# Health Equity at Work

Skills Assessment of Public Health Staff


**September 2010**
**Health Equity Council**

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Skills Assessment of Public Health Staff

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**Health Equity Skills Assessment Team**

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|---|---|
| Gail Brandt | NACDD Health Equity Council |
| Molly Miller | Hawaii State Department of Health |
| Kati Moseley | Oregon State Division of Health |
| Sherri Paxon | Q Pax Unlimited |
| Ann Pobutsky | Hawaii State Department of Health |
| Louise Square | New York State Department of Health |
| Marisa New Wells | Oklahoma State Department of Health |
| Damita Zweiback | Michigan Department of Community Health |

**All quotations used in this report were made by survey participants**

## Executive Summary

The purpose of this report is to provide recommendations the Centers for Disease Control and Prevention (CDC) for assessing the health equity skills needed by the public health workforce. The recommendations are based on a nationwide pilot survey conducted in June, 2010.

The National Association of Chronic Disease Directors' Health Equity Council (NACDD-HEC) formed an Assessment Team (Team) to examine existing public health competencies, conduct key informant interviews, design and disseminated a survey instrument, and develop a process to assess the validity of the survey tool (e.g. Did the survey measure what it intended to measure?).

In July 2010, the Team completed its analysis of the on-line survey of health equity competency skills needed by state chronic disease program staff. Chronic disease directors from thirteen states volunteered to be pilot sites. They disseminated the survey to their staff and colleagues. Over 450 individuals responded to the survey reflecting a 50% response rate. The survey was followed by a series of twelve focus groups consisting of three to four members each. The focus groups were designed to gather information from survey respondents on ways to improve the survey instrument.

For this pilot assessment the Team highlighted the areas where staff most needs training. This need applies to those who report low levels of proficiency across all years of public health experience. The areas below can be grouped into categories with a common theme to create a series of "how to" skill building educational opportunities.

**Across all categories of public health experience, there were 14 of 30 areas where more than 40% of respondents in each category reported low proficiency levels.**

- Use television, radio and print media to describe the costs connected to social determinants of health.
- Provide cultural competency training.
- Provide ongoing training to staff on health equity.
- Include the application of health equity skills into job descriptions.
- Evaluate organizational readiness to work on the social determinants of health.
- Promote promising practices that will aid in fair service delivery.
- Use community-based research to affect social determinants of health and improve health
- Develop community leaders within populations negatively affected by the social determinants of health.
- Advocate for investments that improve the social determinants of health and health equity.
- Incorporate health equity and social determinants of health into public policy and action.
- Identify policies and systems of institutionalized racism and institutional discrimination.
- Develop policies that will impact the social determinants of health and health equity.
- Analyze policies intended to improve social determinants of health.
- Change policies into programs that improve fair service delivery.

**There were statistically significant differences between those with fewer number of years in public health and those with more experience (who reported more proficiency) iin the following skill areas:**

- Recruit a diverse staff reflecting the populations they serve.
- Adapt public health programs to take into account the differences among populations.
- Partner with other organizations to develop strategies to improve health equity.
- Use data to identify health disparities.
- Explain the social determinants of health and identify health equity issues.
- Engage communities to work on the social determinants of health and health equity.
- Provide communities with data on health, the social determinants of health and health equity status.

Based on the pilot assessment results, the following recommendations are proposed:

A) Conduct tri-annual nationwide assessments of all state chronic disease programs using the survey instrument developed in this pilot study. The survey should be modified to include the recommendations of the focus group participants and the observations of the Team workgroup involved in this study.

B) Disseminate overall and individual pilot states results to state chronic disease directors.

C) Host active discussions about the results at annual training conferences for state chronic disease directors & program officers and the CDC staff. Focus discussions on the training needs of public health staff; how competencies translate to work performance; and how improved competency skills lead to better programs, to achieve health equity.

D) Identify and/or develop a series of trainings based on the results of the assessment for public health staff.

E) Develop a three-tier level training approach with each of the six categories for health equity competencies at every level.

Tier 1: For employees self-identifying at a level of “Unaware or Only Aware” proficiency in health equities

Tier 2: For employees self-identifying at a level of “Functional” proficiency in health equities

Tier 3: For employees self-identifying at a level of “Proficient/Expert” proficiency in health equities

Note: across all categories of public health experience, for nearly half of the skill areas more than 40% of respondents reported their proficiency as low.

F) Skills for each tier should build on the previous level and advance skills in communications, cultural competency, program planning and development, analytic assessment, community practice, leadership, and systems thinking.

*“We know that there are a lot of factors that impact health but poverty, coupled with discrimination and education truly determine an individual's health outcome and that of a community…”*

## Introduction & Background

### Public Health History

Public health has had a vital role in curbing or eradicating diseases and conditions that affect the public at large. Laws and practices have helped to stem the epidemics of everything from polio, typhoid and measles to tuberculosis and HIV infection. From the beginning public health interventions were not limited to combating infectious and communicable diseases alone. Child labor laws were enacted to stop workplace exploitation and improve overall conditions for children. Housing laws gave people recourse if their homes were unsafe or unsanitary. We have laws that minimize exposure to secondhand smoke. We have regulations that limit the sodium in processed foods. The foundation of public health is to provide equal opportunities for people to live healthy lives. Therefore, public health practitioners must understand our history of responding to broadly defined needs of the public. We must not limit ourselves to providing only programs focused on specific diseases or conditions and their risk factors. While it is good science to have people with knowledge or expertise in a particular field it may limit our view of the many factors that contribute to diseases or risk factors.

> *"Much of this work is based upon courage, people know what to do, but they are afraid to do it and are afraid to say what needs to be done. We need 'courage skills' training".*

We are entering a new chapter that begins with a foundation in public health history. We have the science and the history that recognize chronic disease as more encompassing than just disease states. Preventing chronic disease is as important as treating chronic conditions and in both prevention and treatment there are social factors that help determine the ultimate outcome.

How do we as public health practitioners begin to incorporate these social factors into our ongoing efforts? Do we have the knowledge? Do we have the necessary skills?

### Background to Assessment

The Health Equity Council was commissioned by the Centers for Disease Control and Prevention - Division of Adult and Community Health to complete a pilot assessment of health equity skills needed by public health staff. The purpose of the assessment is to inform the CDC of education and training needs as identified by the public health professionals who responded to the assessment. Following the completion of the assessment, the NACDD-HEC was asked to make recommendations to the CDC for conducting a full assessment. The CDC will use the assessment results to plan and provide education and training opportunities for public health practitioners. Three criteria were addressed in developing to tool:

1. The assessment should measure **skills** needed to address health equity.
2. Survey participants must work in public health at the **state** level.
3. Public health **competencies** must inform the elements of the assessment tool.

The purpose of this report is to provide recommendations to the CDC for assessing the health equity skills needed by the public health workforce based on this pilot assessment. In June 2010, the Health Equity Council completed an on-line survey of skills needed by chronic disease

program staff working in state health departments. Thirteen state chronic disease directors volunteered to be pilot sites. Over 450 staff responded to the survey. This number represents a nearly 50% response rate based on the number of survey responses received compared with the number distributed by the pilot state chronic disease directors. The survey was followed by a series of 12 focus groups consisting of 3-4 members each. The focus groups were designed to gather information from survey respondents on ways to improve the survey instrument.

Recommendations by the focus groups for the instrument included:

1. Revise selective survey statements in response to focus group feedback
2. Modify the survey to eliminate the "Importance" scale after each question
3. Expand the definitions section
4. Provide examples for some skills statements

Following administration of the final survey, the CDC intends to use the results to identify areas for education and training opportunities to support state public health staff.

### Health Equity Council (NACDD-HEC)

The Health Equity Council was established in July 2005 by NACDD to better address health equity issues within chronic disease programs throughout the U.S. The group has expanded from the initial five people to over 70 members representing thirty-nine states. Members bring experience working to address health equity at the local, state, national and international levels.

Since its inception, the NACDD-HEC has worked diligently to set up its infrastructure and develop a strategic map and profile to address disparities and inequities in populations disproportionately impacted by chronic diseases. The Council has organized itself into four workgroups: advocacy, cultural competency, promising practices, and social determinants of health. Collectively, NACDD-HEC members work to foster the National Association of Chronic Disease Directors' agenda for the elimination of health inequities by providing, leadership and expertise, training, resources, and technical assistance. The Council strives to explain the social determinants of health more fully as well as identify actionable strategies; describe promising practices; and make recommendations to improve organizational cultural competency.

*"…one challenge for PH professionals will be overcoming mistrust as a result of the history/experience of racial/ethnic minorities in accessing local health care systems…"*

## Methodology

### Phase I

**Examine public health competencies for those specific or relevant to health equity**

The Health Equity Skills Assessment Team (Team) reviewed the document from National Association of Chronic Disease Directors that linked (A) **Core Competencies for Public Health Professionals** (Public Health Foundation, 2009) and (B) **NACDD Competencies for Chronic Disease Practice** (2009). The Team added competencies from the following sources: (C) guidelines (#1-5, 8 & 10) based on the modification of the "Essential Services of Public Health" from the **National Association of City and County Health Officials (NACCHO) Guidelines for Achieving Health Equity in Public Health Practice** (2009), (D) the **Association of Schools of Public Health Competencies** for diversity and culture (10), and relevant competencies from environmental health (1), leadership (1) and systems thinking (2), which were part of the Association's "Interdisciplinary/Cross-cutting Competencies" for master's of public health students, and finally, (E) **statements from the National Association of Social Workers (NASW) Code of Ethics** specific to health equity and social justice were added and modified. See Appendix B for references.

After reviewing all competencies the Team selected those relevant to health equity to guide the development of an assessment tool. As a result, a matrix of key health equity competencies was developed (Appendix C). These competencies were then used in developing key informant, survey, and focus group questions for Phase II of the project.

### Phase II

**Conduct key informant interviews for essential skills to include in the assessment**

Next, the Team interviewed a sample of public health professionals with expertise in health equity. Thirteen one-hour individual interviews were conducted over the phone. Participants were asked a series of questions regarding their opinion on health equity skills as well as the assessment design. A transcription of the interviews was analyzed for common themes to use in developing the survey instrument. See Appendix A for list of participants, and Appendix D for key informant interview questions.

### Phase III

**Design an instrument to include essential health equity skills identified in Phases I & II**

In early May 2010 the Team completed survey instrument draft and submitted it for review by the NACDD Science and Epidemiology workgroup. The workgroup examined the instrument for its strength measuring the health equity competency skills of public health employees, and the value of the competency. A draft of the survey was also sent to the Oklahoma Literacy Council for readability.

The survey consisted of 30 health equity skill statements, grouped into six categories: communications, cultural competency, program planning & development, analytic assessment,

community practice, and leadership & systems thinking. Participants were asked to rate both the importance of the skill and their level of proficiency using a five-point Likert scale. June 1, 2010 was the target date for release of the assessment using *the "Survey Monkey*" software application. See Appendix E for a list of skill statements used in the survey and Appendix F for a sample of the survey.

### Phase IV

**Identify pilot states to participate in the survey**

The Team chose a sample of thirteen states to participate in the pilot survey. Locations across a wide geographic distribution were selected, to include states with large and small populations as well as urban and rural states. Puerto Rico and the National Association of State Offices of Minority Health (NASOMH) were also included in the sample.

### Phase V

**Develop a process for obtaining survey feedback following administration of the pilot**

Volunteers from among survey respondents participated in one-hour telephone focus groups. The purpose of the focus groups was to obtain information on ways to improve the survey content and formatting. Twenty-nine individuals representing 13 states participated in one of a series of focus groups. An analysis of the transcriptions of each session revealed recurring themes used to complete this report. See Appendix G for focus group questions and recommendations.

### Phase VI

**Analyze results to identify areas of need as well as ways to improve the survey tool**

Data were obtained from the *Survey Monkey* software application and further analyzed using SPSS/PASW (Statistical Package for the Social Sciences). The results were summarized as simple frequency distributions (Appendix H.1.) and after consultation with the Team, cross-tabulation of survey responses by the number of years in public health was conducted (Appendix H.2.).

> *"…We need skills to radically reshape our cultural norms. The root causes of discrimination, poverty, and other social determinants of health are our society's collective unquestioned acceptance of individualism, consumerism, and unchecked capitalism. As long as these values remain dominant, there will be inequity in one form or another..."*

## Results of Survey Part 1.

### Survey Sample Demographics and Frequencies of Responses

All tabular data on the sample demographics and response frequencies are presented in Appendix H.1. Although this survey was designed as a pilot assessment based on a sample of 13 States, the survey was distributed widely by the state chronic disease directors. More than 450 people representing 20 states responded. In their enthusiasm about the survey, some chronic disease directors forwarded the survey to colleagues who were not part of the pilot state sample. The majority of respondents (88.7%) work for state government. One-half of this pilot assessment sample was comprised of people working in public health for 6-20 years (51.9%), with another 18.4% working in public health for more than 21 years. Almost one-fourth (23.5%) has been working in public health for less than 5 years.

*"…effective communications across cultural groups and building trusted partnerships…"*

#### Communications

More than two-thirds of the respondents thought that at a functional, proficient or expert level, they were able to explain the difference between health equity, health inequities and health disparities (74.4%), describe the effects that the social determinants of health have on health equity for specific populations in their state (72.4%) and describe the effects that policies may have on health equity (73.1%). More than one-half also thought they could focus policy-makers attention on improving social and economic conditions instead of trying to change individual behaviors (58.9%) and less than one-half (43.1%) thought they could use television, radio and print media to describe the costs connected to the social determinants of health. More than 90% of the respondents rated these communication issues as important or very important/essential.

#### Cultural Competency

Three-fourths of the respondents (74.7%) thought that at a functional, proficient or expert level, they could identify the effects of cultural factors on public health services and describe the cultural differences among the populations they served (75.2%). Less than one-half (46.6%) thought they could provide cultural competency training to improve staff skills in working with diverse populations. And, while three-fourths of the respondents thought they could use their knowledge about cultural differences in public health planning (75.8%), two-thirds also thought they had the skills to recruit a diverse staff that reflects the populations they serve (66%). The vast majority of respondents (90-95%) rated these cultural competency issues as important or very important/essential.

#### Program Planning and Development

Just over one-half of the respondents thought that at a functional, proficient or expert level, they could include the use of health equity skills into job descriptions (54.3%) or implement on-going health equity and social determinants of health trainings for staff (50.9%). More than two thirds (71.3%) thought they could adapt public health programs to take into account the differences among populations, while 60.1% thought they could add the social determinants of health and health equity into public policies and actions, and 73.4% thought they could partner with other

organizations to develop strategies to improve health equity. The vast majority of respondents (90-95%) rated these program planning and development issues as important or very important/essential.

### Analytic Assessment

More than three-fourths of the respondents thought that at a functional, proficient or expert level, they could use data to identify health disparities (77.7%), and 71.9% thought they could explain the social determinants of health and identify health equity issues. However, less than 40% thought they could evaluate an organization's readiness to work on the social determinants of health that effect health equity (38.8%). More than one-half of the respondents thought they could analyze the policies intended to improve the social determinants of health and health equity (56.2%) or identify the evidence linking discrimination and health outcomes (58.6%). The vast majority of respondents (90-95%) rated these analytic assessment issues as important or very important/essential.

