homeless. Some key examples include staff of color feeling unable to or unsafe providing constructive feedback and a lack of clarity around the agency’s internal feedback process, shed light on this.

- Employees’ experiences with feeling up-to-date on information, policies, and involvement in decision-making vary by department and manager.

Governance and Operations

- Currently, staff hold feelings of mistrust, precarity, and a sense of unfairness about Health Care for the Homeless’ grievance and reporting process. Fear of unfair treatment or retaliation were found in qualitative and quantitative responses.
- Some personnel policies are seen as inflexible, especially among people of color. For example, some positions are more easily able to navigate requests for time off or support, while others (often lower-rank and lower-paid) employees have a harder time navigating internal systems related to accommodations or paid-time off for medical concerns or scheduling vaccination appointments.

Programs and Services

- Communities of Practice are points of excitement, as staff are eager to refine their own knowledge to offer the highest quality, most-equitable services to their clients. Similarly, pre-COVID events and future plans for collaboration with local communities in Baltimore, are of particular interest.
- Though individuals may be well-meaning, there is concern that a ‘white savior complex’ within the agency affects client engagements and services.
- Staff noted that there are few discussions around intersecting identities, especially gender and sexual orientation for clients. Some examples, such as Health Care for the Homeless’ responsibility and impact on communities of color in Baltimore, its ability to provide affirming services for LBGTQ clients, or more direct engagement with Black communities, were named as areas of potential growth.
- There is interest in conducting an explicit analysis of the harms that the agency has perpetuated or continues to perpetuate against different communities in Baltimore and utilizing a reparations approach to services.

Community Engagement and Partnerships

- Staff are excited about the agency’s Community of Practice sessions, though not all staff including clinicians are able to attend due to their timing. Staff members noted that the Community of Practices could also be more interactive than they have been historically.
- Concerns about who are considered subject experts have been raised. For example, because the Baltimore Police Department (BDP) has been invited to serve as panelists at Community of Practice events to talk about issues of restorative justice and community

safety, Health Care for the Homeless risks ignoring the expertise and lived experiences of grassroots organizations and community organizers.
- Expansions of mobile services, medical outreach components, along with Health Care for the Homeless' presence within the community were requested. Building greater visibility with the Black community in Baltimore would be particularly beneficial.

Contracting and Grantmaking
- Health Care for the Homeless' use of racially equitable contracting practices could be strengthened. Although Health Care for the Homeless' *Procurement Purchasing Policy* mentions "affirmative steps" towards hiring BIPOC contractors, it does not appear to set any concrete targets or goals.

Introduction

Health Care for the Homeless, in the winter of 2021, embarked on a racial equity organizational transformation process in partnership with the Center for Urban and Racial Equity (CURE). This process includes creation of a Racial Equity Working Group, a racial equity assessment to identify strengths and opportunities for improvement, growth and systemic change, and action planning guided by the assessment findings. This report outlines the findings of the assessment including organizational practices and policies that hinder or support racial equity.

For the purposes of the assessment, we defined *racial equity* as the proactive creation and enforcement of practices, policies, values, and actions that produce fair and equitable access, opportunities, treatment, and outcomes for all regardless of race. Racial equity requires a commitment to naming and confronting racism, shifting power, equitable distribution of resources to address historical and contemporary causes of inequities, accountability and transparency, and targeted, intersectional approaches that consider how race interacts with gender, ability, sexuality and other forms of difference to profoundly impact outcomes and experiences.

The assessment included a document review, staff-wide survey, and focus groups with employees, former staff, and clients. To protect employee anonymity and confidence in the assessment process, CURE managed administration of the survey and has not provided access to raw survey or qualitative data to members of Health Care for the Homeless' leadership team. Likewise, all data stemming from focus groups, interviews, or other employee feedback has been analyzed for themes and anonymized within this report.

CURE uses an intentional and systemic framework for racial equity organizational change (REOC) based on four key competency areas: 1) Organizational Commitment to Racial Equity, 2) Shared Language and Analysis, 3) Empowered People, and 4) Equitable Policies and Practices. Our assessment process and strategic planning support services are designed to strengthen and embed racial equity across an organization in each of these domains.

Drawing from CURE's REOC Framework, the table below outlines the domains examined in Health Care for the Homeless' racial equity assessment.

Racial Equity Assessment Domains/Categories

Organizational Culture and Commitment to Racial Equity

- Culture of Belonging
- Vision, Mission and Strategic Plan
- Organizational Focus on Racial Equity
- Leadership

Shared Language and Analysis

- Training, Dialogues and Decision Tools
- EDI Knowledge and Skills

Empowered People

- Discrimination Experience
- Capacity to Act
- Teamwork and Collaboration
- Culture of Learning

Equitable Policies and Practices Hiring, Retention and Advancement

- Inclusive Communications & Decision-Making
- Governance & Operations
- Programs & Services
- Community Engagement & Partnerships
- Contracting & Grantmaking

Understanding and Interpreting the Data

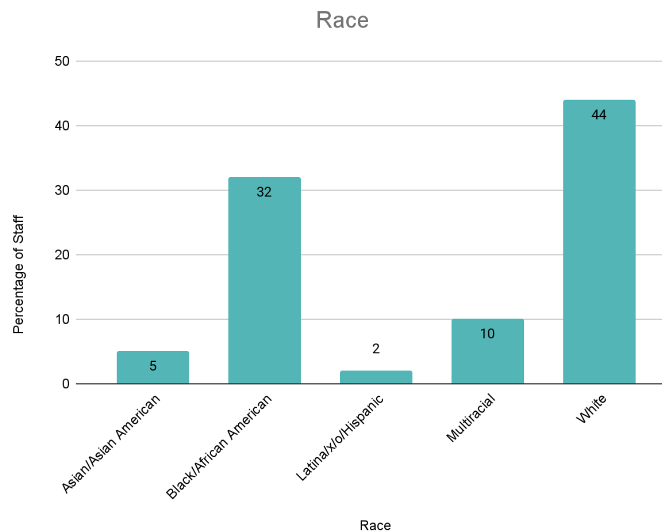
Health Care for the Homeless' racial equity staff survey was administered online in March 2021. One hundred six (n=106) employees completed the survey. Interviews were conducted with seven (7) employees and seventeen (17) employees participated in two focus groups. Additionally, a focus group for former employees included three (3) participants and a client-only focus group included nine (9) clients.

The majority of response choices for survey questions are on a scale of 1 to 5. Survey respondents who did not respond to a particular item or domain scale are not shown and not included in calculations of averages. Survey items with average ratings below 3.5 indicate that overall staff members were neutral or did not have positive responses to the question. CURE recommends that survey items with average ratings below the "cut-off" of 3.5 be prioritized for improvement. If a different scale is used, it will be noted in that section, along with the adjustment "cut-off" score. Comparisons of average ratings across the domains reported below were run for the following demographic variables:

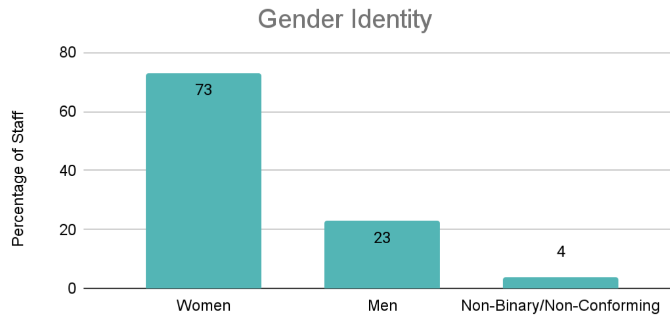
1. Race
2. Gender Identity
3. Race and Gender Identity
4. Age
5. Age and Gender Identity
6. Sexual Orientation
7. Disability Status
8. Economic Background
9. Length at Organization
10. Position
11. Role

Only the most notable differences among these groups are reported. Groups that comprise less than five (5) employees of Health Care for the Homeless staff are not reported to protect confidentiality.

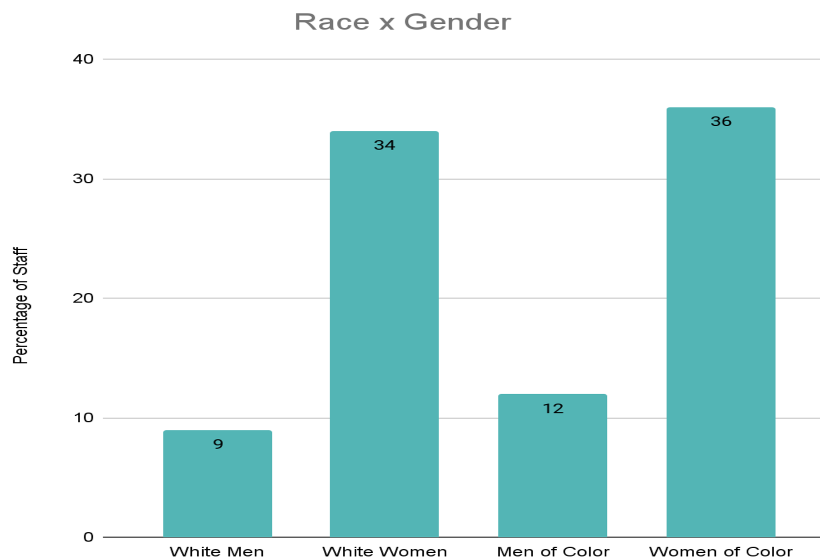
Demographics



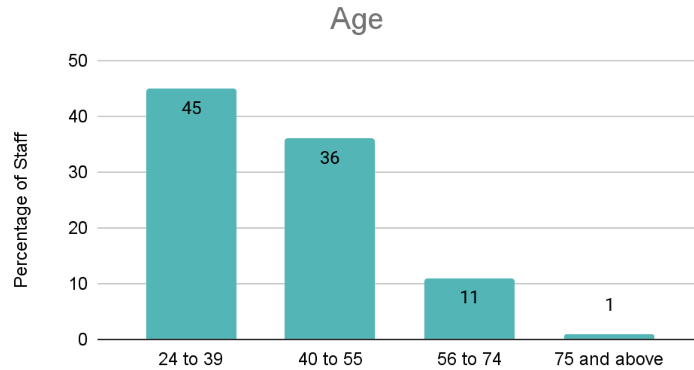
Forty-nine percent (49%) of the sample identified as people of color including 32% Black, 5% Asian/Asian American, 2% Latina/x/o/Hispanic, and 10% Multiracial. Forty-four percent (44%) identified as white, while 7% declined to respond.



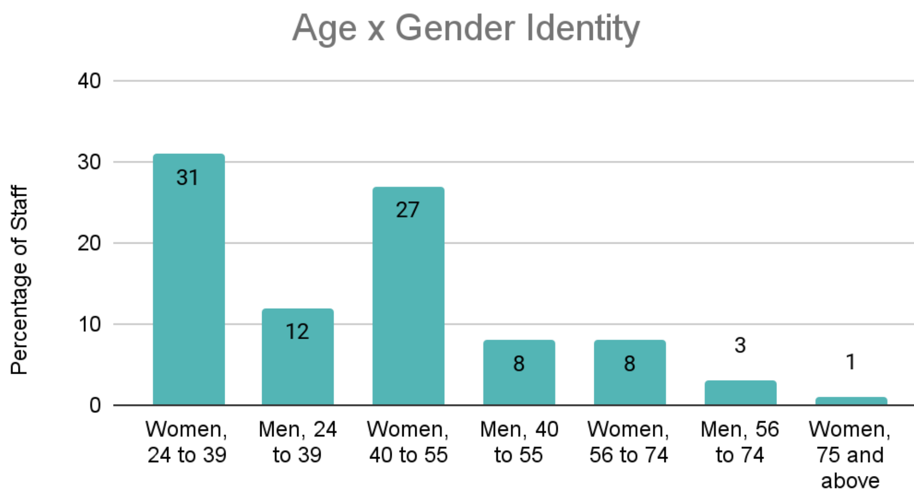
Seventy-three percent (73%) of respondents identified as women, while 23% identified as men. Four percent (4%) identified as Non-Binary/Non-Conforming or declined to answer. Ninety-six percent (96%) of survey respondents did not identify as transgender. Four percent (4%) of respondents preferred not to disclose.



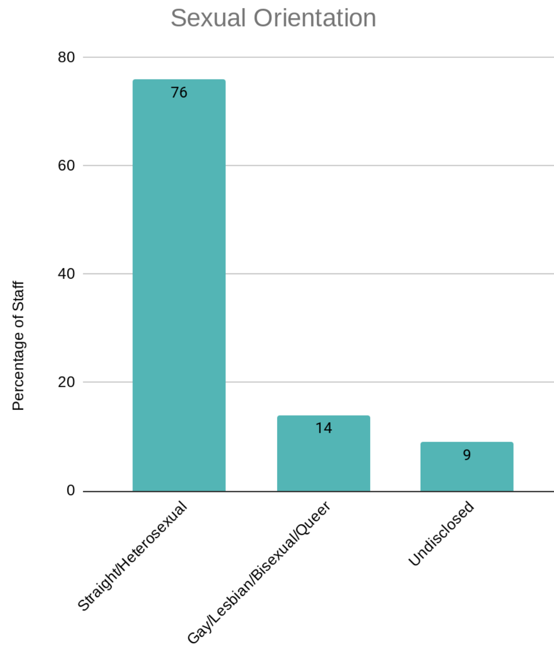
Women of Color comprised the largest percentage (36%) of respondents. Thirty-four percent (34%) of respondents were white women, 12% men of color, and 9% white men.



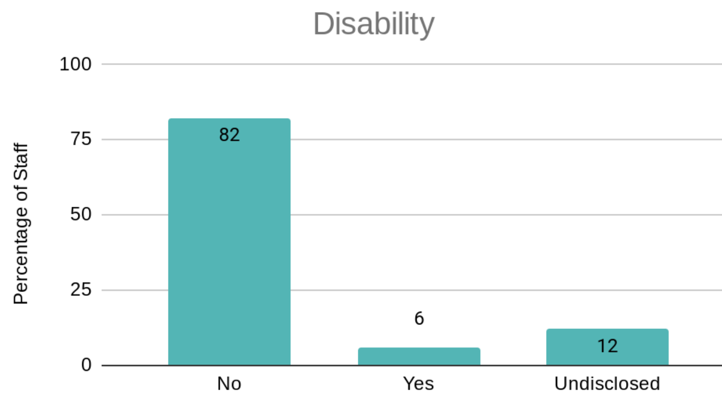
Forty-five percent (45%) of survey respondents were ages 24 to 39, 36% were ages 40 to 55, 11% were ages 56 to 74, 1% were age 75 and above, while 6% preferred not to provide information regarding their age.



Thirty-one percent (31%) of the sample identified as women between the ages of 24 and 39, 27% percent identified as women between the ages of 40 and 55, 12% identified as men between the ages of 24 and 39, 8% identified as women age 56 to 74, 8% identified as men between the ages of 40 and 55, 3% were men age 56 to 74, 1% identified as women age 75 or above, and 10% did not respond to one or both questions.

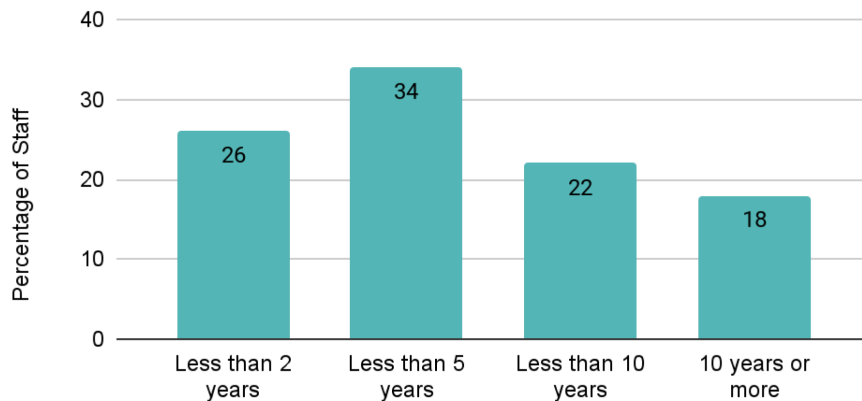


The majority (76%) of respondents identified as straight/heterosexual. Fourteen percent (14%) identified as gay, lesbian, bisexual or queer. Nine percent (9%) preferred not to disclose or did not respond.

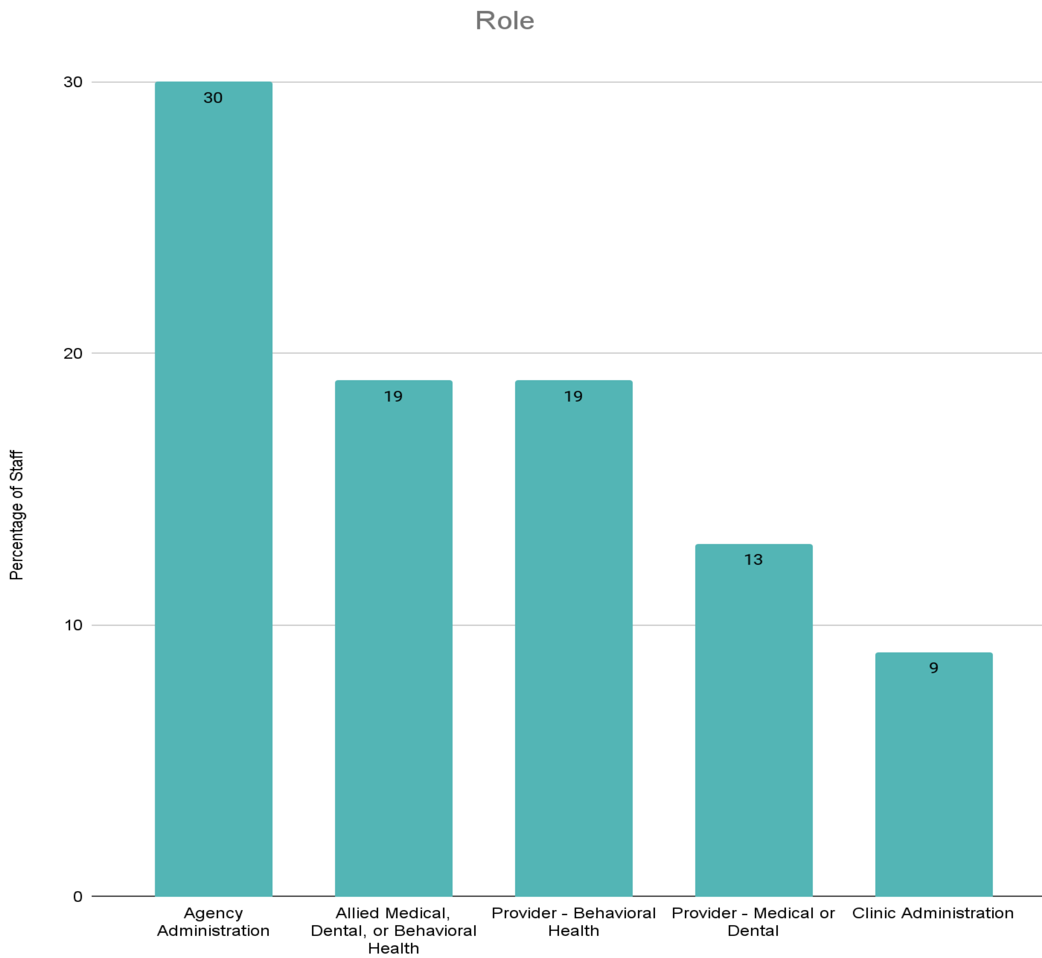


Most (82%) of the respondents reported not having a disability. Approximately 6% reported having a disability. Twelve percent (12%) preferred not to disclose, or did not respond.

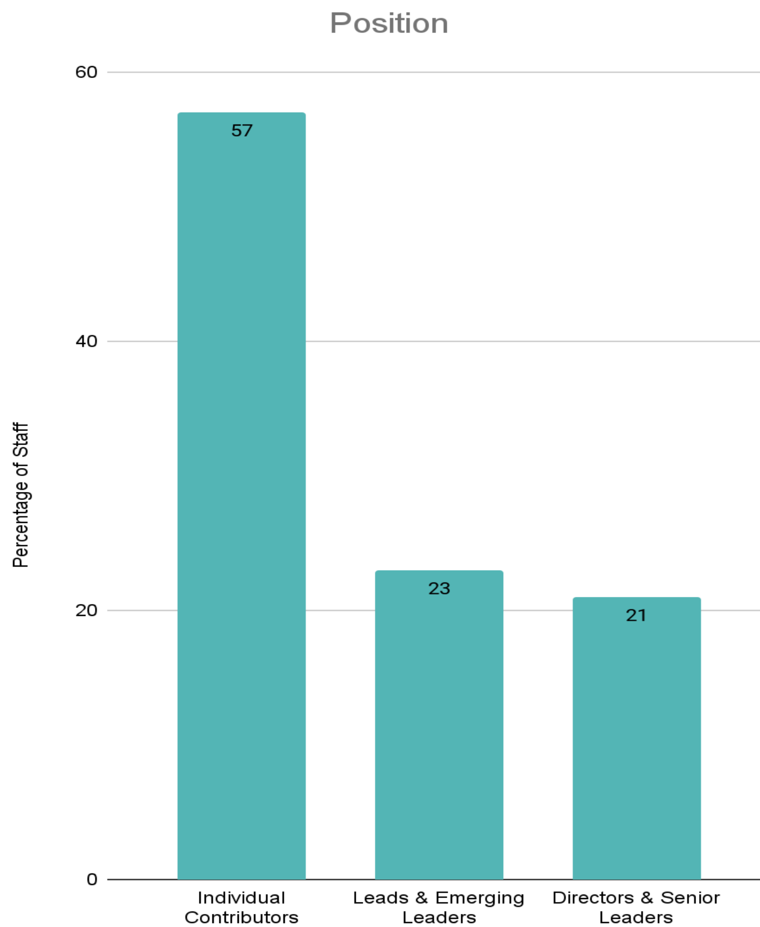
Forty-four percent (44%) of staff reported their childhood economic background as middle class, 19% as upper middle class, 26% as working class/working poor, and 4% as wealthy. Seven percent (7%) preferred not to disclose or did not respond.



The largest percentage (34%) of survey respondents have been at Health Care for the Homeless between 2-5 years.