### Community Practice

More than one half of the respondents thought that at a functional, proficient or expert level, they could engage communities to work on the social determinants of health and health equity (59.6%), use community-based research to affect the social determinants of health and improve health equity (54.8%), yet less than one-half (40.6%) thought they could develop community leaders within populations negatively affected by the social determinants of health. More than two thirds of the respondents thought they could provide communities with data on health, the social determinants of health and health equity status, and more than one-half (51.8%) thought they would advocate for community investments that improve the social determinants of health and health equity. The vast majority of respondents (90-95%) rated these community practice issues as important or very important/essential.

*…we MUST work side by side with [community] if we are to truly develop our health equity skills…*

### Leadership and Systems Thinking

Almost two-thirds of the respondents thought that at a functional, proficient or expert level, they could promote promising practices that would aid in fair service delivery (63.4%), yet less than one-half thought they could identify the policies and systems of institutionalized racism (43.1%), or identify the policies and systems of institutionalized discrimination (45.9%). Just about one-half thought they could develop policies that will affect the social determinants of health and improve health equity (49.9%) or convert policies into programs that improve fair service delivery (47.3%). The vast majority of respondents (90-95%) rated these leadership and systems thinking issues as important or very important/essential.

## Results of Survey Part 2.

### Cross Tabulation of Responses by Level of Public Health Proficiency and Experience

**All tabular data on the cross-tabulation** of all responses are presented in Appendix H.2. Cross tabulated results compare three tiers of proficiency and three levels of importance with public health experience/the number of years in public health (less than 5 years, 6-20 years and more than 21 years). Proficiency was grouped into three tiers from low (tier1=unaware or only aware), medium (tier 2=functional) and high (Tier 3=proficient/expert). Importance was also grouped into three levels from low (1-unimportant/slightly important), medium (2=important) to high (3=very important/essential). For this pilot assessment, we highlighted those areas which seem to be the most needed areas for training with respondents who report low levels of proficiency, not only among those who report having less public health experience, but in the areas where there was low reported levels of proficiency across all years of public health experience. These areas are suggestive of where additional training and information on health equity and the social determinants of health.

### Communications

There was a statistically significant difference ($p < .01$)[1] between those with less public health experience and those with more experience, in their proficiency/ability to "explain the difference between health equity, health inequities and health disparities" (Q1)[2], suggesting a needed are of training for entry level public health workers. At least one-third of those with less public health experience reported being lower in proficiency in "describing the effects that the social determinants of health have on health equity for specific populations in their state" (Q2) and "describing the effects that policies may have on health equity" (Q3), suggesting additional areas for education/training. Across all categories of public health experience/number of years in public health, one-third to one-half of respondents reporting their proficiency as low for being able to "focus policy maker attention on improving social and economic conditions instead of trying to change individual behaviors" (Q4). There were even greater proportions of reported low proficiency across all levels of public health experience for "using television, radio and print media to describe the costs connected to the social determinants of health" (Q5). There was a general trend across all levels of public health experience to rate these communication issues as very important/essential (70-80%). This was slightly less for media utilization (60-70%).

### Cultural Competency

At least one-third of those with less public health experience reported being lower in proficiency in "identifying the effects of cultural factors on public health services" (Q6), "describing the cultural difference among the populations they served" (Q7) and "using their knowledge about cultural differences in public health planning skills to recruit a diverse staff that

*"…I may not be able to fully understand another person's experience with inequity and discrimination, but I can listen with compassion and empathy…"*

[1] Chi-square=15.127
[2] Q1, Q2, Q3… refer to the numbered skill statements in the survey.

reflects the populations they serve" (Q9). Across all categories of public health experience, more than half of respondents reported their proficiency as low for being able to "provide cultural competency training to improve staff skills in working with diverse populations" (Q8). There was a statistically significant difference ($p < .01$)[3] between those with less public health experience and those with the most experience who reported that they have the skills to recruit a diverse staff that reflects the populations they serve" (Q10). There was a general trend across all levels of public health experience to rate most of these cultural competency issues as very important/essential (70-80%), yet this was less so for providing cultural competency training (Q8) at 60-67%, and even less so for the ability to recruit a diverse staff (Q10).

### Program Planning & Development

At least 40% of those with less public health experience reported being lower in proficiency in "adapting public health programs to take into account the differences among populations" (Q13), along with 30% with less public health experience who reported being low on "partnering with other organizations to develop strategies to improve health equity (Q15). These were statistically significant differences between lower and higher levels of public health experience ($p< .01$)[4]. Across all categories of public health experience, more than 40% of respondents reported their proficiency as low for being able to "include the use of health equity skills into job descriptions" (Q11) or "implement on-going health equity and social determinants of health trainings for staff "(Q12). One-third to one-half of respondents reported they had low proficiency in "adding the social determinants of health and health equity into public policies and actions" (Q14). However, there were also statistically significant differences ($p<.01$)[5] for (Q11) and (Q14) as well, whereby those with greater public health experience skewed into two groups: experts and those with reported low proficiency in these two areas. In rating importance, across all categories of public health experience, 50-60% of respondents rated including the use of health equity skills into job descriptions as very important (Q11) and 60-70% who rated implementation of health equity and social determinants of health trainings as important (Q12). In contrast, across all categories of public health experience, 70-80% of respondents rated adapting public health programs to take into account differences among populations (Q13), adding social determinants of health and health equity into public health policies and actions (Q14) and partnering with other organizations to improve health equity as very important.

*"You expect nothing less than everyone doing their part to make the workplace and practices civil and a place of honor for employees and the customers they serve."*

### Analytic Assessment

Among those with less than 5 years of public health experience, 28.3% reported they had low proficiency "to use data to identify health disparities" (Q16) and this was a statistically significant difference compared to those with more public health experience ($p<.01$)[6]. There was also a

[3] 15.595
[4] Chi-square=14.096 (Q13) and 9.845 (Q15).
[5] Chi-square=24.824 (Q11) and 18.392 (Q14).
[6] Chi-square=9.845

statistically significant difference between those with lower versus greater public health experience, with 40.6% of those with lower number of years in public health reporting low proficiency in being able to "explain the social determinants of health and identify health equity issues" (Q17)(p<.01)[7]. In contrast, across all categories of public health experience, there were 57%-65% who reported they had low proficiency in being able to "evaluate an organization's readiness to work on the social determinants of health that effect health equity" (Q18), suggesting an across-the-board training need. Similarly, across all categories of public health experience, one-third of respondents with more than 21 years of experience, along with 42.9% of those with 6-20 years of experience and 53.3% with 0-5 years experience reported low levels of proficiency to "analyze the policies intended to improve the social determinants of health and health equity" (Q19). There was a similar reporting of low proficiency across all levels of public health experience (from 37-49%) on the ability to "identify the evidence linking discrimination and health outcomes" (Q20). The majority rated these analytic assessment issues were important, but using data to identify health inequities had the highest importance rating among all groups (82%), followed in importance by explaining the social determinants of health data and identifying health equity issues 74-79%. The other issues were rated very important by a majority, but in lesser proportions 58-72%).

### Community Practice

There was a statistically significant difference ($p < .01$)[8] between those with less public health experience and those with more experience , in their reported proficiency/ability to "engage communities to work on the social determinants of health and health equity" (Q21); those with the least experience were less able to think they can do this. In contrast, across all levels of experience there were 41-56% of respondents who rated their proficiency as low for "using community-based research to affect the social determinants of health and improve health" (Q22), 55-68% for "developing community leaders within populations negatively affected by the social determinants of health" (Q23), and 44-60% for "advocating for community investments that improve the social determinants of health and health equity" (Q25). There was a statistically significant difference ($p < .01$)[9] between those with less public health experience and those with more experience, in their reported proficiency/ability to "provide communities with data on health, the social determinants of health and health equity status" (Q24); those with more experience reporting more proficiency. Across all levels of experience/number of years in public health, these community practice issues were generally rated very important by the majority of respondents (63-77%). This finding suggests a need for training in an area not traditionally associated with public health practice.

*"Go to the field, feel it, live it and then plan for the change…"*

### Leadership & Systems Thinking

Across all levels of public health experience/number of years in public health, there were reported low proficiency levels among all groups for "promoting promising practices that would

[7] Chi-square=14.760
[8] Chi-square=12.176
[9] Chi-square=10.585

*…Promote internal agency policies to redress institutional racism…*

aid in fair service delivery (29-44%) (Q26), for "identifying the policies and systems of institutionalized racism" (50-60%) (Q27), low proficiencies for "identifying the policies and systems of institutionalized discrimination" (48-62%) (Q28), low proficiencies for the "development of policies that will affect the social determinants of health and improve health equity" (46-62%) (Q29) and low reported proficiencies for "converting policies into programs that improve fair service delivery" (49-63%) (Q30).

*"It's a philosophy as well as a skill."*

*...it is not so much a skill as a way of thinking."*

***"EMPHASIS NEEDS TO BE PUT ON EQUALITY OF OPPORTUNITY WHEN TALKING ABOUT HEALTH EQUITY"***

*"We operate on a lot of assumptions and our policies and practices just pay lip service to the terms health disparities and social determinants…"*

*"I think it is also important to have the personality, enthusiasm and respect (in the community) to generate interest and excitement among community members to motivate change."*

*"Promoting internal agency policies to redress institutional racism."*

*"… have critical discussions about poverty and discrimination issues on a consistent basis. "*

## Results of Focus Groups

### Enhancements to survey tool based on focus group results

Based on feedback from focus group respondents, the Team made **five** modifications to the health equity skills assessment survey tool.

We revised the importance scale to require respondents to prioritize the skills under each section of the assessment. That is, instead of rating the importance of each skill on a five-point Likert scale, respondents are asked to give the five skills in each section of the survey a 1 to 5 ranking *relative* to the other skills in that section. This change was made in response to focus group feedback that participants ranked all the skills either "very important" or "essential". Because of this, the importance scale did not offer meaningful insight on which skills where most important. Analysis of survey responses supports this change. Respondents ranked most skills as "important" or "very important," making it difficult to use these results to prioritize or sequence skills for training.

We added sentences describing the content of each section to the section headings in the survey. This will clarify the purpose of each section, and will help respondents recognize when they have moved into a new section of the tool. This change is in response to comments from focus group participants that some survey questions seemed redundant, but when they looked more closely they found that the context of the section that a question fell under provided more information on the question's meaning. Focus group respondents suggested that it would clarify the meaning of the questions if we made it easier for respondents to understand the intention of the survey sections.

We revised the description of the overall purpose of the assessment to clarify what information the survey results provide and how respondents, agency heads or the CDC can use the assessment results. Focus group participants also suggested that we include a list of resources at the end of the assessment. This list should highlight the NACDD and the CDC technical resources, and encourage survey respondents to contact the Health Equity Council to learn more or take action.

We added cultural competency to the definitions section of the assessment. There was an interesting conversation in several focus group interviews about the questions in the cultural competency section. Participants struggled to respond to questions of general cultural competency, and felt that their proficiency in this area depended on the specific culture under discussion. This observation in itself provides information about the respondent's comfort and proficiency in the area of cultural competency, and their understanding of the set of skills that compose cultural competency.

We added promising practices to the definitions section of the assessment. Focus group participants said that the phrase "promising practices" was not a commonly used or understood term and could use clarification. We added an example of "fair service delivery" to questions 26 and 30. This phrase was not immediately clear to respondents, and is an attempt to be straightforward in describing equitable service delivery.

We revised the definition of institutional racism, clarifying the language and adding an example. It is important to note that focus group respondents struggled with this term; this in itself is telling. Interestingly, focus group respondents did not ask for clarification of the term "institutional discrimination," which is less common and more newly developed term that is not yet widely understood.

In addition to the changes described above, the Team discussed two other substantive changes and agreed that the CDC needed to be involved in decisions about how to address them.

We asked focus group respondents which of the following questions was most appropriate for this assessment, given their job responsibilities:

> "I can focus policy maker attention on improving social and economic conditions instead of trying to change individual behaviors."
>
> "I have the skills to move policy makers to action on the social determinants of health and health equity."

During focus groups, respondents expressed feeling that both questions are important, and that they are very different. Because we know that policy shapes the social determinants of health, ultimately, it is critical that public health takes a role in moving policy makers to change policies that affect social determinants. However, we understand the complicated and sensitive nature of government funding being involved in lobbying, and feel that the CDC should select the final question they would like on the survey based on their expectations for state health departments.

The Team also discussed collecting race/ethnicity demographic data as part of the assessment. This could offer a better understanding of how personal experience mediates proficiency in health equity among public health workers. At the same time, it is critical that the entire public health workforce demonstrates proficiency in skills to achieve health equity; collecting race/ethnic information may inadvertently cloud achievement of this goal by suggesting that responsibility for achieving health equity rests with a sub-group of the nation's public health workforce. See Appendix I for a summary of focus group responses and Appendix J for a revised survey based on the changes described in this section.

## Recommendations

Based on results of the pilot assessment, these recommendations are proposed for continuous development of health equity skills among public health employees:

A) **Conduct tri-annual nationwide assessments** of all state chronic disease programs using the survey instrument developed in this pilot study. The survey should be modified to include the recommendations of the focus group participants and the observations of the Team involved in this study.

B) **Disseminate** overall and individual pilot states **results** to state chronic disease directors.

C) **Host active discussions** about the results at annual training conferences for state chronic disease directors and program officers. Focus discussions on training needs of public health employees; how competencies translate to work performance; and how improved competency skills lead to better programs, to achieve health equity.

D) The Health Equity Council will simultaneously identify or work with CDC to develop a **series of trainings** based on the results of the assessment.

E) **Develop a three-tier level** training approach with each of the six categories for health equity competencies at every level.

Tier 1: For employees self-identifying at a level of "Unaware or Only Aware" proficiency in health equities

Tier 2: For employees self-identifying at a level of "Functional" proficiency in health equities.

Tier 3: For employees self-identifying at a level of "Proficient/Expert" proficiency in health equities

F) **Build on the previous level skills development** and advance knowledge in communications, cultural competency, program planning and development, analytic assessment, community practice, leadership, and systems thinking.

*…we need to educate and empower the communities to make a difference, to demand better policies that impact health and well being…*

**Comments and Questions on Demographics:**

Demographic data collection in any study is essential to understanding the needs of specific segments within the population base as well as uncovering instrument biases. In this pilot assessment emphasis was placed on public health employees' years of service and job roles as key variables for assessing correlations with health equity skill levels. Upon review of the results and recommendations from the focus groups, the Team recommends that the CDC explore the value of including other demographic variables (race, ethnicity, gender, disability, and sexual orientation), in order to determine any national correlations and trends in health equity skills development. Such analysis could (1) reveal biases toward certain population groups based on race, ethnicity, gender, sexual orientation, and disability; and (2) provide valuable information about the diversity of advancement to higher levels of performance and careers within the public health sector. All recommendations would depend on the sample of respondents and cannot reflect proficiencies and importance of those who do not respond.

The National Association of Chronic Disease Directors Health Equity Council is optimistic that skills to address health equity will be included in the core competencies for public health professionals. These skills identified reflect the characteristics that staff of state health departments as well as other public health organizations may want to possess as they work to protect and promote health in our communities-at-large.

## Appendix

## Appendix A. Acknowledgements

Members of the Health Equity Council want to thank the following people for their help in various aspects of this assessment.

### Key Informant Interviewees

| | |
|---|---|
| Betty Bekeymer | University of Washington, School of Nursing |
| Nancy Bradford | New York State Department of Health - Family Health |
| Neil Calman | Institute for Family Health in New York |
| Terry Dwelle | North Dakota Department of Public Health |
| Christie Hoff | WA State Interagency Council on Health Disparities |
| Dave Hoffman | New York State Department of Health |
| Richard Hofrichter | National Association of County and City Health Officials (NACCHO) |
| Christina Johnson-Conley | Private Practice in Washington State |
| Wanda Jones Robinson | NYS Department of Health - AIDS Institute |
| Thomas LaVeist | Johns Hopkins School of Public Health |
| Marilyn Metzler | Centers for Disease Control and Prevention (CDC) |
| Charmaine Ruddock | Bronx - Racial and Ethnic Approaches to Community Health (REACH) |
| Marilyn SItaker | Washington State Department of Health |

### Student Interns

| | |
|---|---|
| Melody Tucker | University of Washington School of Nursing |
| Molly Miller | University of Hawaii School of Social Work |
| Bryan Schultz | St George's University of Grenada |

## Pilot State Chronic Disease Directors

| | |
|---|---|
| Gail Stolz | Alaska |
| Veronica Perez | Arizona |
| Danette Tomiyasu | Hawaii |
| Jill Myers-Geadelmann | Iowa |
| Sue Thomas-Cox | Kentucky |
| Carol Callaghan | Michigan |
| Barbara Pullen-Smith | Nat'l. Assn. State Offices of Minority Health |
| Barbara Wallace | New York |
| Nan Migliozzi | Ohio |
| Darrel Eberly | Oklahoma |
| Madeline Reyes | Puerto Rico |
| Anna Novias | Rhode Island |
| Mike Byrd | South Carolina |
| Sue Grinnell | Washington |
| Joe Grandpre | Wyoming |

## Others

| | |
|---|---|
| Leslie Gelders | Oklahoma Literacy Resource Office |
| Jillian Jacobellis | NACDD Science and Epidemiology Group |

## Appendix B. References


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## Appendix C. Competency Matrix

**See Attachment**

## Appendix D. Key Informant Interviews

### Interview Questions:

1. What skills are most critical for achieving health equity?

2. What types of activities performed by health department officials are most effective in achieving health equity among and between communities?

3. What skills within the public health field do you feel are lacking or need to be strengthened in order to effectively address health disparities?

4. What type of data gathering would be most effective, considering the time spent developing, performing, and analyzing the assessments? (e.g. personal interviews, yes/no questionnaires, numbered scale questions, focus groups, scenarios, combinations)

5. What is the best way to design questions in order to accurately assess skills and avoid bias?

6. What level of discussion with community members is necessary when involved in activities aimed at reducing health disparities?

7. Cultural competency is obviously important in effectively reducing health disparities between different communities of different races, ethnicities, and socioeconomic states. How do we accurately assess the level of this competency among entire health departments while avoiding reporting bias of the interviewee?

8. In order to reduce health disparities and social determinants of health, what levels of flexibility in job classifications are required to effectively address the root causes?

9. Who should we be sure to include in our assessment to ensure widespread representation?

10. What level of staff should we be assessing (senior management, program level staff)?

## Appendix E. Focus Groups Script and Questions

### Script

Hello, my name is Molly Miller. I am working with NACDD to gather information about the Health Equity Council's Health Equity Skills Assessment you recently completed. The purpose of our conversation today is to gain information and advice regarding "How can the Health Equity Council improve the health equity skills assessment?" Thank you for joining this call today. Before we begin do you have any questions about the purpose of this meeting?

I'd like to start with some logistics for this call. First, if for some reason you are disconnected, please dial 1-866-919-4632 and enter 5747861# to rejoin. If you have trouble hearing or being heard, please try disconnecting and calling back in using the number above. Please do let me know if your need to leave the call unexpectedly, and don't mute your line – your responses are important and I don't want to miss anything. Our discussion will last approximately 60 minutes, and I do ask that you stay with us until the end. Some of the most important questions will occur at the end of our discussion. We'll adjourn at XX o'clock.

I will be asking a limited number of questions during this hour, most of which I emailed to you prior to this call. I may add in additional questions during the discussion to clarify or to solicit deeper discussion about a topic. I don't expect that everyone will answer every question, but at the same time, I don't want to leave anyone out of the conversation. If you have an opinion that has not been expressed, I encourage you to share it. If I don't hear from you on an important question, I may ask you directly. In the limited time we have, 60 minutes, I want to pose all the questions so, if it seems that I'm cutting you off please understand.

I am recording our conversation so that we won't miss any of your comments. Your names will NOT be attached to comments in any report that is being prepared.

When you are speaking on the call, please help me by beginning your comments by stating your name. For example, "This is Jane" then make your comment.

We would like to be in a first name basis, so let's take a minute to get acquainted. I'll read through the names of people on the call, and when you hear your name, please introduce yourself and tell us where you are located.

Thank you, now, let's move into talking about the health equity skills assessment.

## Questions

**General**
Let's start with some general questions about taking the assessment.

1. About how long did it take you to complete the survey?
2. Did you complete it all at once or return to it more than once?

**Scales**
The next several questions are about the scales used in the survey. There were two scales, one capture proficiency and one captured importance.

3. What do you suggest we do to make the scales easier to use?

**Skills**
The next several questions are about the content of the survey, the skills sets addressed. How do the skills compare with what you think are needed to achieve health equity?

4. What skills did we leave out?
5. What skill areas weren't clear; how can we improve these?
6. Think about the applicability to your work of each of the following statements. Which one is more appropriate for this survey? [Note: take a quick A/B poll on this, rather than extensive discussion]
   A. *I can focus policy maker attention on improving social and economic conditions instead of trying to change individual behaviors*.
   B. *I have the skills to move policy makers to action on the social determinates of health and health equity.*
7. Was it easy or difficult to rate your proficiency and the importance of the following statement on the assessment: [Note: take a quick poll of easy/difficult, rather than extensive discussion]
8. I can identify the impact of cultural factors on the accessibility, availability and acceptability of public health services.

**Layout, Presentation and Instructions**
I have a few questions about your experience using SurveyMonkey, and how the survey looked on your computer.

9. Several terms were defined at the beginning of the survey. How did you use these definitions when you responded to the survey? Are there other terms need clarification?
10. Is SurveyMonkey an appropriate tool to administer this assessment?

**Close**
The purpose of our discussion today is to provide answers to the question "How can the Health Equity Council improve the health equity skills assessment?"

11. Have we missed anything that answers this question in our discussion today?
12. One area we did not include in this assessment was "Barriers you face in using these skills." How valuable would that information be?

The next step following the full assessment is to make recommendations to CDC for training.

## Appendix F. Sample Survey

The survey below was transferred to the *Survey Monkey* format for dissemination.

***(Cover Page)***
**INTRODUCTION**
**Health Equity Skills for Public Health Professionals**
**We need your help!**

The following brief questionnaire will provide information that will be used to help you achieve success in moving toward health equity in your public health practice.

The dramatic increase in chronic disease among specific populations is a growing concern and threat to affordable health care. Strong evidence linking health to social determinants and the differences in health status are increasingly aligned with the places where people live, work and play. Funders are requiring applicants to integrate health equity in proposals and work plans.

The National Association of Chronic Disease Directors (NACDD) Health Equity Council and the Centers for Disease Control and Prevention are assisting public health practitioners in attaining the qualifications, skills and knowledge needed to strengthen health equity expertise. This assessment will provide the basis for targeted training in health equity, the social determinants of health and cultural competency.

Training modules based on these survey results will increase health equity expertise and assuring staff have a solid understanding of the issues and potential solutions!

Thank you for participating in this 15-minute survey!

Please follow screen instructions by clicking on NEXT PAGE or PREVIOUS PAGE to navigate through the survey and click SUBMIT when you are finished. You may save and exit the program at any time by clicking on SAVE AND RETURN LATER.

Participation in this is voluntary and confidential. If you would prefer to respond to this assessment by mail, please print the survey and send it to:

Attention: Jillian Smith
NACDD Heath Equity Council
2872 Woodcock Blvd Ste 220
Atlanta, GA 30341

**NEXT PAGE**

***(Page 2)***
**DEFINITION OF TERMS**
**(Consider printing a copy of the definitions to reference while responding to the survey.)**
**Health disparities** are differences in the incidence and prevalence of health conditions and health status among groups of people. Most ***health disparities*** are due to certain conditions or result from discrimination based on socioeconomic status, age, race or ethnicity, sexual orientation, gender, gender identity, disability status, geographic location or some combination of these.

**Health inequities** result when the differences are influenced by conditions that are unfair, unjust and avoidable.

**Social determinants of health** are conditions in which we are born, grow, live, work, play and age. For health equity, these conditions include adequate income, secure employment and good working conditions, quality education, safe neighborhoods and housing, food security, the presence of social support networks, health care services and freedom from racism and other forms of discrimination, which all support health.

**Health equity** occurs when all people have the opportunity to be as healthy as possible and no one is limited in achieving good health because of their social position or any other social determinant of health.

**Institutionalized racism** is a structure of policies, practices and norms embedded in government and organizational systems that results in unequal access, based on race, to education, opportunities, power and influence, which perpetuates an inherited disadvantage to population groups.

**Institutionalized discrimination** results in inequitable treatment of population groups based on age, ability, gender, gender identity, sexual orientation, class, ethnicity or socio-economic status. It is generated through a system of policies, practices and norms that operate independently from the prejudices of individuals.

**Skill** is the ability, acquired through knowledge, training or experience, to do something well.

**NEXT PAGE**

***(Page 3)***

**SURVEY QUESTIONS**

**Health Equity Skills for Public Health Professionals**

| Scale | Explanation of Scale |
|---|---|
| **1 Unaware** | I have no knowledge or awareness of this skill<br>*(I have never heard of this concept)* |
| **2 Aware** | I am aware of this skill but have not used it in my public health practice<br>*(I was exposed to this skill in training but haven't used it)* |
| **3 Functional** | I can apply this skill but occasionally require assistance<br>*(I can do this but sometimes need to ask for help)* |
| **4 Proficient** | I can execute this skill in complex situations without guidance<br>*(I have lots of experience with this skill)* |
| **5 Expert** | I can execute this skill in complex situations and have the expertise to coach and support others<br>*(I have done this so much that I am comfortable offering my expertise to others)* |

**For the following statements, please:**

- Indicate your level of proficiency for the skill described in the statement

**Then:**

- Indicate how important the skill is to health equity and social determinants of health expertise

**A) COMMUNICATIONS**

**1. I am able to explain the difference between health equity, health inequities and health disparities.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

How important is this skill for public health professionals in achieving health equity and social determinants of health expertise?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unimportant | Slightly Important | Important | Very Important | Essential |

**2. I can describe the impacts of the social determinants of health on health equity for specific populations in my state.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

How important is this skill for public health professionals in achieving health equity and social determinants of health expertise?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unimportant | Slightly Important | Important | Very Important | Essential |

**3. I can communicate the expected outcomes of policy implementation on health equity.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

How important is this skill for public health professionals in achieving health equity and social determinants of health expertise?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unimportant | Slightly Important | Important | Very Important | Essential |

**4. I have the skills to move policy makers to action on the social determinants of health and health equity.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

How important is this skill for public health professionals in achieving health equity and social determinants of health expertise?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unimportant | Slightly Important | Important | Very Important | Essential |

**5. I can use mass media to describe the social, economic and environmental costs associated with the social determinants of health.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

How important is this skill for public health professionals in achieving health equity and social determinants of health expertise?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unimportant | Slightly Important | Important | Very Important | Essential |

**B) CULTURAL COMPETENCE**

**6. I can identify the effects of cultural factors on public health services.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

How important is this skill for public health professionals in achieving health equity and social determinants of health expertise?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unimportant | Slightly Important | Important | Very Important | Essential |

**7. I can describe the cultural differences among the populations we serve.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

How important is this skill for public health professionals in achieving health equity and social determinants of health expertise?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unimportant | Slightly Important | Important | Very Important | Essential |

**8. I can provide cultural competency training to improve staff skills in working with diverse populations.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

How important is this skill for public health professionals in achieving health equity and social determinants of health expertise?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unimportant | Slightly Important | Important | Very Important | Essential |

**9. I can use my knowledge about cultural differences (values, beliefs and behaviors) in public health planning.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

How important is this skill for public health professionals in achieving health equity and social determinants of health expertise?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unimportant | Slightly Important | Important | Very Important | Essential |

**10. I have the skills to recruit a diverse staff that reflects the populations we serve.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

How important is this skill for public health professionals in achieving health equity and social determinants of health expertise?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unimportant | Slightly Important | Important | Very Important | Essential |

**C) PROGRAM PLANNING AND DEVELOPMENT**

**11. I can include the use of health equity skills into job descriptions.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

How important is this skill for public health professionals in achieving health equity and social determinants of health expertise?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| Unimportant | Slightly Important | Important | Very Important | Essential |

**12. I can implement ongoing health equity and social determinants of health trainings for staff.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

How important is this skill for public health professionals in achieving health equity and social determinants of health expertise?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unimportant | Slightly Important | Important | Very Important | Essential |

**13. I can adapt public health programs to take into account the differences among populations.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

How important is this skill for public health professionals in achieving health equity and social determinants of health expertise?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unimportant | Slightly Important | Important | Very Important | Essential |

**14. I can add the social determinants of health and health equity into public health policies and actions.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

How important is this skill for public health professionals in achieving health equity and social determinants of health expertise?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unimportant | Slightly Important | Important | Very Important | Essential |

**15. I can partner with other organizations to develop strategies to improve health equity.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

How important is this skill for public health professionals in achieving health equity and social determinants of health expertise?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unimportant | Slightly Important | Important | Very Important | Essential |

**D) ANALYTIC ASSESSMENT**

**16. I can use data that identify health inequities.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

How important is this skill for public health professionals in achieving health equity and social determinants of health expertise?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unimportant | Slightly Important | Important | Very Important | Essential |

**17. I can explain social determinants of health data and identify health equity issues.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

How important is this skill for public health professionals in achieving health equity and social determinants of health expertise?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unimportant | Slightly Important | Important | Very Important | Essential |

**18. I can evaluate an organization's readiness to work on the social determinants of health that effect health equity.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

How important is this skill for public health professionals in achieving health equity and social determinants of health expertise?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unimportant | Slightly Important | Important | Very Important | Essential |

**19. I can analyze policies intended to improve the social determinants of health and health equity.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

How important is this skill for public health professionals in achieving health equity and social determinants of health expertise?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unimportant | Slightly Important | Important | Very Important | Essential |

**20. I can identify the evidence linking discrimination and health outcomes.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

How important is this skill for public health professionals in achieving health equity and social determinants of health expertise?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unimportant | Slightly Important | Important | Very Important | Essential |

**E) COMMUNITY PRACTICE**

**21. I can engage communities to work on the social determinants of health and health equity.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