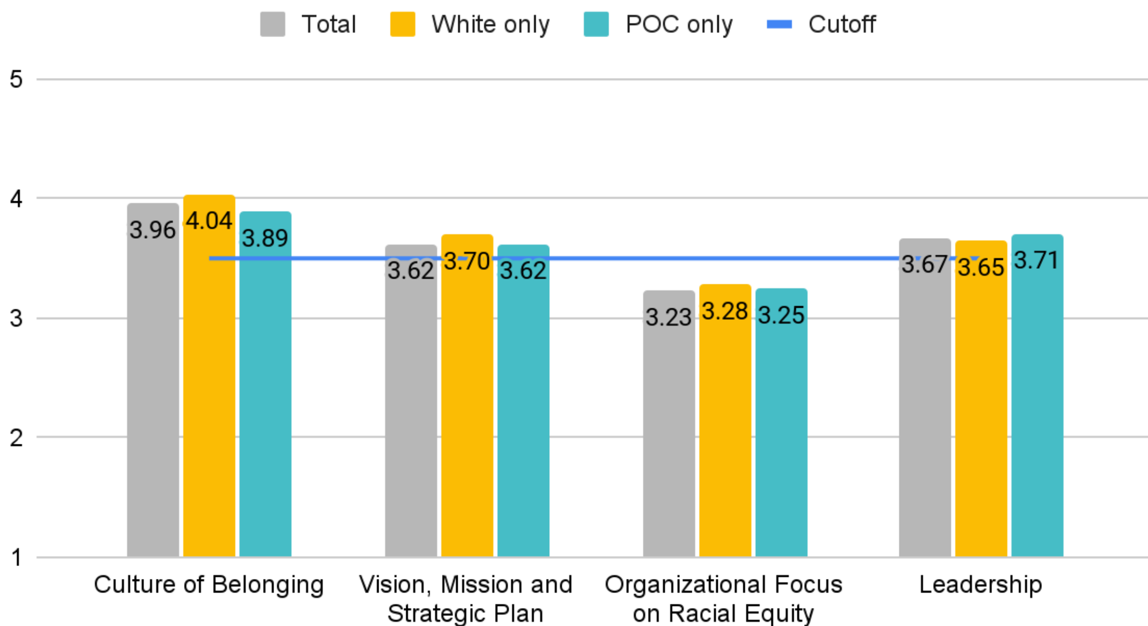
Survey respondents' roles are represented in the graph above. Respondents included 30% from Agency Administration, 19% from Allied Medical, Dental or Behavioral Health, and 19% from Behavioral Health Providers. Ten percent (10%) declined to answer.



The largest group (57%) of survey respondents were individual contributors, followed by leads and emerging leaders (23%) and directors and senior leaders (21%).

Domain Assessments

ORGANIZATIONAL CULTURE AND COMMITMENT TO RACIAL EQUITY
An ongoing and iterative commitment to racial equity including proactive efforts to address historical and current inequities experienced by people of color and other marginalized communities on staff and in communities.



The above chart summarizes the sub-domain averages for survey responses for staff overall and for white staff and staff of color. Sub-domains that fall below the cutoff line should be prioritized for improvement.

Culture of Belonging	Average	White	POC
I work with a culturally diverse staff.	4.04	4.07	4.04
My work environment is supportive of different cultural perspectives.	3.88	4.04	3.75
I feel that I am an integral part of the organization.	3.85	3.91	3.76
I experience respect among individuals and groups with various cultural differences.	4.06	4.04	4.04
I have felt that I could recommend this organization as a good place to work.	4.00	4.13	3.92
Subdomain average	3.96	4.04	3.89

Scale: 1 = Strongly Disagree; 2 = Disagree; 3 = Neither Agree or Disagree; 4 = Agree; 5 = Strongly Agree

Overall, Health Care for the Homeless is described as a “positive,” “supportive,” and “homey” workplace that offers a space for innovation and performance improvement. People feel comfortable approaching others from any level, including the CEO. There is a general sense of openness, authenticity and accountability, little micromanaging, and a high response rate to one another. Moreover, staff have appreciated the investment in building this culture of belonging, particularly through initiatives such as holiday parties, career development, and educational development. Recent additions to this programming, including an official orientation for new employees, along with more authentic discussions about equity, also amplify this work environment. Employees are energized and passionate about their work, aiming to meet clients where they are at. This is reflected in CURE’s analysis of quantitative data, as all average ratings for the “culture of belonging” subdomain and its associated items were above the cut-off value of 3.5. These ratings suggest that the culture of belonging at Health Care for the Homeless is strong. At the same time, recent changes within Health Care for the Homeless have led some staff to feel as if the organization is taking a “more corporate” turn.

Some key changes - such as the rigid implementation of policies and procedures, in addition to the reliance on hierarchical and overtly-professionalized internal practices - have contributed to a shift in Health Care for the Homeless’ organizational culture. These developments may be correlated with staff feeling progressively overwhelmed with work, less connected to their colleagues, and an atmosphere driven by a sense of urgency where employees only interact when needing something from each other. There is an interest for Health Care for the Homeless to develop more opportunities for staff members to engage with one another and receive

formal tours of other departments, especially for staff who started during the COVID-19 pandemic or are located outside of 421.

Vision, Mission and Strategic Plan	Average	White	POC
Health Care for the Homeless’ vision statement demonstrates a commitment to racial equity.	3.62	3.76	3.57
Health Care for the Homeless’ mission statement expresses a commitment to addressing racial equity.	3.41	3.53	3.35
Health Care for the Homeless’ strategic plan features specific goals and objectives around racial equity, diversity, and inclusion.	3.75	3.79	3.76
Subdomain average	3.62	3.70	3.62

Scale: 1 = Strongly Disagree; 2 = Disagree; 3 = Neither Agree or Disagree; 4 = Agree; 5 = Strongly Agree

Much like the questions related to organizational culture, most ratings for the vision, mission, and strategic plan at Health Care for the Homeless were above 3.5. This suggests that staff believe that the agency’s integration of racial equity is reflected within the vision, mission, and strategic plan. However, ratings corresponding with how well the mission statement expresses a commitment to racial equity were mixed. The overall average (3.41) falls below the cut-off and was specifically lower among respondents of color (3.35). In sum, staff do not perceive the mission statement as one that fully reflects a commitment to addressing racial equity.

Organizational Focus on Racial Equity	Average	White	POC
How much does Health Care for the Homeless focus on addressing racial equity within the workplace?	3.56	3.64	3.55
In your opinion, how much does your department focus on addressing racial equity within the workplace?	3.06	3.14	3.04
In your opinion, how much does your department focus on addressing racial equity with clients and other stakeholders?	3.14	3.21	3.12
Subdomain average	3.23	3.28	3.25

Scale: 1 = There is no focus on racial equity at all; 2 = There is rarely a focus on racial equity; 3 = There is sometimes a focus on racial equity; 4 = There is often a focus on racial equity; 5 = There is always a focus on racial equity

Across the survey, focus group and interview data, there was acknowledgement of Health Care for the Homeless' recent work to address racial inequities. Some noteworthy areas were its renewed focus on equity in external Community of Practice meetings, conversations about how anti-Black racism impacts Health Care for the Homeless as a medical provider, some improvement in organizational transparency, work to address bias and discrimination within the agency, and additional internal conversations and racial equity and inclusion. Appreciation for the current Senior Director of Equity and Engagement and the Chief Behavioral Health Officer's leadership in Race, Equity and Inclusion (REI) work were also named, along with excitement about future REI manager hires.

Despite these positive notes, noticeable areas of contention and improvement were evident regarding Health Care for the Homeless' organizational focus on racial equity more broadly. Quantitatively, we see this emerge in data from CURE's organizational assessment survey. The average ratings for this subdomain area were below the 3.5 cut-off for both staff of color and white staff. Additionally, all individual item averages were below 3.5, with the exception of Health Care for the Homeless' focus on addressing racial equity in the workplace. Qualitative data also shed more light on what these ratings mean in practice.

Consistently, CURE encountered sentiments that suggest Health Care for the Homeless' recent focus on racial equity and inclusion have been largely reactive due to the current socio-political climate in the United States. Because this type of organizational work is "trendy," staff also fear that there may not be a substantive, genuine, and long-lasting commitment to racial equity. For example, staff noted that the agency could be more explicit in discussing how the triple threat of COVID-19, the opioid epidemic, and structural racism have directly impacted clients and the work of Health Care for the Homeless.

Some pessimism about Health Care for the Homeless' lack of action and progressive outcomes for people of color was also expressed. Healthcare for Homeless presents itself as equity-focused externally through Communities of Practice and other events, but has not done enough to ensure equity in internal policies and procedures. Employees of color have described instances of racial trauma, microaggressions, and structural barriers within and outside of Health Care for the Homeless. In addition to these encounters, individual and organizational culture at Health Care for the Homeless often overlooks meaningful differences between groups and ignores how "oppressed people can oppress others." Instances where white colleagues - who may also come from gendered or religiously oppressed backgrounds (e.g., white women or white Jewish people), - sometimes rely on those identities to "prove" they understand

oppression, rather than listening to issues or recognizing that they may help reproduce white supremacy, racism, or perpetuate racial, gendered, homophobia, transphobic, or ageist harm against other staff members. Because of these occurrences, along with the wider organizational work needed, it is evident that white staff do not realize how much pain their colleagues of color must shoulder at work.

According to staff, recent REI efforts have not been accompanied by a robust feedback process anchored in staff protections and anonymity where possible. Issues of retaliation were named as major concerns for employees who would like to provide constructive feedback, but feel dissuaded to do so due to individual consequences applied to staff who have spoken up in the past, particularly those of color. Simultaneously, Health Care for the Homeless could benefit from not only representing, but incorporating more staff in its REI journey. For example, it was suggested that Health Care for the Homeless could more explicitly ask Black staff members to help shape the REI work and compensate them for that labor. There are also concerns that the REI committee currently does not have staff across all departments and work teams, including front desk, security, or CMA staff members. While many of the people on the REI committee have institutional power, they do not have direct interaction with clients. In addition to expanding inclusion, Health Care for the Homeless should also consider recognizing staff members who have previously led racial equity work as well. Beyond these sentiments, frustrations about resource allocation were also shared with CURE.

It was also mentioned that there is rarely enough time allotted in small groups or within departments for conversations about racial equity at Health Care for the Homeless. Respondents also worried that Health Care for the Homeless would be unwilling to challenge anything that could cost the agency money. For instance, staff shared anxieties that conversations about finances would cause a pause in racial equity work, rather than integrating racial equity into the financial conversations. Employees were thankful that there is a third-party REI consultant helping to guide the work, expressing concern that internal ongoing power hoarding and worship of the written word would affect Health Care Homeless' REI work.

Leadership	Average	White	POC
The Executive Team often speak about or communicate that racial equity, diversity and inclusion are important for our organization.	4.03	4.11	3.98
The Executive Team participates in and supports discussion of racial bias and inequities that occur in the workplace or in the community.	3.87	3.94	3.85

The Executive Team participates in and supports discussion of gender bias and inequities that occur in the workplace or in the community.	3.26	3.17	3.38
The Executive Team participates in and supports discussion of bias and inequities that lesbian, gay, bisexual, transgender, queer (LGBTQ) people face in the workplace or in the community.	3.25	3.06	3.42
The Executive Team is committed to treating people respectfully.	3.94	3.98	3.94
The Executive Team includes people from diverse racial or ethnic backgrounds.	3.64	3.66	3.65
Subdomain average	3.67	3.65	3.71

Scale: 1 = Strongly Disagree 2= Disagree 3= Neither Agree or Disagree 4=Agree 5=Strongly Agree

Throughout the assessment process, favorable descriptors were shared about Health Care for the Homeless leadership. The CEO, along with other senior leaders, are considered to be “approachable” and have an open door policy. Additionally, there is shared appreciation around the CEO’s email updates and their recent focus on police brutality and Baltimore. These sentiments are reinforced by the survey data, as all average ratings for leadership were above 3.5. However, two individual areas stood out as potential areas for improvement. Specifically, the Executive Team’s participation in and discussions of bias and inequities with regard to gender (3.26) and sexual orientation (3.25) were rated as less favorable on average, relative to other areas. This signals that more racial equity training may be required for senior leadership. As a mostly white leadership team who are also the highest paid staff members and are often not from the Baltimore community, a number of concerns have also been raised about leadership at Health Care for the Homeless.

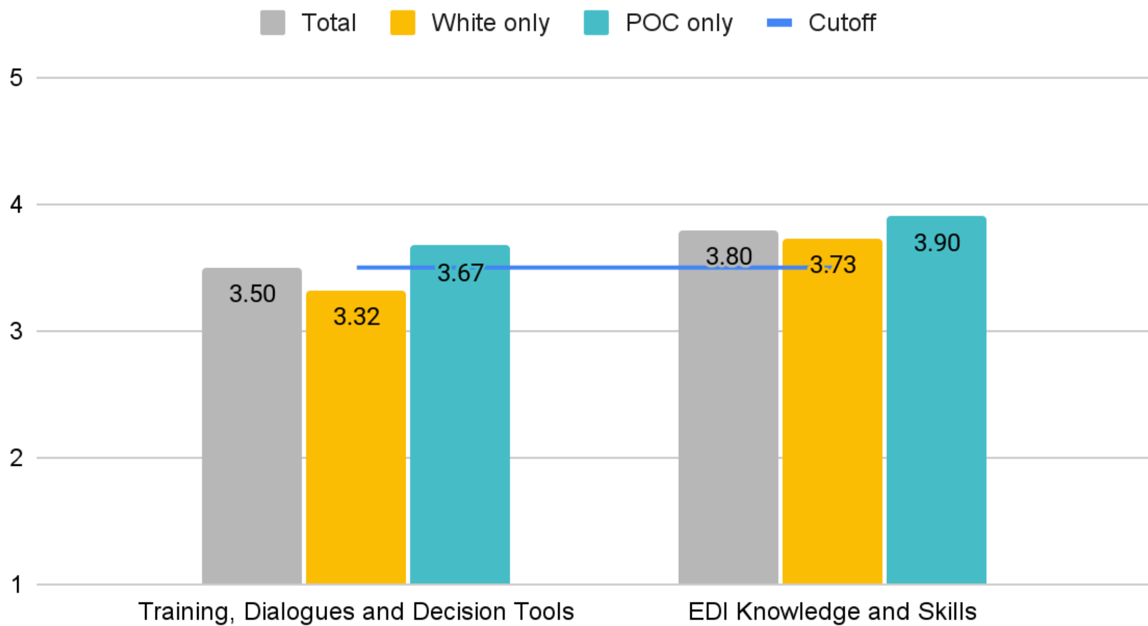
Leaderships’ need for training and professional development regarding issues of race, difference, and inequality are evident in organizational and interpersonal interactions. At times, Health Care for the Homeless leaderships’ racial equity engagements are seen as “performative”: Health Care for the Homeless talks about harm reduction and restorative justice externally but has yet to build a staff and client-centered culture internally. An example of this can be seen in the reported high staff turnover rates, which were met with statistics and defensiveness from leadership, rather than a plan to address turnover at Health Care for the Homeless. Other communications have been flagged for concern:

- The CEO’s email updates including graphic depictions of violence against Black people, can be triggering for staff of color, especially Black staff.

- Within these updates, the names of trans people harmed by structural violence are often excluded.
- In another correspondence, the inclusion of both the anniversary of the creation of the zipper and the anniversary of the acquittal of the officers that murdered Rodney King as 'fun facts' in the same email was inappropriate.

These micro-level behaviors from leadership demonstrate a pressing need for more awareness of racial equity and cultural humility.

SHARED LANGUAGE & ANALYSIS
Prioritization of individual and collaborative learning on equity topics/issues, analysis of the impact of structural and institutional racism on organizational practices, programs, and policies, leading with race and reinforcing intersectionality.



The above chart summarizes the sub-domain averages for survey responses for staff overall and for white staff and staff of color. Sub-domains that fall below the cutoff line should be prioritized for improvement.

Training, Dialogues and Decision Tools	Average	White	POC
At Health Care for the Homeless we have engaged in discussions about what racial equity means to our mission and for how we work.	0.82	0.85	0.87
I have used a racial equity tool for policy, program, services or budget decisions.	0.15	0.11	0.21
I have used a racial equity approach for policy, program, services or budget decisions.	0.36	0.40	0.33
I have received training on racial equity, diversity and inclusion while employed at Health Care for the Homeless.	0.63	0.68	0.63
Subdomain average	0.49	0.51	0.51
Health Care for the Homeless helps employees to recognize biases that foster workplace discrimination or exclusion.	3.10	2.93	3.29
The training I received on racial equity, diversity and inclusion while employed at Health Care for the Homeless was helpful.	3.63	3.58	3.70
Subdomain average	3.50	3.32	3.67

Scale: 0 = No 1 = Yes. The cutoff for these questions is below .5.
Scale: 1 = Strongly Disagree 2= Disagree 3= Neither Agree or Disagree 4=Agree 5=Strongly Agree

Both quantitative and qualitative data suggest that Health Care for the Homeless could do more to support its employees in recognizing biases and workforce discrimination or exclusion. In the survey, both staff of color and white staff rated Health Care for the Homeless as below the cut-off in this area (3.10). Sixty three percent (63%) of respondents have received training on racial equity, diversity and inclusion while employed at Health Care for the Homeless. In focus group discussions, staff expressed their needs for training, as well as a frustration that mostly senior leadership were able to participate in the *Understanding Institutional and Structural Racism* training offered by CURE. In the future, equity trainings should be made available to all staff or include a more transparent process for who is able to participate. White staff, in particular, need to become better equipped to have authentic conversations about race, racism, and racial equity with their Black and brown colleagues.

EDI Knowledge and Skills	Average	White	POC
Individual and interpersonal racism	3.92	3.74	4.12
Institutional and structural racism	3.99	3.89	4.15
Gender bias and sexual harassment	4.08	4.06	4.17
Lesbian, gay, bisexual, transgender, queer (LGBTQ) inclusion	3.75	3.72	3.81
Ableism (discrimination in favor of able-bodied people) and issues affecting people with disabilities	3.55	3.49	3.62
Class-based inequities and bias	3.92	3.83	4.06
Ageism	3.57	3.47	3.67
Intersectionality	3.35	3.40	3.29
White privilege	4.07	3.98	4.19
Subdomain average	3.80	3.73	3.90

Scale: 1 = No Knowledge 2= Aware, but little knowledge 3= Some Knowledge 4= Working Knowledge 5= Advanced Knowledge

The quantitative results highlighted above demonstrate key areas that should be addressed in the future. While most ratings for EDI knowledge and skills were above 3.5, some did not meet this threshold. Knowledge of intersectionality was rated the lowest across all groups assessed, and white respondents, in particular, rated their knowledge of ableism and ageism as lower than 3.5 as well. Within the open-ended survey responses, extended commentary was offered about multiracial and Latinx identity, intersectionality, ableism, ageism, adverse childhood experiences, harm reduction, and trauma-informed care that suggests that Health Care for the Homeless should address these areas specifically to ensure that all employees enjoy a safe and respectful environment.

Perceived Organizational Discomfort Discussing/Addressing EDI Topics	Average	White	POC
Individual and interpersonal racism	56%	51%	60%
Institutional and structural racism	41%	32%	46%
Gender bias and sexual harassment	17%	17%	19%
Lesbian, gay, bisexual, transgender, queer (LGBTQ) inclusion	26%	43%	15%
Ableism (discrimination in favor of able-bodied people) and issues affecting people with disabilities	20%	26%	12%
Class-based inequities and bias	33%	30%	38%
Ageism	13%	13%	15%
Intersectionality	26%	32%	23%
White privilege	56%	45%	69%
Subdomain average	32%	32%	33%

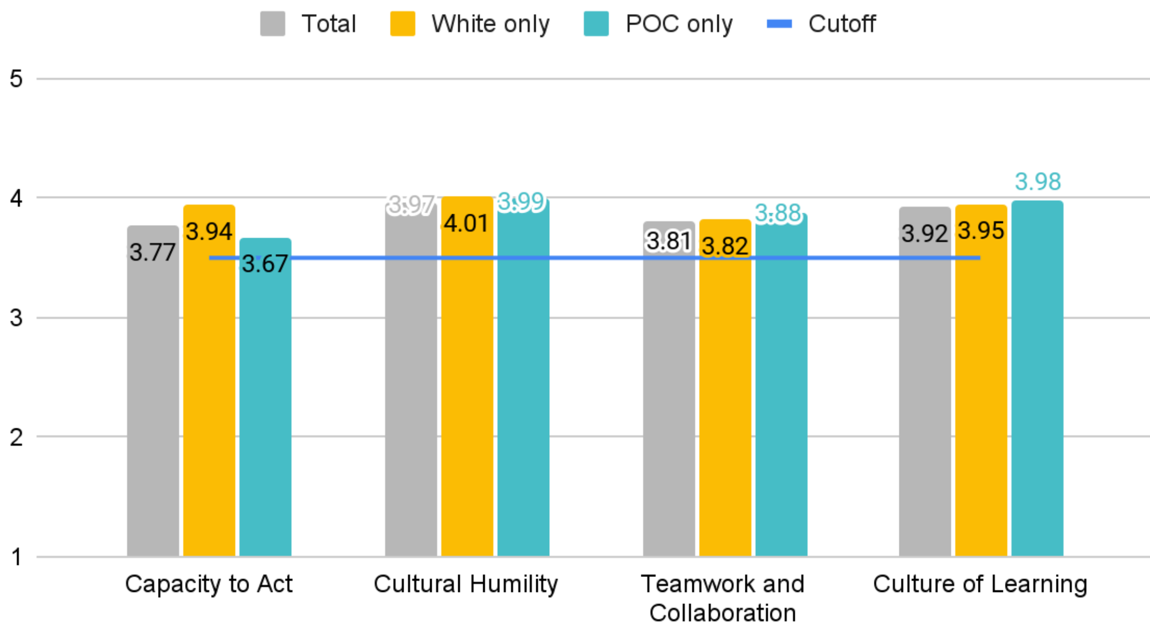
The cutoff for these questions is above 0.5.