How important is this skill for public health professionals in achieving health equity and social determinants of health expertise?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unimportant | Slightly Important | Important | Very Important | Essential |

**22. I can use community-based research to affect the social determinants of health and improve health equity.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

How important is this skill for public health professionals in achieving health equity and social determinants of health expertise?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unimportant | Slightly Important | Important | Very Important | Essential |

**23. I can develop community leaders within populations negatively affected by the social determinants of health**.

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

How important is this skill for public health professionals in achieving health equity and social determinants of health expertise?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unimportant | Slightly Important | Important | Very Important | Essential |

**24. I can provide communities with data on health, the social determinants of health and health equity status**.

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

How important is this skill for public health professionals in achieving health equity and social determinants of health expertise?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unimportant | Slightly Important | Important | Very Important | Essential |

**25. I can advocate for community investments that improve the social determinants of health and health equity.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

How important is this skill for public health professionals in achieving health equity and social determinants of health expertise?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unimportant | Slightly Important | Important | Very Important | Essential |

**F) LEADERSHIP AND SYSTEMS THINKING**

**26. I can promote promising practices that will aid in fair service delivery.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

How important is this skill for public health professionals in achieving health equity and social determinants of health expertise?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unimportant | Slightly Important | Important | Very Important | Essential |

**27. I can identify the policies and systems of institutionalized racism**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

How important is this skill for public health professionals in achieving health equity and social determinants of health expertise?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unimportant | Slightly Important | Important | Very Important | Essential |

**28. I can to identify the policies and systems of institutionalized discrimination.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

How important is this skill for public health professionals in achieving health equity and social determinants of health expertise?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unimportant | Slightly Important | Important | Very Important | Essential |

**29. I can develop policies that will affect the social determinants of health and improve health equity.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

How important is this skill for public health professionals in achieving health equity and social determinants of health expertise?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unimportant | Slightly Important | Important | Very Important | Essential |

**30. I can convert policies into programs that improve fair service delivery.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

How important is this skill for public health professionals in achieving health equity and social determinants of health expertise?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unimportant | Slightly Important | Important | Very Important | Essential |

**Identify any skill sets not covered in the assessment that you consider critical in working with health equity and social determinants of health issues.**

**What are some ways to increase skills around health equity, the social determinants of health and cultural competency, other than typical training sessions?**

**LAST PAGE**

The NACDD NACDD-HEC and CDC appreciate your time and effort in responding to this survey. Clicking on the icon below will take you to a separate site to enter your contact information and any comments you may have regarding the assessment.

**NEXT PAGE**

**Demographics**

State you represent

Position in public health

- Manager
- Program Coordinator
- Epidemiologist or Research Investigator
- Operational Support

Years in Public Health

- < 5 years
- 6-10 years
- >10 years

## Appendix G. Health Equity Skills Statements Without Scales

For easy reference skills statements are listed without the *importance* and *proficiency* scales...

### Communications

1. I can explain the difference between health equity, health inequities and health disparities.
2. I can describe the effects that the social determinants of health have on health equity for specific populations in my state.
3. I can describe the effects that policies may have on health equity.
4. I can focus policy maker attention on improving social and economic conditions instead of trying to change individual behaviors.
5. I can use television, radio and print media to describe the costs connected to the social determinants of health.

### Cultural Competence

6. I can identify the effects of cultural factors on public health services.
7. I can describe the cultural differences among the populations we serve.
8. I can provide cultural competency training to improve staff skills in working with diverse populations.
9. I can use my knowledge about cultural differences (values, beliefs and behaviors) in public health planning.
10. I have the skills to recruit a diverse staff that reflects the populations we serve.

### Program Planning and Development

11. I can include the use of health equity skills into job descriptions.
12. I can implement ongoing health equity and social determinants of health trainings for staff.
13. I can adapt public health programs to take into account the differences among populations.
14. II can add the social determinants of health and health equity into public health policies and actions.
15. I can partner with other organizations to develop strategies to improve health equity.

### Analytic Assessment

16. I can use data that identify health inequities.
17. I can explain social determinants of health data and identify health equity issues.
18. I can evaluate an organization's readiness to work on the social determinants of health that effect health equity.
19. I can analyze policies intended to improve the social determinants of health and health equity.
20. I can identify the evidence linking discrimination and health outcomes.

### Community Practice

21. I can engage communities to work on the social determinants of health and health equity.
22. I can use community-based research to affect the social determinants of health and improve health equity.
23. I can develop community leaders within populations negatively affected by the social determinants of health.
24. I can provide communities with data on health, the social determinants of health and health equity status
25. I can advocate for community investments that improve the social determinants of health and health equity.

### Leadership and Systems Thinking

26. I can promote promising practices that will aid in fair service delivery.
27. I can identify the policies and systems of institutionalized racism.
28. I can to identify the policies and systems of institutionalized discrimination.
29. I can develop policies that will affect the social determinants of health and improve health equity.
30. I can convert policies into programs that improve fair service delivery.

## Appendix H. 1. Results
## Survey Sample Demographics & Frequencies of Responses

| Respondent State | | Frequency | Percent |
|---|---|---|---|
| Valid | | 129 | 28.6 |
| | AK | 18 | 4.0 |
| | AR | 1 | .2 |
| | AZ | 6 | 1.3 |
| | CT | 1 | .2 |
| | DE | 1 | .2 |
| | GA | 1 | .2 |
| | HI | 10 | 2.2 |
| | IA | 34 | 7.5 |
| | IN | 2 | .4 |
| | KY | 10 | 2.2 |
| | MD | 1 | .2 |
| | MI | 41 | 9.1 |
| | MN | 1 | .2 |
| | MO | 2 | .4 |
| | MS | 3 | .7 |
| | NC | 2 | .4 |
| | NE | 1 | .2 |
| | NJ | 1 | .2 |
| | NM | 1 | .2 |
| | NY | 41 | 9.1 |
| | OH | 17 | 3.8 |
| | OK | 11 | 2.4 |
| | PA | 1 | .2 |
| | PR | 4 | .9 |
| | RI | 20 | 4.4 |
| | SC | 35 | 7.8 |
| | TN | 1 | .2 |
| | UT | 1 | .2 |
| | VA | 1 | .2 |
| | VT | 1 | .2 |
| | WA | 48 | 10.6 |

| | | | |
|---|---|---|---|
| | WV | 1 | .2 |
| | WY | 3 | .7 |
| | Total | 451 | 100.0 |

| Respondents place of employment | | Frequency | Percent |
|---|---|---|---|
| Valid | | 28 | 6.2 |
| | Government, federal | 12 | 2.7 |
| | Government, state | 400 | 88.7 |
| | Other (please specify) | 11 | 2.4 |
| | Total | 451 | 100.0 |

| Respondents employment-Other | | Frequency | Percent |
|---|---|---|---|
| Valid | | 440 | 97.6 |
| | Community based organization | 1 | .2 |
| | NASOM | 2 | .4 |
| | NASOMH | 5 | 1.1 |
| | not for profit | 1 | .2 |
| | State Office of Minority Health and Public Health Policy | 1 | .2 |
| | Statewide Coalition | 1 | .2 |
| | Total | 451 | 100.0 |

| Respondents position | | Frequency | Percent |
|---|---|---|---|
| Valid | | 399 | 88.5 |
| | Administrative Assistant | 1 | .2 |
| | Assist in program management/consultation | 1 | .2 |

| | | |
|---|---|---|
| community health consultant | 1 | .2 |
| consultant | 1 | .2 |
| Consultant | 2 | .4 |
| contract manager | 1 | .2 |
| Contract manager | 1 | .2 |
| Contract Manager | 2 | .4 |
| educator | 1 | .2 |
| evaluation specialist | 1 | .2 |
| Evaluator of public health programs | 1 | .2 |
| Financial | 1 | .2 |
| Graduate Assistant | 1 | .2 |
| Graduate Assistant-PH.D. Candidate in Epidemiology | 1 | .2 |
| Health Communications Manager | 1 | .2 |
| health educator | 1 | .2 |
| Health Educator | 1 | .2 |
| Health Equity Coordinator | 1 | .2 |
| Health Program Consultant | 1 | .2 |
| HSC3 | 1 | .2 |
| ITS2 | 1 | .2 |
| Lead Analyst for Federal Program | 1 | .2 |
| Local Public Health Consultant | 1 | .2 |
| manages a program intervention component | 1 | .2 |
| NASOM | 1 | .2 |
| NASOMH | 1 | .2 |
| Nurse Consultant | 1 | .2 |
| Nurse Educator | 1 | .2 |

| | | | |
|---|---|---|---|
| | other | 1 | .2 |
| | president/ceo | 1 | .2 |
| | professional development | 1 | .2 |
| | Program and evaluation consultant | 1 | .2 |
| | Program consultant | 1 | .2 |
| | Program Consultant | 1 | .2 |
| | Program consultant | 1 | .2 |
| | Program Evaluator | 1 | .2 |
| | Program professional development/public education coordination | 1 | .2 |
| | Program staff | 1 | .2 |
| | Project Manager, Health Educator | 1 | .2 |
| | Public Health Consultant | 1 | .2 |
| | public health rep | 1 | .2 |
| | Public Health Rep | 1 | .2 |
| | Public Health Representative/Trainer | 1 | .2 |
| | Secretary | 1 | .2 |
| | Staff | 1 | .2 |
| | Supervisor under Program manager responsible for specific program work, but not entire program | 1 | .2 |
| | support staff | 1 | .2 |
| | Tech | 1 | .2 |
| | Trainer, policy writer | 1 | .2 |
| | WIC trainer | 1 | .2 |
| | Total | 451 | 100.0 |

| Number of years in public health | Frequency | Percent |
|---|---|---|
| Valid | 28 | 6.2 |
| 00-05 | 106 | 23.5 |
| 06-20 | 234 | 51.9 |
| >21 | 83 | 18.4 |
| Total | 451 | 100.0 |

**NACDD-HEC Assessment Pilot Survey Results-Overall Responses/Mean scores**

| CODES: | |
|---|---|
| PROFICIENCY<br><br>1=unaware<br>2=aware<br>3=functional<br>4=proficient<br>5=expert | IMPORTANCE<br>1=UNIMPORTANT<br>2=SLIGHTLY IMPORTANT<br>3=IMPORTANT<br>4=VERY IMPORTANT<br>5=ESSENTIAL |

**COMMUNICATIONS**

***Q1. I can explain the difference between health equity, health inequities and health disparities.***

**Q1A-PROFICIENCY OF RESPONDENT (mean=3.87)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unaware | 21 | 4.7 | 4.7 | 4.7 |
| | aware | 94 | 20.8 | 21.0 | 25.7 |
| | functional | 167 | 37.0 | 37.3 | 62.9 |
| | proficient | 140 | 31.0 | 31.3 | 94.2 |
| | expert | 26 | 5.8 | 5.8 | 100.0 |
| | Total | 448 | 99.3 | 100.0 | |
| Missing | System | 3 | .7 | | |
| Total | | 451 | 100.0 | | |

**Q1B-IMPORTANCE TO RESPONDENT (mean=3.98)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unimportant | 5 | 1.1 | 1.1 | 1.1 |
| | slightly important | 19 | 4.2 | 4.3 | 5.4 |
| | important | 110 | 24.4 | 24.8 | 30.2 |
| | very important | 157 | 34.8 | 35.4 | 65.7 |
| | essential | 152 | 33.7 | 34.3 | 100.0 |
| | Total | 443 | 98.2 | 100.0 | |
| Missing | System | 8 | 1.8 | | |
| Total | | 451 | 100.0 | | |

***Q2. I can describe the effects that the social determinants of health have on health equity for specific populations in my state.***

**Q2A-PROFICIENCY OF RESPONDENT (mean=3.07)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unaware | 17 | 3.8 | 3.8 | 3.8 |
| | aware | 110 | 24.4 | 24.7 | 28.5 |
| | functional | 169 | 37.5 | 38.0 | 66.5 |
| | proficient | 123 | 27.3 | 27.6 | 94.2 |
| | expert | 26 | 5.8 | 5.8 | 100.0 |
| | Total | 445 | 98.7 | 100.0 | |
| Missing | System | 6 | 1.3 | | |
| Total | | 451 | 100.0 | | |

**Q2B-IMPORTANCE TO RESPONDENT (mean=4.05)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unimportant | 3 | .7 | .7 | .7 |
| | slightly important | 17 | 3.8 | 3.8 | 4.5 |
| | important | 91 | 20.2 | 20.4 | 24.9 |
| | very important | 177 | 39.2 | 39.8 | 64.7 |
| | essential | 157 | 34.8 | 35.3 | 100.0 |
| | Total | 445 | 98.7 | 100.0 | |
| Missing | System | 6 | 1.3 | | |
| Total | | 451 | 100.0 | | |

***Q3. I can describe the effects that policies may have on health equity.***

**Q3A-PROFICIENCY OF RESPONDENT (mean=3.07)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unaware | 27 | 6.0 | 6.1 | 6.1 |
| | aware | 93 | 20.6 | 20.9 | 26.9 |
| | functional | 183 | 40.6 | 41.0 | 67.9 |
| | proficient | 110 | 24.4 | 24.7 | 92.6 |
| | expert | 33 | 7.3 | 7.4 | 100.0 |
| | Total | 446 | 98.9 | 100.0 | |
| Missing | System | 5 | 1.1 | | |
| Total | | 451 | 100.0 | | |

**Q3B-IMPORTANCE TO RESPONDENT (mean=4.09)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unimportant | 6 | 1.3 | 1.4 | 1.4 |
| | slightly important | 13 | 2.9 | 2.9 | 4.3 |
| | important | 74 | 16.4 | 16.7 | 20.9 |
| | very important | 194 | 43.0 | 43.7 | 64.6 |
| | essential | 157 | 34.8 | 35.4 | 100.0 |
| | Total | 444 | 98.4 | 100.0 | |
| Missing | System | 7 | 1.6 | | |
| Total | | 451 | 100.0 | | |

***Q4. I can focus policy maker attention on improving social and economic conditions instead of trying to change individual behaviors.***

**Q4A-PROFICIENCY OF RESPONDENT (mean=2.82)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unaware | 38 | 8.4 | 8.5 | 8.5 |
| | aware | 145 | 32.2 | 32.6 | 41.1 |
| | functional | 145 | 32.2 | 32.6 | 73.7 |
| | proficient | 93 | 20.6 | 20.9 | 94.6 |
| | expert | 24 | 5.3 | 5.4 | 100.0 |
| | Total | 445 | 98.7 | 100.0 | |
| Missing | System | 6 | 1.3 | | |
| Total | | 451 | 100.0 | | |

**Q4B-IMPORTANCE TO RESPONDENT (mean=4.10)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unimportant | 4 | .9 | .9 | .9 |
| | slightly important | 14 | 3.1 | 3.2 | 4.1 |
| | important | 95 | 21.1 | 21.5 | 25.6 |
| | very important | 152 | 33.7 | 34.4 | 60.0 |
| | essential | 177 | 39.2 | 40.0 | 100.0 |
| | Total | 442 | 98.0 | 100.0 | |
| Missing | System | 9 | 2.0 | | |
| Total | | 451 | 100.0 | | |

***Q5. I can use television, radio and print media to describe the costs connected to the social determinants of health.***