According to the survey results, staff perceive greater organizational comfort with discussing and addressing gender bias and sexual harassment, LGBTQ inclusion, ableism, classism, ageism, and intersectionality. Conversely, white privilege and individual and interpersonal racism are areas of discomfort, with more than half of respondents indicating organizational discomfort discussing and addressing white privilege and individual and interpersonal racism. Items above 50% indicate that more than half of agency staff believe there is discomfort with discussing or addressing a reported topic. Despite these ratings, qualitative responses offer somewhat of a different perspective.

Internally, employees described receiving pushback when trying to get Health Care for the Homeless to acknowledge Black History Month, Pride Month, and Asian American Pacific Islander Heritage Month. The forced disbanding of the Health Equity Committee that organized a pride celebration, the centering of the agency's role with helping the LGBTQ community as opposed to the actual communities who champion pride (e.g., trans women and people of color), and the handling of previous staff feedback in this area have all contributed to feelings of

frustration around Health Care for the Homeless' approach to working with LGBTQ staff members.

EMPOWERED PEOPLE
Staff and organizational constituents of color are structurally situated to access power and all staff have the individual skills to practice inclusive leadership and support equity in the workplace and the communities in which they operate.



The above chart summarizes the sub-domain averages for survey responses for staff overall and for white staff and staff of color. Sub-domains that fall below the cutoff line should be prioritized for improvement.

Discrimination Experience	Average	White	POC
I have felt uncomfortable or out of place at work because of my race or ethnicity.	2.42	2.04	2.67
I have felt uncomfortable or out of place at work because of my religion.	2.11	1.95	2.16
I have felt uncomfortable or out of place at work because of my sexual orientation.	1.78	1.72	1.77
I have felt uncomfortable or out of place at work because of my disability.	2.03	1.96	1.92
I have felt uncomfortable or out of place at work because of my gender identity.	1.83	1.64	1.89
I have felt uncomfortable or out of place at work because of my perceived age.	2.18	2.13	2.16
I have felt uncomfortable or out of place at work because of my actual age.	2.02	1.94	2.00
Subdomain average	2.07	1.93	2.07

Scale: 1= Strongly Disagree 2= Disagree 3= Neither Agree or Disagree 4=Agree 5=Strongly Agree
The cutoff for these questions is 1.5 and above.

A high percentage (27%) of staff indicated that they have felt some level of discomfort because of their race or ethnicity. This includes 15% of white staff and 35% of staff of color: 40% of Asian staff members, 38% of Black employees, and 23% of Multiracial staff. Latina/x/o/Hispanic respondents were not reported due to the low number of respondents from this category.

In the table above, we explore the experiences of employees as it relates to discrimination and other adverse experiences at work. This scale, unlike others, is evaluated with a cut-off score of 1.5, as opposed to others with a cut-off score of 3.5. At CURE, we recognize that any reports of discrimination or microaggressions at work are serious. Likewise, psycho-social research affirms that people often underreport and underdefine experiences of discrimination, despite their frequent occurence. As one can see above, all areas related to discrimination experience exceed our benchmark of 1.5.

Some reported experiences of exclusion and differential treatment are shared below:

- Black staff have reported feeling singled out and that they are receiving unfair treatment compared to their non-Black colleagues. Employees of color often do not feel comfortable within the Convalescent Care Program, which may be contributing to turnover.
- Male supervisors frequently penalize female employees in yearly evaluations for being "too aggressive" and "lacking self-awareness.” This is detrimental not only emotionally, but because these are tied to compensation adjustments, economically as well.
- Queer and transgender staff have experienced poor treatment as a result of homophobia and transphobia.
- Staff report denial of disability accommodations when requested.
- There have been some racial slurs used by providers to administrative staff.

This survey data, along with qualitative feedback shared with CURE staff in workshops and other communications, suggests that Health Care for the Homeless could do more to ensure that all employees are treated with respect and feel just as valuable as other employees regardless of position or department.

Capacity to Act	Average	White	POC
All employees have a responsibility to promote workplace racial equity, diversity and inclusion.	4.41	4.64	4.25
I feel I have organizational support to promote racial equity.	3.87	4.13	3.71
If I raised a concern about discrimination, I am confident Health Care for the Homeless would do what is right.	3.51	3.60	3.46
There is support for people who share their experiences with incidents where race is a factor.	3.29	3.38	3.27
Subdomain average	3.77	3.94	3.67

Scale: 1 = Strongly Disagree 2= Disagree 3= Neither Agree or Disagree 4=Agree 5=Strongly Agree

Averages for the organization’s capacity to act were above 3.5 among all groups assessed. A few items stood out as potential areas for improvement. In particular, all groups indicated that there may not be enough support for people who share their experiences with racialized incidents, and people of color specifically reported that they aren’t as confident as white staff that their concerns about discrimination would result in rightful action from Health Care for the Homeless.

Cultural Humility	Average	White	POC
I am aware of how my beliefs, values and privileges hinder or help my understanding of the perspectives and experiences of people of different racial and cultural backgrounds from my own.	4.03	4.09	4.04
I have taken steps (for example through trainings, self-reflection, personal relationships, etc.) to understand how my biases affect how I interact with people of different racial and cultural backgrounds from my own.	4.02	4.19	3.90
I regularly have personally meaningful interactions and have learned from people of different racial and cultural backgrounds from my own.	4.15	4.23	4.15
I am familiar with the strengths and resources of the clients that we serve.	4.13	4.15	4.19
I understand how my biases impact the clients that we serve.	3.92	3.85	4.08
I feel comfortable talking about race and racism at work.	3.58	3.55	3.56
Subdomain average	3.97	4.01	3.99

Scale: 1 = Strongly Disagree 2= Disagree 3= Neither Agree or Disagree 4=Agree 5=Strongly Agree

Interestingly, employees self-assessment of cultural humility were above 3.5 on average for all groups assessed. This was true for both the subdomain-wide average and for the individual areas assessed item-by-item. These ratings suggest a disconnect between the experiences people are having and individuals' perceptions of their own actions in the workplace, since in other areas of the survey and assessment, respondents have explicitly reported or demonstrated discomfort talking about race and racism, a lack of understanding about how privilege impacts people from different backgrounds, and a concern about "white-savior" approaches to client-relationships.

Teamwork & Collaboration	Average	White	POC
My environment encourages teamwork and collaboration.	4.06	4.02	4.16
Agency leadership supports collaboration between teams and departments.	3.60	3.64	3.63
Subdomain average	3.81	3.82	3.88

Scale: 1 = Strongly Disagree 2= Disagree 3= Neither Agree or Disagree 4=Agree 5=Strongly Agree

Teamwork and collaboration were rated strongly among all groups, with the subdomain average and the average scores for all items falling above the threshold of 3.5. Generally, staff feel that they can go to anyone and ask for help with a client or for more information. Nevertheless, there is sometimes tension between different departments: depending on the department or area, greater concentrations of information silos are prevalent. In our engagement with Health Care for the Homeless staff and in our review of qualitative data, CURE was informed that clinicians and other sector-specific employees often are siloed within their professional focus. As a result, these staff members miss out on trainings, cross-agency collaboration and thought-partnership, and team building activities.

Culture of Learning	Average	White	POC
Health Care for the Homeless has a culture that encourages learning, growth, and change.	3.93	3.94	4.04
Health Care for the Homeless is making positive changes to its culture.	3.91	3.96	3.92
Subdomain average	3.92	3.95	3.98

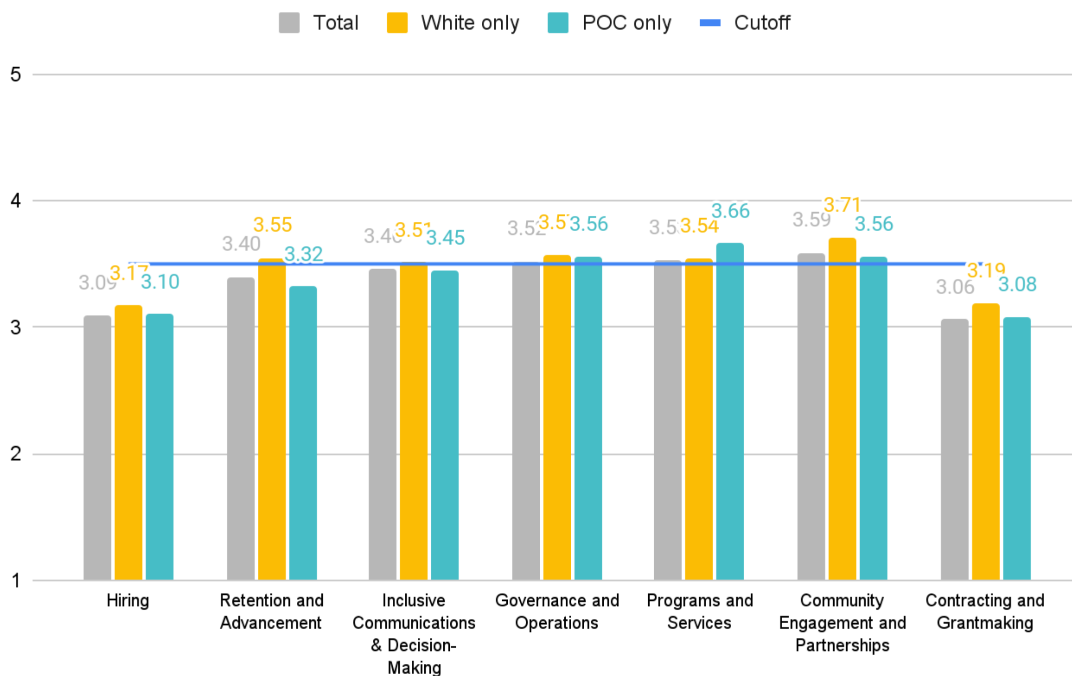
Scale: 1 = Strongly Disagree 2= Disagree 3= Neither Agree or Disagree 4=Agree 5=Strongly Agree

In the table above, responses regarding Health Care for the Homeless' culture and promotion of learning, growth and change are provided. Average subdomain scores and individual item averages were all above 3.5 for all groups, suggesting that Health Care for the Homeless promotes a culture of learning. When exploring qualitative data, CURE found more information about how this manifests in practice. Both within CURE workshops and within focus groups, interviews, and long-form survey responses, staff members took time to offer positive affirmations about Health Care for the Homeless' racial equity journey and wider organizational

culture. Similarly, others shared appreciation for the workshops, trainings, and learning opportunities that Health Care for the Homeless offers staff on an ongoing basis.

To enhance this culture of learning, CURE also noted areas needing attention - one of which being the tuition reimbursement policy. Specifically, while some staff members have been able to use the tuition reimbursement policy to receive additional degrees and get promoted, there are concerns that tuition reimbursement is uneven across the board. Inequities about this program were also highlighted. For instance, medical providers receive more tuition reimbursement than peer advocates.

EQUITABLE POLICIES AND PRACTICES
Written and enforceable policies and practices that specifically prioritize equity across key areas.



The above chart summarizes the sub-domain averages for staff overall and for white staff and staff of color. Sub-domains that fall below the cutoff line should be prioritized for improvement.