**Q5A-PROFICIENCY OF RESPONDENT (mean=2.46)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unaware | 64 | 14.2 | 14.4 | 14.4 |
| | aware | 189 | 41.9 | 42.6 | 57.0 |
| | functional | 123 | 27.3 | 27.7 | 84.7 |
| | proficient | 58 | 12.9 | 13.1 | 97.7 |
| | expert | 10 | 2.2 | 2.3 | 100.0 |
| | Total | 444 | 98.4 | 100.0 | |
| Missing | System | 7 | 1.6 | | |
| Total | | 451 | 100.0 | | |

**Q5B-IMPORTANCE TO RESPONDENT (mean=3.64)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unimportant | 5 | 1.1 | 1.1 | 1.1 |
| | slightly important | 35 | 7.8 | 8.0 | 9.1 |
| | important | 148 | 32.8 | 33.6 | 42.7 |
| | very important | 176 | 39.0 | 40.0 | 82.7 |
| | essential | 76 | 16.9 | 17.3 | 100.0 |
| | Total | 440 | 97.6 | 100.0 | |
| Missing | System | 11 | 2.4 | | |
| Total | | 451 | 100.0 | | |

## CULTURAL COMPETENCE

***Q6. I can identify the effects of cultural factors on public health services.***

**Q6A-PROFICIENCY OF RESPONDENT (mean=3.18)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unaware | 15 | 3.3 | 3.4 | 3.4 |
| | aware | 96 | 21.3 | 21.9 | 25.3 |
| | functional | 159 | 35.3 | 36.2 | 61.5 |
| | proficient | 131 | 29.0 | 29.8 | 91.3 |
| | expert | 38 | 8.4 | 8.7 | 100.0 |
| | Total | 439 | 97.3 | 100.0 | |
| Missing | System | 12 | 2.7 | | |
| Total | | 451 | 100.0 | | |

**Q6B-IMPORTANCE TO RESPONDENT (mean=4.05)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unimportant | 2 | .4 | .5 | .5 |
| | slightly important | 10 | 2.2 | 2.3 | 2.8 |
| | important | 98 | 21.7 | 22.6 | 25.3 |
| | very important | 180 | 39.9 | 41.5 | 66.8 |
| | essential | 144 | 31.9 | 33.2 | 100.0 |
| | Total | 434 | 96.2 | 100.0 | |
| Missing | System | 17 | 3.8 | | |
| Total | | 451 | 100.0 | | |

***Q7. I can describe the cultural differences among the populations we serve.***

**Q7A-PROFICIENCY OF RESPONDENT (mean=3.18)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unaware | 11 | 2.4 | 2.5 | 2.5 |
| | aware | 98 | 21.7 | 22.3 | 24.8 |
| | functional | 165 | 36.6 | 37.5 | 62.3 |
| | proficient | 132 | 29.3 | 30.0 | 92.3 |
| | expert | 34 | 7.5 | 7.7 | 100.0 |
| | Total | 440 | 97.6 | 100.0 | |
| Missing | System | 11 | 2.4 | | |
| Total | | 451 | 100.0 | | |

**Q7B-IMPORTANCE TO RESPONDENT (mean=4.09)**

**Q7B**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unimportant | 3 | .7 | .7 | .7 |
| | slightly important | 12 | 2.7 | 2.8 | 3.4 |
| | important | 82 | 18.2 | 18.9 | 22.3 |
| | very important | 185 | 41.0 | 42.5 | 64.8 |
| | essential | 153 | 33.9 | 35.2 | 100.0 |
| | Total | 435 | 96.5 | 100.0 | |
| Missing | System | 16 | 3.5 | | |
| Total | | 451 | 100.0 | | |

***Q8. I can provide cultural competency training to improve staff skills in working with diverse populations.***

**Q8A-PROFICIENCY OF RESPONDENT (mean=2.06)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unaware | 59 | 13.1 | 13.4 | 13.4 |
| | aware | 176 | 39.0 | 40.1 | 53.5 |
| | functional | 114 | 25.3 | 26.0 | 79.5 |
| | proficient | 63 | 14.0 | 14.4 | 93.8 |
| | expert | 27 | 6.0 | 6.2 | 100.0 |
| | Total | 439 | 97.3 | 100.0 | |
| Missing | System | 12 | 2.7 | | |
| Total | | 451 | 100.0 | | |

**Q8B-IMPORTANCE TO RESPONDENT (mean=3.84)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unimportant | 7 | 1.6 | 1.6 | 1.6 |
| | slightly important | 22 | 4.9 | 5.1 | 6.7 |
| | important | 125 | 27.7 | 28.8 | 35.5 |
| | very important | 159 | 35.3 | 36.6 | 72.1 |
| | essential | 121 | 26.8 | 27.9 | 100.0 |
| | Total | 434 | 96.2 | 100.0 | |
| Missing | System | 17 | 3.8 | | |
| Total | | 451 | 100.0 | | |

***Q9. I can use my knowledge about cultural differences (values, beliefs and behaviors) in public health planning.***

**Q9A-PROFICIENCY OF RESPONDENT (mean=3.19)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unaware | 15 | 3.3 | 3.4 | 3.4 |
| | aware | 91 | 20.2 | 20.8 | 24.2 |
| | functional | 164 | 36.4 | 37.4 | 61.6 |
| | proficient | 130 | 28.8 | 29.7 | 91.3 |
| | expert | 38 | 8.4 | 8.7 | 100.0 |
| | Total | 438 | 97.1 | 100.0 | |
| Missing | System | 13 | 2.9 | | |
| Total | | 451 | 100.0 | | |

**Q9B-IMPORTANCE TO RESPONDENT (mean=4.10)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unimportant | 2 | .4 | .5 | .5 |
| | slightly important | 15 | 3.3 | 3.5 | 3.9 |
| | important | 81 | 18.0 | 18.8 | 22.7 |
| | very important | 172 | 38.1 | 39.9 | 62.6 |
| | essential | 161 | 35.7 | 37.4 | 100.0 |
| | Total | 431 | 95.6 | 100.0 | |
| Missing | System | 20 | 4.4 | | |
| Total | | 451 | 100.0 | | |

***Q10. I have the skills to recruit a diverse staff that reflects the populations we serve.***

**Q10A-PROFICIENCY OF RESPONDENT (mean=3.01)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unaware | 34 | 7.5 | 7.8 | 7.8 |
| | aware | 115 | 25.5 | 26.3 | 34.0 |
| | functional | 138 | 30.6 | 31.5 | 65.5 |
| | proficient | 115 | 25.5 | 26.3 | 91.8 |
| | expert | 36 | 8.0 | 8.2 | 100.0 |
| | Total | 438 | 97.1 | 100.0 | |
| Missing | System | 13 | 2.9 | | |
| Total | | 451 | 100.0 | | |

**Q10B-IMPORTANCE TO RESPONDENT (mean=3.89)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unimportant | 8 | 1.8 | 1.9 | 1.9 |
| | slightly important | 24 | 5.3 | 5.6 | 7.4 |
| | important | 101 | 22.4 | 23.4 | 30.8 |
| | very important | 174 | 38.6 | 40.3 | 71.1 |
| | essential | 125 | 27.7 | 28.9 | 100.0 |
| | Total | 432 | 95.8 | 100.0 | |
| Missing | System | 19 | 4.2 | | |
| Total | | 451 | 100.0 | | |

## PROGRAM PLANNING AND DEVELOPMENT

***Q11. I can include the use of health equity skills into job descriptions.***

**Q11A-PROFICIENCY OF RESPONDENT (mean= 2.65)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unaware | 60 | 13.3 | 13.9 | 13.9 |
| | aware | 137 | 30.4 | 31.8 | 45.7 |
| | functional | 146 | 32.4 | 33.9 | 79.6 |
| | proficient | 72 | 16.0 | 16.7 | 96.3 |
| | expert | 16 | 3.5 | 3.7 | 100.0 |
| | Total | 431 | 95.6 | 100.0 | |
| Missing | System | 20 | 4.4 | | |
| Total | | 451 | 100.0 | | |

**Q11B-IMPORTANCE TO RESPONDENT (mean=3.58)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unimportant | 10 | 2.2 | 2.3 | 2.3 |
| | slightly important | 35 | 7.8 | 8.2 | 10.5 |
| | important | 150 | 33.3 | 35.0 | 45.6 |
| | very important | 164 | 36.4 | 38.3 | 83.9 |
| | essential | 69 | 15.3 | 16.1 | 100.0 |
| | Total | 428 | 94.9 | 100.0 | |
| Missing | System | 23 | 5.1 | | |
| Total | | 451 | 100.0 | | |

***Q12. I can implement ongoing health equity and social determinants of health trainings for staff.***

**Q12A-PROFICIENCY OF RESPONDENT (mean=2.61)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unaware | 60 | 13.3 | 14.0 | 14.0 |
| | aware | 151 | 33.5 | 35.2 | 49.2 |
| | functional | 136 | 30.2 | 31.7 | 80.9 |
| | proficient | 62 | 13.7 | 14.5 | 95.3 |
| | expert | 20 | 4.4 | 4.7 | 100.0 |
| | Total | 429 | 95.1 | 100.0 | |
| Missing | System | 22 | 4.9 | | |
| Total | | 451 | 100.0 | | |

**Q12B-IMPORTANCE TO RESPONDENT (mean=3.72)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unimportant | 9 | 2.0 | 2.1 | 2.1 |
| | slightly important | 26 | 5.8 | 6.1 | 8.2 |
| | important | 130 | 28.8 | 30.5 | 38.7 |
| | very important | 172 | 38.1 | 40.4 | 79.1 |
| | essential | 89 | 19.7 | 20.9 | 100.0 |
| | Total | 426 | 94.5 | 100.0 | |
| Missing | System | 25 | 5.5 | | |
| Total | | 451 | 100.0 | | |

***Q13. I can adapt public health programs to take into account the differences among populations.***

**Q13A-PROFICIENCY OF RESPONDENT (mean=2.61)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unaware | 25 | 5.5 | 5.8 | 5.8 |
| | aware | 98 | 21.7 | 22.8 | 28.7 |
| | functional | 175 | 38.8 | 40.8 | 69.5 |
| | proficient | 103 | 22.8 | 24.0 | 93.5 |
| | expert | 28 | 6.2 | 6.5 | 100.0 |
| | Total | 429 | 95.1 | 100.0 | |
| Missing | System | 22 | 4.9 | | |
| Total | | 451 | 100.0 | | |

**Q13B-IMPORTANCE TO RESPONDENT (mean=3.72)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unimportant | 3 | .7 | .7 | .7 |
| | slightly important | 10 | 2.2 | 2.3 | 3.0 |
| | important | 91 | 20.2 | 21.1 | 24.1 |
| | very important | 188 | 41.7 | 43.6 | 67.7 |
| | essential | 139 | 30.8 | 32.3 | 100.0 |
| | Total | 431 | 95.6 | 100.0 | |
| Missing | System | 20 | 4.4 | | |
| Total | | 451 | 100.0 | | |

***Q14. I can add the social determinants of health and health equity into public health policies and actions.***

**Q14A-PROFICIENCY OF RESPONDENT (mean=4.04)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unaware | 32 | 7.1 | 7.5 | 7.5 |
| | aware | 139 | 30.8 | 32.5 | 40.0 |
| | functional | 169 | 37.5 | 39.5 | 79.4 |
| | proficient | 73 | 16.2 | 17.1 | 96.5 |
| | expert | 15 | 3.3 | 3.5 | 100.0 |
| | Total | 428 | 94.9 | 100.0 | |
| Missing | System | 23 | 5.1 | | |
| Total | | 451 | 100.0 | | |

**Q14B-IMPORTANCE TO RESPONDENT (mean=2.77)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unimportant | 5 | 1.1 | 1.2 | 1.2 |
| | slightly important | 13 | 2.9 | 3.0 | 4.2 |
| | important | 92 | 20.4 | 21.5 | 25.7 |
| | very important | 177 | 39.2 | 41.4 | 67.1 |
| | essential | 141 | 31.3 | 32.9 | 100.0 |
| | Total | 428 | 94.9 | 100.0 | |
| Missing | System | 23 | 5.1 | | |
| Total | | 451 | 100.0 | | |

***Q15. I can partner with other organizations to develop strategies to improve health equity.***

**Q15A-PROFICIENCY OF RESPONDENT (mean=4.02)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unaware | 22 | 4.9 | 5.1 | 5.1 |
| | aware | 92 | 20.4 | 21.4 | 26.6 |
| | functional | 129 | 28.6 | 30.1 | 56.6 |
| | proficient | 149 | 33.0 | 34.7 | 91.4 |
| | expert | 37 | 8.2 | 8.6 | 100.0 |
| | Total | 429 | 95.1 | 100.0 | |
| Missing | System | 22 | 4.9 | | |
| Total | | 451 | 100.0 | | |

**Q15B-IMPORTANCE TO RESPONDENT (mean=4.11)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unimportant | 3 | .7 | .7 | .7 |
| | slightly important | 13 | 2.9 | 3.0 | 3.7 |
| | important | 75 | 16.6 | 17.5 | 21.2 |
| | very important | 181 | 40.1 | 42.2 | 63.4 |
| | essential | 157 | 34.8 | 36.6 | 100.0 |
| | Total | 429 | 95.1 | 100.0 | |
| Missing | System | 22 | 4.9 | | |
| Total | | 451 | 100.0 | | |

**ANALYTIC ASSESSMENT**

***Q16. I can use data that identify health inequities.***

**Q16A-PROFICIENCY OF RESPONDENT (mean=3.30)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unaware | 23 | 5.1 | 5.4 | 5.4 |
| | aware | 72 | 16.0 | 16.8 | 22.2 |
| | functional | 134 | 29.7 | 31.3 | 53.5 |
| | proficient | 150 | 33.3 | 35.0 | 88.6 |
| | expert | 49 | 10.9 | 11.4 | 100.0 |
| | Total | 428 | 94.9 | 100.0 | |
| Missing | System | 23 | 5.1 | | |
| Total | | 451 | 100.0 | | |

**Q16B-IMPORTANCE TO RESPONDENT (mean=4.17)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unimportant | 1 | .2 | .2 | .2 |
| | slightly important | 11 | 2.4 | 2.6 | 2.8 |
| | important | 64 | 14.2 | 15.0 | 17.8 |
| | very important | 187 | 41.5 | 43.9 | 61.7 |
| | essential | 163 | 36.1 | 38.3 | 100.0 |
| | Total | 426 | 94.5 | 100.0 | |
| Missing | System | 25 | 5.5 | | |
| Total | | 451 | 100.0 | | |

***Q17. I can explain social determinants of health data and identify health equity issues.***

**Q17A-PROFICIENCY OF RESPONDENT (mean=3.11)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unaware | 37 | 8.2 | 8.6 | 8.6 |
| | aware | 83 | 18.4 | 19.4 | 28.0 |
| | functional | 145 | 32.2 | 33.9 | 61.9 |
| | proficient | 123 | 27.3 | 28.7 | 90.7 |
| | expert | 40 | 8.9 | 9.3 | 100.0 |
| | Total | 428 | 94.9 | 100.0 | |
| Missing | System | 23 | 5.1 | | |
| Total | | 451 | 100.0 | | |

**Q17B-IMPORTANCE TO RESPONDENT (mean=4.03)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unimportant | 3 | .7 | .7 | .7 |
| | slightly important | 13 | 2.9 | 3.1 | 3.8 |
| | important | 81 | 18.0 | 19.1 | 22.8 |
| | very important | 200 | 44.3 | 47.1 | 69.9 |
| | essential | 128 | 28.4 | 30.1 | 100.0 |
| | Total | 425 | 94.2 | 100.0 | |
| Missing | System | 26 | 5.8 | | |
| Total | | 451 | 100.0 | | |

***Q18. I can evaluate an organization's readiness to work on the social determinants of health that effect health equity.***

**Q18A-PROFICIENCY OF RESPONDENT (mean=2.34)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unaware | 88 | 19.5 | 20.7 | 20.7 |
| | aware | 172 | 38.1 | 40.5 | 61.2 |
| | functional | 108 | 23.9 | 25.4 | 86.6 |
| | proficient | 45 | 10.0 | 10.6 | 97.2 |
| | expert | 12 | 2.7 | 2.8 | 100.0 |
| | Total | 425 | 94.2 | 100.0 | |
| Missing | System | 26 | 5.8 | | |
| Total | | 451 | 100.0 | | |

**Q18B-IMPORTANCE TO RESPONDENT (mean=3.71)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unimportant | 7 | 1.6 | 1.6 | 1.6 |
| | slightly important | 18 | 4.0 | 4.2 | 5.9 |
| | important | 142 | 31.5 | 33.4 | 39.3 |
| | very important | 181 | 40.1 | 42.6 | 81.9 |
| | essential | 77 | 17.1 | 18.1 | 100.0 |
| | Total | 425 | 94.2 | 100.0 | |
| Missing | System | 26 | 5.8 | | |
| Total | | 451 | 100.0 | | |

***Q19. I can analyze policies intended to improve the social determinants of health and health equity.***

**Q19A-PROFICIENCY OF RESPONDENT (mean=2.67)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unaware | 57 | 12.6 | 13.3 | 13.3 |
| | aware | 130 | 28.8 | 30.4 | 43.8 |
| | functional | 150 | 33.3 | 35.1 | 78.9 |
| | proficient | 78 | 17.3 | 18.3 | 97.2 |

| | | | | | |
|---|---|---|---|---|---|
| | expert | 12 | 2.7 | 2.8 | 100.0 |
| | Total | 427 | 94.7 | 100.0 | |
| Missing | System | 24 | 5.3 | | |
| Total | | 451 | 100.0 | | |

**Q19B-IMPORTANCE TO RESPONDENT (mean=3.89)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unimportant | 3 | .7 | .7 | .7 |
| | slightly important | 15 | 3.3 | 3.5 | 4.2 |
| | important | 110 | 24.4 | 25.8 | 30.0 |
| | very important | 194 | 43.0 | 45.5 | 75.6 |
| | essential | 104 | 23.1 | 24.4 | 100.0 |
| | Total | 426 | 94.5 | 100.0 | |
| Missing | System | 25 | 5.5 | | |
| Total | | 451 | 100.0 | | |

***20. I can identify the evidence linking discrimination and health outcomes.***

**Q20A-PROFICIENCY OF RESPONDENT (mean=2.78)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unaware | 47 | 10.4 | 11.1 | 11.1 |
| | aware | 129 | 28.6 | 30.4 | 41.5 |
| | functional | 141 | 31.3 | 33.3 | 74.8 |
| | proficient | 83 | 18.4 | 19.6 | 94.3 |
| | expert | 24 | 5.3 | 5.7 | 100.0 |
| | Total | 424 | 94.0 | 100.0 | |
| Missing | System | 27 | 6.0 | | |
| Total | | 451 | 100.0 | | |

**Q20B-IMPORTANCE TO RESPONDENT (mean=3.87)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unimportant | 3 | .7 | .7 | .7 |
| | slightly important | 21 | 4.7 | 5.0 | 5.7 |
| | important | 122 | 27.1 | 28.8 | 34.4 |
| | very important | 162 | 35.9 | 38.2 | 72.6 |
| | essential | 116 | 25.7 | 27.4 | 100.0 |
| | Total | 424 | 94.0 | 100.0 | |
| Missing | System | 27 | 6.0 | | |
| Total | | 451 | 100.0 | | |

**COMMUNITY PRACTICE**

***Q21. I can engage communities to work on the social determinants of health and health equity.***

**Q21A-PROFICIENCY OF RESPONDENT (mean=2.80)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unaware | 47 | 10.4 | 11.1 | 11.1 |
| | aware | 124 | 27.5 | 29.3 | 40.4 |
| | functional | 144 | 31.9 | 34.0 | 74.5 |
| | proficient | 84 | 18.6 | 19.9 | 94.3 |
| | expert | 24 | 5.3 | 5.7 | 100.0 |
| | Total | 423 | 93.8 | 100.0 | |
| Missing | System | 28 | 6.2 | | |
| Total | | 451 | 100.0 | | |

**Q21B-IMPORTANCE TO RESPONDENT (mean=4.00)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unimportant | 5 | 1.1 | 1.2 | 1.2 |

| | | | | | |
|---|---|---|---|---|---|
| | slightly important | 16 | 3.5 | 3.8 | 5.0 |
| | important | 94 | 20.8 | 22.2 | 27.1 |
| | very important | 167 | 37.0 | 39.4 | 66.5 |
| | essential | 142 | 31.5 | 33.5 | 100.0 |
| | Total | 424 | 94.0 | 100.0 | |
| Missing | System | 27 | 6.0 | | |
| Total | | 451 | 100.0 | | |

***Q22. I can use community-based research to affect the social determinants of health and improve health equity.***

**Q22A-PROFICIENCY OF RESPONDENT (mean=2.68)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unaware | 52 | 11.5 | 12.3 | 12.3 |
| | aware | 139 | 30.8 | 32.9 | 45.3 |
| | functional | 140 | 31.0 | 33.2 | 78.4 |
| | proficient | 73 | 16.2 | 17.3 | 95.7 |
| | expert | 18 | 4.0 | 4.3 | 100.0 |
| | Total | 422 | 93.6 | 100.0 | |
| Missing | System | 29 | 6.4 | | |
| Total | | 451 | 100.0 | | |

**Q22B-IMPORTANCE TO RESPONDENT (mean=3.84)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unimportant | 5 | 1.1 | 1.2 | 1.2 |
| | slightly important | 20 | 4.4 | 4.7 | 5.9 |
| | important | 114 | 25.3 | 27.0 | 32.9 |
| | very important | 183 | 40.6 | 43.3 | 76.1 |
| | essential | 101 | 22.4 | 23.9 | 100.0 |
| | Total | 423 | 93.8 | 100.0 | |
| Missing | System | 28 | 6.2 | | |

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unimportant | 5 | 1.1 | 1.2 | 1.2 |
| | slightly important | 20 | 4.4 | 4.7 | 5.9 |
| | important | 114 | 25.3 | 27.0 | 32.9 |
| | very important | 183 | 40.6 | 43.3 | 76.1 |
| | essential | 101 | 22.4 | 23.9 | 100.0 |
| | Total | 423 | 93.8 | 100.0 | |
| Missing | System | 28 | 6.2 | | |
| Total | | 451 | 100.0 | | |

***Q23. I can develop community leaders within populations negatively affected by the social determinants of health.***

**Q23A-PROFICIENCY OF RESPONDENT (mean=2.38)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unaware | 76 | 16.9 | 18.1 | 18.1 |
| | aware | 173 | 38.4 | 41.2 | 59.3 |
| | functional | 114 | 25.3 | 27.1 | 86.4 |
| | proficient | 48 | 10.6 | 11.4 | 97.9 |
| | expert | 9 | 2.0 | 2.1 | 100.0 |
| | Total | 420 | 93.1 | 100.0 | |
| Missing | System | 31 | 6.9 | | |
| Total | | 451 | 100.0 | | |

**Q23B-IMPORTANCE TO RESPONDENT (mean=3.89)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unimportant | 6 | 1.3 | 1.4 | 1.4 |
| | slightly important | 21 | 4.7 | 5.0 | 6.4 |

| | | | | | |
|---|---|---|---|---|---|
| | important | 110 | 24.4 | 26.1 | 32.5 |
| | very important | 162 | 35.9 | 38.5 | 71.0 |
| | essential | 122 | 27.1 | 29.0 | 100.0 |
| | Total | 421 | 93.3 | 100.0 | |
| Missing | System | 30 | 6.7 | | |
| Total | | 451 | 100.0 | | |

***Q24. I can provide communities with data on health, the social determinants of health and health equity status***

**Q24A-PROFICIENCY OF RESPONDENT (mean=3.08)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unaware | 37 | 8.2 | 8.7 | 8.7 |
| | aware | 98 | 21.7 | 23.0 | 31.7 |
| | functional | 129 | 28.6 | 30.3 | 62.0 |
| | proficient | 118 | 26.2 | 27.7 | 89.7 |
| | expert | 44 | 9.8 | 10.3 | 100.0 |
| | Total | 426 | 94.5 | 100.0 | |
| Missing | System | 25 | 5.5 | | |
| Total | | 451 | 100.0 | | |

**Q24B-IMPORTANCE TO RESPONDENT (mean=3.94)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unimportant | 5 | 1.1 | 1.2 | 1.2 |
| | slightly important | 14 | 3.1 | 3.3 | 4.5 |
| | important | 101 | 22.4 | 23.9 | 28.4 |
| | very important | 184 | 40.8 | 43.6 | 72.0 |
| | essential | 118 | 26.2 | 28.0 | 100.0 |
| | Total | 422 | 93.6 | 100.0 | |
| Missing | System | 29 | 6.4 | | |
| Total | | 451 | 100.0 | | |

***Q25. I can advocate for community investments that improve the social determinants of health and health equity.***

**Q25A-PROFICIENCY OF RESPONDENT (mean=2.68)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unaware | 50 | 11.1 | 11.8 | 11.8 |
| | aware | 154 | 34.1 | 36.3 | 48.1 |
| | functional | 120 | 26.6 | 28.3 | 76.4 |
| | proficient | 82 | 18.2 | 19.3 | 95.8 |
| | expert | 18 | 4.0 | 4.2 | 100.0 |
| | Total | 424 | 94.0 | 100.0 | |
| Missing | System | 27 | 6.0 | | |
| Total | | 451 | 100.0 | | |

**Q25B-IMPORTANCE TO RESPONDENT (mean=3.92)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unimportant | 5 | 1.1 | 1.2 | 1.2 |
| | slightly important | 18 | 4.0 | 4.3 | 5.5 |
| | important | 99 | 22.0 | 23.6 | 29.0 |
| | very important | 182 | 40.4 | 43.3 | 72.4 |
| | essential | 116 | 25.7 | 27.6 | 100.0 |
| | Total | 420 | 93.1 | 100.0 | |
| Missing | System | 31 | 6.9 | | |
| Total | | 451 | 100.0 | | |

**LEADERSHIP AND SYSTEMS THINKING**

***Q26. I can promote promising practices that will aid in fair service delivery.***

**Q26A-PROFICIENCY OF RESPONDENT (mean=2.86)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unaware | 48 | 10.6 | 11.3 | 11.3 |
| | aware | 107 | 23.7 | 25.2 | 36.6 |
| | functional | 148 | 32.8 | 34.9 | 71.5 |
| | proficient | 99 | 22.0 | 23.3 | 94.8 |
| | expert | 22 | 4.9 | 5.2 | 100.0 |
| | Total | 424 | 94.0 | 100.0 | |
| Missing | System | 27 | 6.0 | | |
| Total | | 451 | 100.0 | | |

**Q26B-IMPORTANCE TO RESPONDENT (mean=3.89)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unimportant | 3 | .7 | .7 | .7 |
| | slightly important | 15 | 3.3 | 3.6 | 4.3 |
| | important | 115 | 25.5 | 27.5 | 31.8 |
| | very important | 178 | 39.5 | 42.6 | 74.4 |
| | essential | 107 | 23.7 | 25.6 | 100.0 |
| | Total | 418 | 92.7 | 100.0 | |
| Missing | System | 33 | 7.3 | | |
| Total | | 451 | 100.0 | | |

***Q27. I can identify the policies and systems of institutionalized racism.***

**Q27A-PROFICIENCY OF RESPONDENT (mean=2.51)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unaware | 65 | 14.4 | 15.4 | 15.4 |
| | aware | 175 | 38.8 | 41.5 | 56.9 |
| | functional | 100 | 22.2 | 23.7 | 80.6 |
| | proficient | 65 | 14.4 | 15.4 | 96.0 |
| | expert | 17 | 3.8 | 4.0 | 100.0 |

| | | | | | |
|---|---|---|---|---|---|
| | Total | 422 | 93.6 | 100.0 | |
| Missing | System | 29 | 6.4 | | |
| Total | | 451 | 100.0 | | |

**Q27B-IMPORTANCE TO RESPONDENT (mean=3.86)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unimportant | 3 | .7 | .7 | .7 |
| | slightly important | 29 | 6.4 | 6.9 | 7.6 |
| | important | 112 | 24.8 | 26.5 | 34.1 |
| | very important | 156 | 34.6 | 37.0 | 71.1 |
| | essential | 122 | 27.1 | 28.9 | 100.0 |
| | Total | 422 | 93.6 | 100.0 | |
| Missing | System | 29 | 6.4 | | |
| Total | | 451 | 100.0 | | |

***Q28. I can to identify the policies and systems of institutionalized discrimination.***

**Q28A-PROFICIENCY OF RESPONDENT (mean=2.54)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unaware | 66 | 14.6 | 15.7 | 15.7 |
| | aware | 162 | 35.9 | 38.5 | 54.2 |
| | functional | 108 | 23.9 | 25.7 | 79.8 |
| | proficient | 70 | 15.5 | 16.6 | 96.4 |
| | expert | 15 | 3.3 | 3.6 | 100.0 |
| | Total | 421 | 93.3 | 100.0 | |
| Missing | System | 30 | 6.7 | | |
| Total | | 451 | 100.0 | | |

**Q28B-IMPORTANCE TO RESPONDENT (mean=3.87)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unimportant | 2 | .4 | .5 | .5 |
| | slightly important | 26 | 5.8 | 6.2 | 6.7 |
| | important | 117 | 25.9 | 27.9 | 34.5 |
| | very important | 153 | 33.9 | 36.4 | 71.0 |
| | essential | 122 | 27.1 | 29.0 | 100.0 |
| | Total | 420 | 93.1 | 100.0 | |
| Missing | System | 31 | 6.9 | | |
| Total | | 451 | 100.0 | | |

***Q29. I can develop policies that will affect the social determinants of health and improve health equity.***

**Q29A-PROFICIENCY OF RESPONDENT (mean=2.57)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unaware | 59 | 13.1 | 13.9 | 13.9 |
| | aware | 153 | 33.9 | 36.2 | 50.1 |
| | functional | 135 | 29.9 | 31.9 | 82.0 |
| | proficient | 63 | 14.0 | 14.9 | 96.9 |
| | expert | 13 | 2.9 | 3.1 | 100.0 |
| | Total | 423 | 93.8 | 100.0 | |
| Missing | System | 28 | 6.2 | | |
| Total | | 451 | 100.0 | | |