Hiring	Average	White	POC
Outreach for hiring new employees is broad and includes a variety of strategies to recruit racially and culturally diverse staff members.	3.13	3.26	3.15
Health Care for the Homeless job postings explicitly encourage applications from underrepresented groups such as people of color, women, LGBTQ people and people with disabilities.	3.05	3.09	3.04
Subdomain average	3.09	3.17	3.10

Scale: 1 = Strongly Disagree 2= Disagree 3= Neither Agree or Disagree 4=Agree 5=Strongly Agree

In the table above, average ratings related to hiring were rated below the cut-off value by all groups. Individual item averages were also all below 3.5, indicating hiring processes should be prioritized to support racial equity. Earlier in this report, it was noted that senior leadership at Health Care for the Homeless is mostly white. Through our assessment, we also discovered that the Management team and clinical staff are mostly white, while frontline staff are predominantly of color. In addition to this inequity, respondents shared that Health Care for the Homeless may not be as deliberate in recruitment for positions outside of board members and senior leadership.

Staff members also raised concerns that interview questions are not centered around diversity, equity, or inclusion. This may be impacted by administrative and access barriers within the hiring process. Consequently, there is a lack of Asian Americans and Spanish-speaking staff members in the agency. Additionally, while Health Care for the Homeless has been able to hire a number of Black staff including Black men, many felt that these hires have been for the most part limited to facility, security, front line positions, and entry-level work.

With these findings taken together, it is clear that more equitable hiring practices are needed at Health Care for the Homeless. While the Behavioral Health team has become racially diverse, staff expressed excitement about working to diversify the agency's psychiatrists. Relatedly, there is interest in developing additional deliberate recruitment strategies especially for medical professionals from the Historically Black Colleges and Universities in the area. Staff members are particularly interested in having the agency place a focus on Black Case Managers through

recruitment. There have been discussions about developing a pipeline program for people in the community to receive funding for their education towards becoming a nurse and then a job at Health Care for the Homeless as a nurse upon graduation.

Retention and Advancement	Average	White	POC
Opportunities for training and professional development are distributed fairly and transparently.	3.30	3.34	3.35
Performance reviews are based on objective criteria that minimize personal biases and prejudices.	3.50	3.64	3.44
I receive recognition and praise for my good work similar to others who do good work.	3.58	3.55	3.63
I am confident that my compensation is fair and equitable when compared to others with similar job titles and performance reviews.	2.92	3.28	2.71
When there are career advancement opportunities, I am aware of them.	3.51	3.51	3.54
Staff of my racial background remain long-term employees.	3.52	3.83	3.38
Staff of diverse ethnic, racial and cultural backgrounds are equitably promoted.	3.18	3.43	3.00
I see myself still working here in two years.	3.65	3.81	3.54
Subdomain average	3.40	3.55	3.32

Scale: 1 = Strongly Disagree 2= Disagree 3= Neither Agree or Disagree 4=Agree 5=Strongly Agree

Among the total sample (3.40) and among people of color in particular (3.30), average ratings for retention and advancement were below the cut-off value. Both staff of color and white staff indicated that staff of diverse racial and cultural backgrounds are not equitably promoted. Additionally, when asked whether they believe their compensation is fair and equitable compared to others with similar titles and performance, most staff disagreed. A noticeably lower level of agreement was reported by staff of color (2.71) than that of white staff (3.28) to this question. People of color also reported that staff of their racial background less commonly remain long-term employees. In qualitative responses, staff offered more clarity regarding these ratings.

Throughout the assessment process, employees have acknowledged that, while there have been many internal promotions, many of these positions have gone to white candidates. Instead of addressing staff concerns, Health Care for the Homeless often fosters discussions about possibilities for advancement within the organization that echo shared myths about upward mobility. Social scientists and economists have illustrated that upward mobility, particularly as it connects to race and other factors, is not attainable on the wide-spread level often suggested by peers, media, and social institutions. Concrete examples of this inequity can be seen at Health Care for the Homeless, as staff of color are often in lower-paying jobs at Health Care for the Homeless and pathways to advance to the next level are unclear. Beyond this, concerns about salary were expressed in focus groups, interviews and open-ended survey responses.

In our survey, white men (3.80) were also more likely to be confident that their compensation is fair and equitable when compared to others with similar job titles and performance reviews than other groups by race and gender: white women (3.14), women of color (2.69), men of color (2.58). While there have been some conversations about paying people who have multiple language skills additional compensation, the conversations have not yet produced any changes.

Staff expressed a need for clearer standards on how to receive a promotion and that they are not always aware when promotional opportunities are available. There are concerns that the agency overvalues academic degrees rather than past job performance when considering promotions. Additionally, when hiring for Chief positions is delayed, it has left a number of staff unsure of their future with the agency.

Staff also raised concerns that hourly workers, who are predominantly of color, at Health Care for the Homeless have to take time off of work to get COVID-19 vaccinations, while salaried employees are able use their administrative time or their flexible time to get vaccinated. When staff tried to advocate for hazard pay for employees who were working on the front lines throughout the pandemic, they felt as though they were repeatedly told that the agency does not have enough money to provide hazard pay, all while giving promotions and pay increases to already highly paid positions. Other concerns regarding salary inequities at Health Care for the Homeless include:

- inconsistent raises in general
- percentage-based merit raises that impact people in higher-paid positions more favorably

- male employees having higher salaries than female employees in the same positions
- lack of a cost of living adjustment last year which had an especially negative impact on lower paid workers

There is also significant frustration amongst staff that the agency has not had a clear message around how it plans to spend the more than $2 million from the Coronavirus Aid, Relief, and Economic Security (CARES) Act funds that it will receive. The frustration comes from staff members often receiving much less, sometimes only half, of the salary that they could make working at other similar medical providers in the area. Some staff at Health Care for the Homeless are living paycheck to paycheck. This was described as a "very serious issue" that should be a "top priority."

Staff members were concerned about the large number of people who have left the agency, noting that according to job satisfaction surveys, behavioral health counselors in particular may be experiencing higher levels of burnout and leaving Health Care for the Homeless. Staff also noted that policies and actions including discipline and firing of employees, has had an especially adverse effect on Black employees. The following were listed as reasons staff may have left Health Care for the Homeless:

- Lack of BIPOC especially Black leadership
- Undermining and questioning staffs' decisions
- Microaggressions especially from management level staff
- Cliquish culture
- Lack of staff input in decision-making
- A corporate culture that emphasizes the bottom line rather than clients
- Being asked to fill out REI focused surveys but seeing little action taken because of them
- Feelings that people have been promoted based off of friendships
- Promoting people who were not ready for the positions that they were put in
- Racial inequities in promotions
- Lack of pay equity
- Distrust that information shared with Human Resources will be kept confidential

It was suggested that being more systematic with conducting and analyzing exit interviews when employees leave, providing more training and training guides, and hosting retreats and workshops on self-care and avoiding burnout may help to address turnover at Health Care for the Homeless.

Inclusive Communications and Decision-Making	Average	White	POC
When decisions are made that directly affect my work, I am included in the decision-making process and/or review of a proposed decision prior to it being finalized.	3.01	3.28	2.83
Supervisors and managers in my chain of command encourage employees to speak up when I have concerns.	3.70	3.72	3.69
Supervisors and managers in my chain of command coach me on the most effective ways to speak up when I have concerns.	3.26	3.30	3.25
Supervisors and managers listen to my ideas.	3.89	3.91	3.90
Efforts are made to ensure information is shared consistently throughout Health Care for the Homeless in a timely manner.	3.43	3.36	3.56
Subdomain average	3.46	3.51	3.45

Scale: 1 = Never 2= Rarely 3= Sometimes 4=Usually 5=Always

Ratings of inclusive communication and decision-making were below 3.5 for the total sample and among staff of color across many of the items explored in this subdomain. Additionally, staff of color and white staff reported below cut-off ratings for being included in decisions that directly affect their work before those decisions are finalized, and receiving coaching from supervisors and managers on ways to speak up about concerns. Responses also differed by position within the organization. Individual Contributors (2.72) were less likely than staff from other positions: Leads & Emerging Leader (3.04), Directors and Senior Leaders (3.77) to feel that when decisions are made that directly affect their work, that they are included in the decision-making process and/or review of a proposed decision prior to it being finalized. Overall, the survey data indicate there are not enough efforts to ensure information is shared consistently and in a timely manner throughout Health Care for the Homeless. These survey findings correlate with several key themes that emerged in the focus groups, interviews and open-ended survey responses:

- Experiences with feeling up-to-date on information and involved in decision-making vary by department and manager. Some all-staff meetings have shifted to include a focus on leadership getting to know specific teams and team members. Many members of the Executive team have an ‘open door policy’ and numerous staff members described strong relationships with supervisors, where they can provide feedback and trust that their supervisor will act on or elevate the feedback as needed. Recently, some staff have

also been asked to help write certain policies and procedures. Others noted instances where decisions were slowed down in order to ensure more collaboration and group decision-making showing that it can occur at Health Care for the Homeless. The agency is doing work to look at innovative ways to make workflows more efficient for staff and services better for clients. Unfortunately, some staff feel as though their expertise is questioned by managers.

- Staff of color, direct care, and clinical staff in particular have found it more difficult to feel like they have a voice, feel like they can propose changes, or feel like they have tools and the resources that they need to institute change. Others shared that hierarchy and bureaucracy slow down communication and work.

- Staff shared that some of the meetings where people can talk with the Executive team have an agenda driven by the Executive team rather than an open conversation or an agenda driven by staff. Some employees have become skeptical of all-staff meetings, noting that they may be a good place to acknowledge anniversaries and birthdays but not to try and have important conversations as has happened in the past, as staff may have a lot to share but may not feel comfortable speaking up in a large group setting. It was noted that staff members could be given more notice if they are going to be expected to speak at an all-staff meeting.

Pre-COVID, there were more opportunities to talk with upper-level management including the Executive team. For example, Health Care for the Homeless used to have an Innovation Challenge but that is not currently taking place. More opportunities, such as the monthly brown-bag lunches held in prior years, could help provide forums to exchange ideas with staff and support change at the agency outside of all-staff meetings. Additionally, including non-leadership in decision-making, cross-team communication, and creating an environment where staff do not fear retaliation for sharing ideas and feedback could all be improved at the agency.