**Q29B-IMPORTANCE TO RESPONDENT (mean=3.96)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unimportant | 3 | .7 | .7 | .7 |
| | slightly important | 14 | 3.1 | 3.3 | 4.1 |
| | important | 109 | 24.2 | 26.1 | 30.1 |
| | very important | 163 | 36.1 | 39.0 | 69.1 |

| | | | | | |
|---|---|---|---|---|---|
| | essential | 129 | 28.6 | 30.9 | 100.0 |
| | Total | 418 | 92.7 | 100.0 | |
| Missing | System | 33 | 7.3 | | |
| Total | | 451 | 100.0 | | |

***Q30. I can convert policies into programs that improve fair service delivery.***

**Q30A-PROFICIENCY OF RESPONDENT (mean=2.52)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unaware | 65 | 14.4 | 15.4 | 15.4 |
| | aware | 157 | 34.8 | 37.3 | 52.7 |
| | functional | 127 | 28.2 | 30.2 | 82.9 |
| | proficient | 57 | 12.6 | 13.5 | 96.4 |
| | expert | 15 | 3.3 | 3.6 | 100.0 |
| | Total | 421 | 93.3 | 100.0 | |
| Missing | System | 30 | 6.7 | | |
| Total | | 451 | 100.0 | | |

**Q30B-IMPORTANCE TO RESPONDENT (mean=3.92)**

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | unimportant | 4 | .9 | 1.0 | 1.0 |
| | slightly important | 14 | 3.1 | 3.3 | 4.3 |
| | important | 114 | 25.3 | 27.1 | 31.4 |
| | very important | 166 | 36.8 | 39.5 | 71.0 |
| | essential | 122 | 27.1 | 29.0 | 100.0 |
| | Total | 420 | 93.1 | 100.0 | |
| Missing | System | 31 | 6.9 | | |
| Total | | 451 | 100.0 | | |

## Appendix H.2. Results

### Cross Tabulations of Responses by Level of Public Health Proficiency & Experience

**HEALTH EQUITY SKILLS ASSESSMENT-PILOT SURVEY RESULTS (N=451)**

| CODES: | |
|---|---|
| PROFICIENCY<br>Tier 1=unaware or only aware<br>Tier 2=functional<br>Tier 3=proficient/expert | IMPORTANCE<br>1=UNIMPORTANT/SLIGHTLY IMPORTANT<br>2=IMPORTANT<br>3=VERY IMPORTANT/ESSENTIAL |

**COMMUNICATIONS**

1. **I can explain the difference between health equity, health inequities and health disparities.**

**A. PROFICIENCY by Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q1AR | tier1 | Count | 28 | 56 | 17 | 101 |
| | | % | 26.4%[10] | 24.1% | 20.5% | 24.0% |
| | tier2 | Count | 47 | 92 | 20 | 159 |
| | | % | 44.3% | 39.7% | 24.1% | 37.8% |
| | tier3 | Count | 31 | 84 | 46 | 161 |
| | | % | 29.2% | 36.2% | 55.4% | 38.2% |
| Total | | Count | 106 | 232 | 83 | 421 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**B. IMPORTANCE by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q1BR | 1.00 | Count | 5 | 12 | 3 | 20 |
| | | % | 4.7% | 5.2% | 3.7% | 4.8% |
| | 2.00 | Count | 24 | 52 | 26 | 102 |
| | | % | 22.6% | 22.6% | 31.7% | 24.4% |
| | 3.00 | Count | 77 | 166 | 53 | 296 |
| | | % | 72.6% | 72.2% | 64.6% | 70.8% |
| Total | | Count | 106 | 230 | 82 | 418 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

[10] % with highlights indicate significant results

**2. I can describe the effects that the social determinants of health have on health equity for specific populations in my state.**

**A. PROFICIENCY by**
**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q2AR | tier1 | Count | 36 | 64 | 16 | 116 |
| | | % | 34.0% | 27.6% | 19.3% | 27.6% |
| | tier2 | Count | 44 | 87 | 30 | 161 |
| | | % | 41.5% | 37.5% | 36.1% | 38.2% |
| | tier3 | Count | 26 | 81 | 37 | 144 |
| | | % | 24.5% | 34.9% | 44.6% | 34.2% |
| Total | | Count | 106 | 232 | 83 | 421 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**B. IMPORTANCE by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q2BR | 1.00 | Count | 3 | 10 | 4 | 17 |
| | | % | 2.8% | 4.3% | 4.8% | 4.0% |
| | 2.00 | Count | 20 | 40 | 22 | 82 |
| | | % | 18.9% | 17.2% | 26.5% | 19.5% |
| | 3.00 | Count | 83 | 182 | 57 | 322 |
| | | % | 78.3% | 78.4% | 68.7% | 76.5% |
| Total | | Count | 106 | 232 | 83 | 421 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**3. I can describe the effects that policies may have on health equity.**
**A. PROFICIENCY by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q3AR | tier1 | Count | 35 | 54 | 20 | 109 |
| | | % | 33.0% | 23.3% | 24.1% | 25.9% |
| | tier2 | Count | 43 | 98 | 31 | 172 |
| | | % | 40.6% | 42.2% | 37.3% | 40.9% |
| | tier3 | Count | 28 | 80 | 32 | 140 |
| | | % | 26.4% | 34.5% | 38.6% | 33.3% |
| Total | | Count | 106 | 232 | 83 | 421 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**B. IMPORTANCE by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q3BR | 1.00 | Count | 2 | 10 | 3 | 15 |
| | | % | 1.9% | 4.3% | 3.6% | 3.6% |
| | 2.00 | Count | 19 | 30 | 16 | 65 |
| | | % | 17.9% | 13.0% | 19.3% | 15.5% |
| | 3.00 | Count | 85 | 190 | 64 | 339 |
| | | % | 80.2% | 82.6% | 77.1% | 80.9% |
| Total | | Count | 106 | 230 | 83 | 419 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**4. I can focus policy maker attention on improving social and economic conditions instead of trying to change individual behaviors.**

**A. PROFICIENCY by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q4AR | tier1 | Count | 52 | 90 | 27 | 169 |
| | | % | 50.0% | 38.6% | 32.5% | 40.2% |
| | tier2 | Count | 32 | 79 | 26 | 137 |
| | | % | 30.8% | 33.9% | 31.3% | 32.6% |
| | tier3 | Count | 20 | 64 | 30 | 114 |
| | | % | 19.2% | 27.5% | 36.1% | 27.1% |
| Total | | Count | 104 | 233 | 83 | 420 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**B. IMPORTANCE by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q4BR | 1.00 | Count | 4 | 10 | 3 | 17 |
| | | % | 3.8% | 4.3% | 3.6% | 4.1% |
| | 2.00 | Count | 20 | 47 | 16 | 83 |
| | | % | 19.2% | 20.4% | 19.3% | 19.9% |
| | 3.00 | Count | 80 | 173 | 64 | 317 |
| | | % | 76.9% | 75.2% | 77.1% | 76.0% |
| Total | | Count | 104 | 230 | 83 | 417 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**5. I can use television, radio and print media to describe the costs connected to the social determinants of health.**

**A. PROFICIENCY by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q5AR | tier1 | Count | 65 | 131 | 41 | 237 |
| | | % | 61.3% | 57.0% | 49.4% | 56.6% |
| | tier2 | Count | 27 | 58 | 32 | 117 |
| | | % | 25.5% | 25.2% | 38.6% | 27.9% |
| | tier3 | Count | 14 | 41 | 10 | 65 |
| | | % | 13.2% | 17.8% | 12.0% | 15.5% |
| Total | | Count | 106 | 230 | 83 | 419 |
| | | % w | 100.0% | 100.0% | 100.0% | 100.0% |

**B. IMPORTANCE by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q5BR | 1.00 | Count | 11 | 14 | 11 | 36 |
| | | % | 10.5% | 6.1% | 13.4% | 8.7% |
| | 2.00 | Count | 38 | 71 | 27 | 136 |
| | | % | 36.2% | 31.1% | 32.9% | 32.8% |
| | 3.00 | Count | 56 | 143 | 44 | 243 |
| | | % | 53.3% | 62.7% | 53.7% | 58.6% |
| Total | | Count | 105 | 228 | 82 | 415 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |



**CULTURAL COMPETENCE**

**6. I can identify the effects of cultural factors on public health services.**
**A. PROFICIENCY by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q6AR | tier1 | Count | 36 | 53 | 18 | 107 |
| | | % | 34.3% | 22.6% | 22.0% | 25.4% |
| | tier2 | Count | 35 | 91 | 26 | 152 |
| | | % | 33.3% | 38.9% | 31.7% | 36.1% |
| | tier3 | Count | 34 | 90 | 38 | 162 |
| | | % | 32.4% | 38.5% | 46.3% | 38.5% |
| Total | | Count | 105 | 234 | 82 | 421 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**B. IMPORTANCE by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q6BR | 1.00 | Count | 2 | 9 | 1 | 12 |
| | | % | 1.9% | 3.9% | 1.2% | 2.9% |
| | 2.00 | Count | 23 | 51 | 19 | 93 |
| | | % | 22.3% | 22.1% | 23.2% | 22.4% |
| | 3.00 | Count | 78 | 171 | 62 | 311 |
| | | % | 75.7% | 74.0% | 75.6% | 74.8% |
| Total | | Count | 103 | 231 | 82 | 416 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**7. I can describe the cultural differences among the populations we serve.**
**A. PROFICIENCY by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q7AR | tier1 | Count | 29 | 59 | 17 | 105 |
| | | % | 27.6% | 25.2% | 20.5% | 24.9% |
| | tier2 | Count | 39 | 87 | 32 | 158 |
| | | % | 37.1% | 37.2% | 38.6% | 37.4% |
| | tier3 | Count | 37 | 88 | 34 | 159 |
| | | % | 35.2% | 37.6% | 41.0% | 37.7% |
| Total | | Count | 105 | 234 | 83 | 422 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**B. IMPORTANCE by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q7BR | 1.00 | Count | 2 | 11 | 2 | 15 |
| | | % | 2.0% | 4.7% | 2.4% | 3.6% |
| | 2.00 | Count | 21 | 42 | 16 | 79 |
| | | % | 20.6% | 18.1% | 19.3% | 18.9% |
| | 3.00 | Count | 79 | 179 | 65 | 323 |
| | | % | 77.5% | 77.2% | 78.3% | 77.5% |
| Total | | Count | 102 | 232 | 83 | 417 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**8. I can provide cultural competency training to improve staff skills in working with diverse populations.**

**A. PROFICIENCY by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q8AR | tier1 | Count | 67 | 117 | 42 | 226 |
| | | % | 64.4% | 50.0% | 50.6% | 53.7% |
| | tier2 | Count | 17 | 68 | 24 | 109 |
| | | % | 16.3% | 29.1% | 28.9% | 25.9% |
| | tier3 | Count | 20 | 49 | 17 | 86 |
| | | % | 19.2% | 20.9% | 20.5% | 20.4% |
| Total | | Count | 104 | 234 | 83 | 421 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**B. IMPORTANCE by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q8BR | 1.00 | Count | 7 | 14 | 8 | 29 |
| | | % | 6.9% | 6.1% | 9.6% | 7.0% |
| | 2.00 | Count | 28 | 62 | 26 | 116 |
| | | % | 27.5% | 26.8% | 31.3% | 27.9% |
| | 3.00 | Count | 67 | 155 | 49 | 271 |
| | | % | 65.7% | 67.1% | 59.0% | 65.1% |
| Total | | Count | 102 | 231 | 83 | 416 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**9. I can use my knowledge about cultural differences (values, beliefs and behaviors) in public health planning.**

**A. PROFICIENCY by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q9AR | tier1 | Count | 34 | 55 | 15 | 104 |
| | | % | 32.7% | 23.6% | 18.1% | 24.8% |
| | tier2 | Count | 30 | 86 | 37 | 153 |
| | | % | 28.8% | 36.9% | 44.6% | 36.4% |
| | tier3 | Count | 40 | 92 | 31 | 163 |
| | | % | 38.5% | 39.5% | 37.3% | 38.8% |
| Total | | Count | 104 | 233 | 83 | 420 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**B. IMPORTANCE by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q9BR | 1.00 | Count | 1 | 13 | 3 | 17 |
| | | % | 1.0% | 5.7% | 3.7% | 4.1% |
| | 2.00 | Count | 20 | 37 | 20 | 77 |
| | | % | 19.8% | 16.1% | 24.4% | 18.6% |
| | 3.00 | Count | 80 | 180 | 59 | 319 |
| | | % | 79.2% | 78.3% | 72.0% | 77.2% |
| Total | | Count | 101 | 230 | 82 | 413 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**10. I have the skills to recruit a diverse staff that reflects the populations we serve.**
**A. PROFICIENCY by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q10AR | tier1 | Count | 48 | 75 | 16 | 139 |
| | | % | 46.2% | 32.2% | 19.3% | 33.1% |
| | tier2 | Count | 28 | 75 | 30 | 133 |
| | | % | 26.9% | 32.2% | 36.1% | 31.7% |
| | tier3 | Count | 28 | 83 | 37 | 148 |
| | | % | 26.9% | 35.6% | 44.6% | 35.2% |
| Total | | Count | 104 | 233 | 83 | 420 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**B. IMPORTANCE by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q10BR | 1.00 | Count | 6 | 19 | 4 | 29 |
| | | % | 5.8% | 8.3% | 4.9% | 7.0% |
| | 2.00 | Count | 24 | 50 | 22 | 96 |
| | | % | 23.3% | 21.8% | 26.8% | 23.2% |
| | 3.00 | Count | 73 | 160 | 56 | 289 |
| | | % | 70.9% | 69.9% | 68.3% | 69.8% |
| Total | | Count | 103 | 229 | 82 | 414 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**PROGRAM PLANNING AND DEVELOPMENT**

**11. I can include the use of health equity skills into job descriptions.**

**A. PROFICIENCY by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q11AR | 1.00 | Count | 63 | 93 | 36 | 192 |
| | | % | 59.4% | 40.1% | 43.4% | 45.6% |
| | 2.00 | Count | 26 | 97 | 19 | 142 |
| | | % | 24.5% | 41.8% | 22.9% | 33.7% |
| | 3.00 | Count | 17 | 42 | 28 | 87 |
| | | % | 16.0% | 18.1% | 33.7% | 20.7% |
| Total | | Count | 106 | 232 | 83 | 421 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**B. IMPORTANCE by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q11BR | 1.00 | Count | 13 | 23 | 8 | 44 |
| | | % | 12.4% | 10.0% | 9.6% | 10.5% |
| | 2.00 | Count | 40 | 79 | 25 | 144 |
| | | % | 38.1% | 34.3% | 30.1% | 34.4% |
| | 3.00 | Count | 52 | 128 | 50 | 230 |
| | | % | 49.5% | 55.7% | 60.2% | 55.0% |
| Total | | Count | 105 | 230 | 83 | 418 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**12. I can implement ongoing health equity and social determinants of health trainings for staff.**