Governance and Operations	Average	White	POC
Policies promote fair treatment of employees regardless of their race and culture.	3.71	3.77	3.73
Personnel policies and procedures are flexible enough to accommodate staff members' unique circumstances.	3.44	3.60	3.42
Dress and appearance in the workplace is non-discriminatory.	3.90	3.87	3.98
There is a clear process to confidentially report grievances and instances of unfair treatment.	3.42	3.40	3.50
I feel I can report grievances and instances of unfair treatment without negative consequences.	3.26	3.30	3.35
I trust Health Care for the Homeless to be fair to all employees.	3.38	3.49	3.37
Subdomain average	3.52	3.57	3.56

Scale: 1 = Strongly Disagree 2= Disagree 3= Neither Agree or Disagree 4=Agree 5=Strongly Agree

Average ratings for the governance and operations subdomain were slightly above the cut-off value among all groups. However, some individual areas were rated below 3.5, suggesting areas for improvement. Specifically, staff of color (3.37) and white staff (3.49) indicated lower trust in Health Care for the Homeless to be fair to all employees. Similarly, staff expressed hesitancy (3.26) in feeling that they could report grievances and unfair treatment without negative consequences. Across the total sample and among people of color in particular, personnel policies and procedures may not be flexible enough to accommodate staff members' unique circumstances. According to qualitative responses, some agency policies and procedures that are creating or reinforcing existing inequities include:

- Some departments receiving recognition while other departments are barely recognized for good work
- Hourly workers are written up for being late while salaried workers are not reprimanded for being late
- Facilities and security staff members have had to go into Health Care for the Homeless during snow days, even when the clinic was closed but other staff were allowed to telework
- The lowest paid staff have to pay the same amount for their health care plans as "Chief" level staff

- Optional all-staff meetings especially those focused on supporting each other after difficult events occur, are often held during clinic hours resulting in most clinicians not being able to attend
- Spaces including the clinic at 201 not accounting for staffs' diverse needs including pregnancy
- The agency's family death policy centers an Anglo definition of family
- Lack of a clear process for reporting grievances
- Referring staff to the Employee Assistance Program (EAP) without first building trust with them
- Staff members being uncomfortable raising concerns for fear of job security or being retaliated against
- Lack of standardized policies and procedures on the clinical side

Some staff feel that the Executive team, the Human Resources team, and the managerial team genuinely want to support employees even if they do not always know how to. Staff shared examples where Human Resources was helpful in deescalating interpersonal conflict within the agency.

Staff members were appreciative of the number of free therapy sessions Health Care for the Homeless provides as part of its benefits package and staff enjoyed when the Housing Services Department provided training for their staff around trauma-informed care from a self-care perspective. Employees noted that the agency deployed more than 100 computers and worked to increase bandwidth on the server when staff members had to telework due to COVID-19.

Programs and Services	Average	White	POC
In your opinion, how much does Health Care for the Homeless focus on addressing racial equity in its programs and services?	3.53	3.54	3.66

Scale: 1 = There is no focus on racial equity at all 2= There is rarely a focus on racial equity 3= There is sometimes a focus on racial equity 4= There is often a focus on racial equity 5= There is always a focus on racial equity

Although the average rating here is slightly above 3.5, there is room to strengthen how Health Care for the Homeless focuses on racial equity in its programs and services. Staff noted that there are few discussions around intersecting identities, especially gender and sexual orientation for clients, with some staff sharing that they have been told that LGBTQ services are not needed as the agency does not have a large LGBTQ client population. However, staff argued that the agency should be more explicit in communication that it offers 'gender affirming' care

to transgender people. It was suggested that Health Care for the Homeless could do additional work to restore a positive reputation in the community about how it treats trans clients as Black trans women clients in particular may not have had good experiences with the agency.

Many staff members serve clients from a place of humility and assuming positive intent. Health Care for the Homeless recently has begun to talk about how people are treating clients, in a more deliberate way. Clients reported appreciation for services, convenience of interactions when receiving care, and feeling understood by staff who went “above and beyond” in their service. However, staff and clients agreed that Health Care for the Homeless could do more to ensure a culture of respect is present from staff to clients. Additional areas that the agency should work to address were identified in qualitative data. Some of them include:

- Client spaces are not allergen free
- Staff recommending that families separate when services are provided
- Clients do not have places to keep important documents
- There are strict client protocols including only a 15 minute grace period for appointments
- Clients are not given notice when a specific staff member is leaving the agency and appropriate arrangements are not always made for clients when a staff member leaves
- Lack of confidentiality with some patient information and lack of transparency with other information
- Services are not always provided from a trauma-informed approach that acknowledges the economic, psychological, mental, and physical trauma clients may be experiencing
- Clients feel that they cannot provide feedback on services for fear of losing those services
- Lack of training for client facing staff members
- Lack of ‘peer advocate’ style training for supervisors in client facing roles
- Promised changes to the physical layout of buildings that would support safety for all have not been followed through on
- Little calling back of clients, incorrect scheduling, lost paperwork
- Not enough staff members and capacity to complete the work
- Unachievable targets for staff to complete
- Lack of staff respect for homeless people in general
- Hours of operation, including not being open in the evening, that are not client-centered
- Lack of opportunities for clients to directly shape services

While there have been some conversations about anti-Blackness at Health Care for the

Homeless, staff noted that anti-Black racism continues to impact how clients are served at the agency. Although there has been some work done around securing third-party translation services to better serve Spanish speaking clients, much of this work has been paused due to COVID-19.

Externally, Health Care for the Homeless could do more to address inequities relating to the communities it serves. There is interest in conducting an explicit analysis of the harms that the agency has perpetuated or continues to perpetuate against different communities in Baltimore and in the region and utilizing a reparations approach to services. Staff are also seeking more tools and resources for anti-racist clinical practices.

Community Engagement and Partnerships	Average	White	POC
In your opinion, how much does Health Care for the Homeless focus on addressing racial equity in its community engagement and partnerships? (elected officials, donors, community-based organizations, etc.)	3.59	3.71	3.56

Scale: 1 = There is no focus on racial equity at all 2= There is rarely a focus on racial equity 3= There is sometimes a focus on racial equity 4= There is often a focus on racial equity 5= There is always a focus on racial equity

Contracting and Grantmaking	Average	White	POC
In your opinion, how much does Health Care the Homeless focus on addressing racial equity in its contracting?	3.06	3.19	3.08

Scale: 1 = There is no focus on racial equity at all 2= There is rarely a focus on racial equity 3= There is sometimes a focus on racial equity 4= There is often a focus on racial equity 5= There is always a focus on racial equity

All racial demographic groups reported that Health Care for the Homeless focuses adequately on addressing racial equity in its community engagement and partnerships, with all average subdomain scores above 3.5. At the same time, the ratings for contracts and grantmaking were below the cut-off value among all groups, suggesting that contracting practices at Health Care for the Homeless can be improved.

While many staff were excited about the agency's Community of Practices, staff noted that not all staff, especially clinical staff, are able to attend due to the timing of the Community of Practice. Staff also expressed concerns that because the Baltimore Police Department (BDP) is invited to serve as panelists at Community of Practice events to talk about issues of restorative

justice and community safety, that the agency is elevating the BPD as subject matter experts in the space rather than grassroots organizations and community organizers. Staff members noted that the Community of Practices could also be more interactive than they have been historically.

Many undocumented Latinx immigrant clients do not have health insurance. Health Care for the Homeless could be more explicit in its public policy work around alternatives to racist immigration policies in the United States and ensuring that undocumented clients can receive Medicaid. Health Care for the Homeless leadership has not been as outspoken about violence and hate crimes against Asian American communities. The lack of a race explicit focus in conversations around how to serve clients has led some to feel that the agency has a ‘white savior complex’ where well meaning individuals work for the agency but there is a hesitation to be race explicit when discussing client services.

Staff were interested in expanding mobile services, medical outreach components and having a larger presence within the community, including at community fairs. Staff noted that building larger visibility especially with the Black community in Baltimore could be beneficial. Providing staff members additional training on program development and community building could help to promote greater racial equity in interactions with community, and in partnering with other agencies especially health education agencies that may be able to share resources that could be helpful for reducing racial health inequities. Staff noted that Health Care for the Homeless could be more explicit in conversations with stakeholders including donors and partners about the agency’s renewed commitment to racial equity.

Conclusions and Call to Action

Health Care for the Homeless has taken affirmative steps to reinforce its commitment to racial equity, including focusing on racial equity in strategic planning and across the organization. The agency has also worked to build a positive and supportive culture with approachable members of leadership, a broad sense of teamwork, and a culture of learning. Other achievements include the diversification of the Behavioral Health team, the Executive team, and the Directors, along with a prioritization of internal advancement and promotion. Moreover, decisions have been slowed down in order to ensure more collaboration and group decision-making. During the pandemic, Health Care for the Homeless worked to support its staff by providing free therapy sessions, training around trauma-informed care, and computers. These actions offer a pathway forward in Health Care for the Homeless' equity journey.

Health Care for the Homeless, however, can have more explicit discussions about racial equity and how structural racism has directly impacted clients and its work. The agency can do more to increase knowledge of Race, Equity and Inclusion (REI) concepts among leadership and provide more REI focused training and discussions to all staff. Health Care for the Homeless can work to address discrimination and feelings of discomfort. The agency can better recruit, hire, and promote BIPOC (Black, Indigenous and People of Color) staff, ensure that staff have a role in decision-making, and can set targets for procurement with BIPOC businesses and organizations. Health Care for the Homeless can do more to ensure that all policies and procedures for both staff and clients alike have a racial equity focus.

CURE believes Health Care for the Homeless can be an anti-racist organization that practices actively works to dismantle oppressive systems that contribute to racial inequities in health care. Health Care for the Homeless can ensure its mission and vision reflect collaborative racial equity priorities from communities served. Additionally, Health Care for the Homeless leaders and staff can better articulate the importance of racial equity to their work and continually cultivate skills and capacity to practice racial equity. Health Care for the Homeless is well positioned to be a place where staff have a voice and trust they have power and ownership in decision-making and accountability for racial equity. Health Care for the Homeless can facilitate improved capacity of BIPOC communities to co-design programs, services, systems and policy solutions that dismantle structural racism and improve outcomes in communities of color. Additionally, Health Care for the Homeless can become a place where BIPOC staff are hired, supported, retained and have equitable opportunities to advance. Health Care for the Homeless can use restorative justice and trauma-informed processes to respond to racialized incidents and other forms of harm, and can advance racial economic justice through contracting and grantmaking.

With this vision in mind, and based on the findings of the assessment, CURE is recommending a non-exhaustive series of interventions to address institutional and interpersonal inequity at Health Care for the Homeless.

Organizational Culture and Commitment to Racial Equity

- **Review the Current Make-up of the REI Committee to Ensure There is Representation From All Departments and Staff Levels**

  Ensuring that staff members from across the agency are able to influence the REI work supports power-sharing and increased engagement as more staff feel as though their voice matters in the change process

- **Develop More Opportunities for Staff Members to Interact with one Another and Receive Tours of Other Departments**

  Creating additional ways for staff members to meet with and understand the work of their colleagues builds a culture of connection at Health Care for the Homeless

- **Compensate BIPOC Staff and Provide Time-Off for Self-Care Especially among Black Staff Members Leading the REI Work**

  The organization's REI work has accelerated in the last year in large part due to the movement for Black Lives. Explicit recognition of the underlying drivers of change occurring at Health Care for the Homeless and compensation for the expertise, leadership and emotional labor of Black staff and staff of color in the change process signals that Health Care for the Homeless values these contributions.

- **Ensure Every Member of Leadership has an Explicit Plan to Increase Their Knowledge Around REI Concepts Including Gender Bias and LGBTQ Bias**

  Developing plans for members of leadership to become more knowledgeable on equity issues fosters the conditions for equitable treatment and outcomes for staff and clients with marginalized identities at Health Care for the Homeless

Shared Language and Analysis

- **Ensure Future Equity Trainings Are Open to All Staff and that Staff Receive Tools and Resources to Support Anti-Racist Clinical Practices**

  Providing opportunities for all staff members to attend equity trainings provides a foundation for building shared language and analysis of equity topics and issues and how those learnings can be put into practice at Health Care for the Homeless

- **Develop Additional Training Opportunities for All Staff Focused on Multiracial Identity, Latinx Identity, Adverse Childhood Experiences, Harm Reduction, Trauma-Informed Care, and Intersectionality**

  Specialized training to further build knowledge and skills is essential for equipping staff with the tools, resources and support needed to create an inclusive, safe and affirming experience for colleagues and clients

- **Create a Calendar of Events that Celebrates Marginalized Identities and Their Histories Including but not Limited to Black History Month, Pride Month, and Asian American Pacific Islander Heritage Month**

  Greater intentionality around recognizing cultural and identity-based observances fosters a practice and environment of more explicit celebration and honoring of the rich diversity and strengths of Health Care for the Homeless' staff, clients and communities served by the organization

- **Reinstate the Health Equity Committee and Allow for Them to Directly Shape Programming for Staff and Client Services at the Agency**

  Staff noted the value that the Health Equity Committee brought to the agency including activities focused on LGBTQ communities that could be deepened by reinstating the committee or supporting a similar team to take on the work that the committee led.

- **Conduct an Analysis of the Harms that the Agency has Perpetuated and Continues to Perpetuate and Utilize a Reparations Approach to Services**

  Situating client services within a reparations model addresses past and on-going harms

caused in the community

Empowered People

- **Develop a Plan to Address the Differential Treatment of Staff Based on Race, Sexual Orientation, Disability, Department and Other Forms of Difference**

  Creating a plan to follow up on every single report of discomfort increases the sense of accountability, builds trust that concerns and grievances will be taken seriously, and develops a culture of no tolerance for differential treatment.

Equitable Policies and Practices

Hiring

- **Engage in Additional Deliberate Recruitment of BIPOC Medical Professionals and Case Managers**

  Expanding recruitment efforts to intentionally target potential employees of color including Black men ensures that clients are receiving services from someone who looks like them

- **Review Interview and Other Hiring Procedures for Their Potential Equity Implications**

  A detailed review of job announcements, degree requirements, and interview protocols can reduce bias and offer an opportunity to expand how equity is operationalized in the organization's hiring processes

Retention and Advancement

- **Practice Salary Justice**

  Some primary steps towards Salary Justice include increased transparency regarding salary bands for all current and future positions, correcting and maintaining salary equity across gender and racial demographics, and considering salary disparity adjustment models. Sharing additional information on compensation will allow for staff members to make informed decisions about their career, along with allowing them to advocate for more equitable pay with similar positions. A salary disparity adjustment

model would ensure that those at the top do not continue to drastically out-pace lower earners through percentage increases.

- **Engage in an External Compensation Study to Ensure Equity in Pay and Raises**

  Ensuring equitable compensation at the agency retains staff members across all areas of Health Care for the Homeless

- **Create Clear Promotional Pathways**

  Developing clear promotional pathways and ensuring that staff members are able to grow at Health Care for the Homeless will retain knowledgeable and experienced team members and allow for staff from diverse backgrounds to see themselves at the organization for the long-term.

- **Develop Additional Job-Specific Training Opportunities Including Written Training Guides**

  Creating additional training ensures that new employees or employees transferring positions are set up for success

- **Conduct Systematic Analysis of Employee Exit Interviews**

  Analyzing exit interviews helps the agency to better understand the reasons why employees leave so that it can work to address them

- **Host Retreats and Workshops on Self-Care and Avoiding Burnout**

  Health Care for the Homeless can reinforce self-care as an organizational value by creating spaces and opportunities for staff to receive organizational and peer support that prioritizes wellness and reduces employee burnout and turnover

- **Develop a Plan Around How the Agency Plans to Spend CARES Act Funding**

  Communicating how the agency plans to spend future money responds to staff needs and addresses employee concerns about retention and funding for positions

Inclusive Communications and Decision-Making

- **Allow Staff to Drive the Agenda for Any Meetings that Include the Executive Team**

  Ensuring that staff members are able to help create the agenda for meetings with leadership supports a non-hierarchical culture focused on accountability and mutual respect

- **Provide Forums That Prioritize Staff of Color, Direct Care Staff, and Clinical Staff for Leadership to Listen to and Exchange Ideas with Staff**

  Developing additional opportunities for feedback and input will allow staff to make decisions and innovate together

Governance and Operations

- **Review All Policies Including but not Limited to the Non-Discrimination Policy, Family Death Policy, Tuition Reimbursement Policy for Their Equity Implications**

  Creating policies that are reflective of the different needs and experiences of marginalized staff members helps to address systemic inequities for staff at the agency

Programs and Services

- **Secure Third-party Translation Services to Better Serve Spanish Speaking Clients**

  Bringing in third-party translation services ensures that clients needs are being met and that multilingual staff members are not overburdened and can focus on providing culturally responsive services

- **Ensure that the Agency's Advocacy Agenda Includes a Focus on Immigration Policies and Undocumented People Receiving Medicaid**

  An immigration focused agenda in the agency's public policy work would align with a core priority to improve health care coverage for Health Care for the Homeless' immigrant clients.

- **Develop Explicit Communication that Health Care for the Homeless Offers Gender Affirming Care to Transgender People**

  Ensuring that clients know they will receive gender affirming care addresses historical harm and allows clients to receive the tailored services they need

- **Develop a Plan to Address the Client-Focused Issues Raised in This Assessment**

  Several opportunities for improvement and applying an equity lens to client services were identified including the need for more consistent application of trauma-informed approaches to service delivery and opportunities for clients to provide feedback on services received and to directly shape Health Care for the Homeless' services.

Community Engagement and Partnerships

- **Review Community of Practices Timing, Panelists, and Agenda to Ensure Racial Equity**

  Ensuring that more staff members can attend and contribute to Community of Practices will help Health Care for the Homeless advance its racial equity agenda more cohesively throughout the organization.

- **Expand Mobile Services and Medical Outreach Components of the Clinic**

  Meeting clients where they are through expanded services increases Health Care for the Homeless' reach, impact and ability to serve a wide variety of clients

- **Develop a Larger Presence within the Community, Especially within the Black Community in Baltimore, Including Attending Community Fairs**

  Creating a presence within communities of color in Baltimore ensures that clients from different races and backgrounds are being served

- **Provide Staff Members Additional Training on Program Development and Community Building**

  Developing opportunities for staff to be trained in program development and community building will help to institutionalize equitable community engagement

practices across the organization.

- **Review Donor and Partner Materials for Their Explicit Focus on Racial Equity**

  Health Care for the Homeless can ensure that external parties are knowledgeable of the agency's commitment to racial equity through its donor and partner materials and through the creation of guidelines for donors and partnerships that align with this commitment.

Contracting and Grantmaking

- **Set Procurement Goals with BIPOC Contractors**

  Determining targets for spending with small businesses started by Black, Indigenous, Latinx and Asian American business owners supports economic justice in communities of color

Appendix: Document Review and Analysis Summary

CURE reviewed approximately 20 documents as part of the organizational assessment process. As with other components of the assessment, the document analysis provided an additional view into how Health Care for the Homeless is currently institutionalizing racial equity and offered opportunities to highlight areas for further improvement, growth and transformation. One key takeaway from the document analysis is that *race*, *racism* and *racial equity* often go unmentioned. Another takeaway is that a disparity exists in Health Care for the Homeless' discourse on equity and the internal policies, procedures, and practices that shape employee experiences. There are, however, several documents that demonstrate existing and ongoing efforts at Health Care for the Homeless to operationalize equity concepts and principles. Taken together, these documents underscore the opportunity for Health Care for the Homeless to be bolder and more explicit in its commitment to racial equity.

Domain: Organizational Culture and Commitment to Racial Equity
Sub-domain: Mission, Vision, and Strategic Plan

- CURE noted that according to the *Core Competencies* document provided, "justice" is named as a value, and the core competencies in general reflect traits that empowered people may embody. CURE found that the "values difference" competency could be strengthened.
- The *2019 Strategic Plan* does not include racial equity or equity related goals. Goals related to housing are not centered on client ownership or client-led housing development. Goal 3 could also be reframed to better align with the agency's commitment to racial equity.

Domain: Shared Language and Analysis
Sub-domain: Training, Dialogues and Decision Tools

- CURE found that results from the *2021 Staff Engagement Survey* support many of the findings of CURE's 2021 Racial Equity Organizational Assessment including staff referencing equity concerns especially around intersectionality, race, LGBTQ, and disability. CURE noted that no racial analysis, or BIPOC breakdown appears to have been completed within the survey.

Domain: Equitable Policies and Practices
Sub-domain: Hiring

- According to *Comparison of Staffing,* BIPOC applicants are applying to the agency but are not being hired often.

Sub-domain: Retention and Advancement

- CURE noted that based on *EEO Data Analysis,* the agency becomes more white closer to leadership positions with higher compensation and more institutional power.

Domain: Equitable Policies and Practices
Sub-domain: Governance and Operations

- CURE found Health Care for the Homeless to have a strong *Hardship Loans Policy* and *Whistleblower Policy.*
- CURE noted that according to the *2020 Benefits* document provided*,* part-time staff are eligible for benefits in addition to full-time staff.
- The *2021 NHO Agenda* demonstrates that onboarding includes a focus on racial equity and harm reduction and a budget overview.
- While Health Care for the Homeless*' Non-Discrimination Policy* may meet legal standards, it could be framed as an "Anti-discrimination or Anti-harassment policy" and could be more explicit on what racial discrimination/harassment may entail and what the agency will do to address it*.*
- The *Endowment Policy* and *HCH By-Laws* both do not appear to have an equity lens. As crucial governance and operations documents, it is important that explicit language attentive to maintaining and advancing an equitable workplace across identities is embedded in these texts.
- CURE noted that in the *2019 Annual Report,* the racialized language on page 2 could be more explicit about systems*.*
- Based on the *2019 Board Survey + Board Composition,* Health Care for the Homeless could increase client and BIPOC representation, make equity a focus of accountability, and ensure clients are the ultimate accountability partners.
- Executive compensation seems inconsistent across titles according to the *2019 990.* CURE found that it may be worth it to engage in a formal external compensation study in order to prevent bias in salary.

Domain: Equitable Policies and Practices
Sub-domain: Programs and Services

- While CURE found that the agency's *Client Release Form* is clear about client rights to non-retaliation or termination of services, it does not appear to provide compensation to clients for the use of their story. Compensation is an important, material component of equitable practices.
- The *Addictions Philosophy of Care* treats clients as active participants in care and seems to utilize some harm reduction philosophy. However, it does not appear to contain language or indicators around mandatory reporting, the relationship with the criminal legal system, or disparate impact and targeting due to race.
- The *Client Handbook* outlines clients' right to nondiscrimination and addresses that substance use disorders will not be shared or reported. CURE noted that some of the Client responsibilities including being on time and written requests could strengthen their racial equity focus as they may be difficult for those who rely on public transportation, have extenuating life circumstances, for those with low literacy, or for those who do not speak and write English as their first language. The Consumer Relations Committee detailed in the *Client Handbook* feels very "corporate" and less accountable to the community; this may suggest that Health Care for the Homeless' bureaucratic approach and practices may not embody equitable solutions responsive to client needs and self-determination.

Domain: Equitable Policies and Practices
Sub-domain: Contracting and Grantmaking

- Although the *Procurement Purchasing Policy* mentions "affirmative steps" towards BIPOC contractors, it does not appear to set any concrete targets or goals.