**A. PROFICIENCY by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q12AR | 1.00 | Count | 66 | 105 | 34 | 205 |
| | | % | 62.3% | 45.5% | 41.5% | 48.9% |
| | 2.00 | Count | 26 | 82 | 24 | 132 |
| | | % | 24.5% | 35.5% | 29.3% | 31.5% |
| | 3.00 | Count | 14 | 44 | 24 | 82 |
| | | % | 13.2% | 19.0% | 29.3% | 19.6% |
| Total | | Count | 106 | 231 | 82 | 419 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**B. IMPORTANCE**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q12BR | 1.00 | Count | 8 | 20 | 7 | 35 |
| | | % | 7.5% | 8.7% | 8.9% | 8.4% |
| | 2.00 | Count | 34 | 70 | 19 | 123 |
| | | % | 32.1% | 30.3% | 24.1% | 29.6% |
| | 3.00 | Count | 64 | 141 | 53 | 258 |
| | | % | 60.4% | 61.0% | 67.1% | 62.0% |
| Total | | Count | 106 | 231 | 79 | 416 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**13. I can adapt public health programs to take into account the differences among populations.**

**A. PROFICIENCY by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q13AR | 1.00 | Count | 43 | 57 | 19 | 119 |
| | | % | 40.6% | 24.7% | 23.2% | 28.4% |
| | 2.00 | Count | 43 | 93 | 35 | 171 |
| | | % | 40.6% | 40.3% | 42.7% | 40.8% |
| | 3.00 | Count | 20 | 81 | 28 | 129 |
| | | % | 18.9% | 35.1% | 34.1% | 30.8% |
| Total | | Count | 106 | 231 | 82 | 419 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**B. IMPORTANCE**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q13BR | 1.00 | Count | 2 | 8 | 3 | 13 |
| | | % | 1.9% | 3.4% | 3.7% | 3.1% |
| | 2.00 | Count | 20 | 50 | 17 | 87 |
| | | % | 18.9% | 21.5% | 20.7% | 20.7% |
| | 3.00 | Count | 84 | 175 | 62 | 321 |
| | | % | 79.2% | 75.1% | 75.6% | 76.2% |
| Total | | Count | 106 | 233 | 82 | 421 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**14. I can add the social determinants of health and health equity into public health policies and actions.**

**A. PROFICIENCY by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q14AR | 1.00 | Count | 54 | 85 | 27 | 166 |
| | | % | 50.9% | 37.0% | 32.9% | 39.7% |
| | 2.00 | Count | 44 | 92 | 30 | 166 |
| | | % | 41.5% | 40.0% | 36.6% | 39.7% |
| | 3.00 | Count | 8 | 53 | 25 | 86 |
| | | % | 7.5% | 23.0% | 30.5% | 20.6% |
| Total | | Count | 106 | 230 | 82 | 418 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**B. IMPORTANCE**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q14BR | 1.00 | Count | 4 | 10 | 4 | 18 |
| | | % | 3.8% | 4.3% | 4.8% | 4.3% |
| | 2.00 | Count | 17 | 49 | 21 | 87 |
| | | % | 16.3% | 21.2% | 25.3% | 20.8% |
| | 3.00 | Count | 83 | 172 | 58 | 313 |
| | | % | 79.8% | 74.5% | 69.9% | 74.9% |
| Total | | Count | 104 | 231 | 83 | 418 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**15. I can partner with other organizations to develop strategies to improve health equity.**

**A. PROFICIENCY by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q15AR | 1.00 | Count | 33 | 58 | 20 | 111 |
| | | % | 31.1% | 25.2% | 24.1% | 26.5% |
| | 2.00 | Count | 40 | 60 | 24 | 124 |
| | | % | 37.7% | 26.1% | 28.9% | 29.6% |
| | 3.00 | Count | 33 | 112 | 39 | 184 |
| | | % | 31.1% | 48.7% | 47.0% | 43.9% |
| Total | | Count | 106 | 230 | 83 | 419 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**B. IMPORTANCE by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q15BR | 1.00 | Count | 2 | 9 | 5 | 16 |
| | | % | 1.9% | 3.9% | 6.0% | 3.8% |
| | 2.00 | Count | 18 | 39 | 14 | 71 |
| | | % | 17.1% | 16.9% | 16.9% | 16.9% |
| | 3.00 | Count | 85 | 183 | 64 | 332 |
| | | % | 81.0% | 79.2% | 77.1% | 79.2% |
| Total | | Count | 105 | 231 | 83 | 419 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**ANALYTIC ASSESSMENT**

**16. I can use data that identify health inequities.**

**A. PROFICIENCY by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q16AR | 1.00 | Count | 30 | 48 | 15 | 93 |
| | | % | 28.3% | 20.6% | 18.3% | 22.1% |
| | 2.00 | Count | 37 | 73 | 21 | 131 |
| | | % | 34.9% | 31.3% | 25.6% | 31.1% |
| | 3.00 | Count | 39 | 112 | 46 | 197 |
| | | % | 36.8% | 48.1% | 56.1% | 46.8% |
| Total | | Count | 106 | 233 | 82 | 421 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**B. IMPORTANCE by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q16BR | 1.00 | Count | 1 | 8 | 3 | 12 |
| | | % | .9% | 3.5% | 3.7% | 2.9% |
| | 2.00 | Count | 18 | 32 | 12 | 62 |
| | | % | 17.0% | 13.9% | 14.6% | 14.8% |
| | 3.00 | Count | 87 | 191 | 67 | 345 |
| | | % | 82.1% | 82.7% | 81.7% | 82.3% |
| Total | | Count | 106 | 231 | 82 | 419 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**17. I can explain social determinants of health data and identify health equity issues.**
**A. PROFICIENCY by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q17AR | 1.00 | Count | 43 | 57 | 17 | 117 |
| | | % | 40.6% | 24.5% | 20.7% | 27.8% |
| | 2.00 | Count | 33 | 85 | 25 | 143 |
| | | % | 31.1% | 36.5% | 30.5% | 34.0% |
| | 3.00 | Count | 30 | 91 | 40 | 161 |
| | | % | 28.3% | 39.1% | 48.8% | 38.2% |
| Total | | Count | 106 | 233 | 82 | 421 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**B. IMPORTANCE by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q17BR | 1.00 | Count | 3 | 10 | 3 | 16 |
| | | % | 2.9% | 4.3% | 3.6% | 3.8% |
| | 2.00 | Count | 24 | 39 | 16 | 79 |
| | | % | 22.9% | 17.0% | 19.3% | 18.9% |
| | 3.00 | Count | 78 | 181 | 64 | 323 |
| | | % | 74.3% | 78.7% | 77.1% | 77.3% |
| Total | | Count | 105 | 230 | 83 | 418 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**18. I can evaluate an organization's readiness to work on the social determinants of health that effect health equity.**

**A. PROFICIENCY by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q18AR | 1.00 | Count | 69 | 138 | 47 | 254 |
| | | % | 65.7% | 59.7% | 57.3% | 60.8% |
| | 2.00 | Count | 25 | 61 | 22 | 108 |
| | | % | 23.8% | 26.4% | 26.8% | 25.8% |
| | 3.00 | Count | 11 | 32 | 13 | 56 |
| | | % | 10.5% | 13.9% | 15.9% | 13.4% |
| Total | | Count | 105 | 231 | 82 | 418 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**B. IMPORTANCE**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q18BR | 1.00 | Count | 6 | 13 | 5 | 24 |
| | | % | 5.7% | 5.7% | 6.0% | 5.7% |
| | 2.00 | Count | 31 | 82 | 25 | 138 |
| | | % | 29.5% | 35.7% | 30.1% | 33.0% |
| | 3.00 | Count | 68 | 135 | 53 | 256 |
| | | % | 64.8% | 58.7% | 63.9% | 61.2% |
| Total | | Count | 105 | 230 | 83 | 418 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**19. I can analyze policies intended to improve the social determinants of health and health equity.**

**A. PROFICIENCY by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q19AR | 1.00 | Count | 56 | 100 | 27 | 183 |
| | | % | 53.3% | 42.9% | 32.9% | 43.6% |
| | 2.00 | Count | 33 | 80 | 35 | 148 |
| | | % | 31.4% | 34.3% | 42.7% | 35.2% |
| | 3.00 | Count | 16 | 53 | 20 | 89 |
| | | % | 15.2% | 22.7% | 24.4% | 21.2% |
| Total | | Count | 105 | 233 | 82 | 420 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**B. IMPORTANCE by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q19BR | 1.00 | Count | 4 | 10 | 4 | 18 |
| | | % | 3.8% | 4.3% | 4.8% | 4.3% |
| | 2.00 | Count | 25 | 60 | 20 | 105 |
| | | % | 23.6% | 26.1% | 24.1% | 25.1% |
| | 3.00 | Count | 77 | 160 | 59 | 296 |
| | | % | 72.6% | 69.6% | 71.1% | 70.6% |
| Total | | Count | 106 | 230 | 83 | 419 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**20. I can identify the evidence linking discrimination and health outcomes.**
**A. PROFICIENCY by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q20AR | 1.00 | Count | 51 | 92 | 30 | 173 |
| | | % | 48.6% | 40.0% | 36.6% | 41.5% |
| | 2.00 | Count | 29 | 82 | 27 | 138 |
| | | % | 27.6% | 35.7% | 32.9% | 33.1% |
| | 3.00 | Count | 25 | 56 | 25 | 106 |
| | | % | 23.8% | 24.3% | 30.5% | 25.4% |
| Total | | Count | 105 | 230 | 82 | 417 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**B. IMPORTANCE by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q20BR | 1.00 | Count | 5 | 14 | 5 | 24 |
| | | % | 4.8% | 6.1% | 6.0% | 5.8% |
| | 2.00 | Count | 28 | 69 | 21 | 118 |
| | | % | 26.7% | 30.1% | 25.3% | 28.3% |
| | 3.00 | Count | 72 | 146 | 57 | 275 |
| | | % | 68.6% | 63.8% | 68.7% | 65.9% |
| Total | | Count | 105 | 229 | 83 | 417 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**COMMUNITY PRACTICE**

**21. I can engage communities to work on the social determinants of health and health equity.**

**A. PROFICIENCY by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q21AR | 1.00 | Count | 55 | 85 | 29 | 169 |
| | | % | 52.4% | 37.1% | 34.9% | 40.5% |
| | 2.00 | Count | 34 | 81 | 26 | 141 |
| | | % | 32.4% | 35.4% | 31.3% | 33.8% |
| | 3.00 | Count | 16 | 63 | 28 | 107 |
| | | % | 15.2% | 27.5% | 33.7% | 25.7% |
| Total | | Count | 105 | 229 | 83 | 417 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**B. IMPORTANCE**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q21BR | 1.00 | Count | 2 | 15 | 3 | 20 |
| | | % | 1.9% | 6.5% | 3.6% | 4.8% |
| | 2.00 | Count | 22 | 46 | 23 | 91 |
| | | % | 21.2% | 19.9% | 27.7% | 21.8% |
| | 3.00 | Count | 80 | 170 | 57 | 307 |
| | | % | 76.9% | 73.6% | 68.7% | 73.4% |
| Total | | Count | 104 | 231 | 83 | 418 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**22. I can use community-based research to affect the social determinants of health and improve health equity.**

**A. PROFICIENCY by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q22AR | 1.00 | Count | 57 | 95 | 37 | 189 |
| | | % | 55.9% | 41.1% | 44.6% | 45.4% |
| | 2.00 | Count | 28 | 82 | 27 | 137 |
| | | % | 27.5% | 35.5% | 32.5% | 32.9% |
| | 3.00 | Count | 17 | 54 | 19 | 90 |
| | | % | 16.7% | 23.4% | 22.9% | 21.6% |
| Total | | Count | 102 | 231 | 83 | 416 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**B. IMPORTANCE**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q22BR | 1.00 | Count | 4 | 17 | 4 | 25 |
| | | % | 3.8% | 7.4% | 4.9% | 6.0% |
| | 2.00 | Count | 29 | 58 | 24 | 111 |
| | | % | 27.9% | 25.1% | 29.3% | 26.6% |
| | 3.00 | Count | 71 | 156 | 54 | 281 |
| | | % | 68.3% | 67.5% | 65.9% | 67.4% |
| Total | | Count | 104 | 231 | 82 | 417 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**23. I can develop community leaders within populations negatively affected by the social determinants of health.**

**A. PROFICIENCY by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q23AR | 1.00 | Count | 71 | 130 | 45 | 246 |
| | | % | 68.3% | 57.0% | 54.9% | 59.4% |
| | 2.00 | Count | 23 | 66 | 22 | 111 |
| | | % | 22.1% | 28.9% | 26.8% | 26.8% |
| | 3.00 | Count | 10 | 32 | 15 | 57 |
| | | % | 9.6% | 14.0% | 18.3% | 13.8% |
| Total | | Count | 104 | 228 | 82 | 414 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**B. IMPORTANCE by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q23BR | 1.00 | Count | 3 | 18 | 5 | 26 |
| | | % | 2.9% | 7.8% | 6.0% | 6.3% |
| | 2.00 | Count | 25 | 56 | 25 | 106 |
| | | % | 24.5% | 24.3% | 30.1% | 25.5% |
| | 3.00 | Count | 74 | 156 | 53 | 283 |
| | | % | 72.5% | 67.8% | 63.9% | 68.2% |
| Total | | Count | 102 | 230 | 83 | 415 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**24. I can provide communities with data on health, the social determinants of health and health equity status.**

**A. PROFICIENCY by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q24AR | 1.00 | Count | 43 | 64 | 26 | 133 |
| | | % | 41.3% | 27.5% | 31.3% | 31.7% |
| | 2.00 | Count | 24 | 83 | 20 | 127 |
| | | % | 23.1% | 35.6% | 24.1% | 30.2% |
| | 3.00 | Count | 37 | 86 | 37 | 160 |
| | | % | 35.6% | 36.9% | 44.6% | 38.1% |
| Total | | Count | 104 | 233 | 83 | 420 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**B. IMPORTANCE**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q24BR | 1.00 | Count | 2 | 14 | 3 | 19 |
| | | % | 2.0% | 6.0% | 3.7% | 4.6% |
| | 2.00 | Count | 25 | 49 | 23 | 97 |
| | | % | 24.5% | 21.1% | 28.0% | 23.3% |
| | 3.00 | Count | 75 | 169 | 56 | 300 |
| | | % | 73.5% | 72.8% | 68.3% | 72.1% |
| Total | | Count | 102 | 232 | 82 | 416 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**25. I can advocate for community investments that improve the social determinants of health and health equity.**

**A. PROFICIENCY by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q25AR | 1.00 | Count | 62 | 103 | 36 | 201 |
| | | % | 59.6% | 44.4% | 43.9% | 48.1% |
| | 2.00 | Count | 23 | 72 | 22 | 117 |
| | | % | 22.1% | 31.0% | 26.8% | 28.0% |
| | 3.00 | Count | 19 | 57 | 24 | 100 |
| | | % | 18.3% | 24.6% | 29.3% | 23.9% |
| Total | | Count | 104 | 232 | 82 | 418 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**B. IMPORTANCE by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q25BR | 1.00 | Count | 5 | 13 | 4 | 22 |
| | | % | 4.8% | 5.7% | 4.8% | 5.3% |
| | 2.00 | Count | 23 | 51 | 23 | 97 |
| | | % | 22.1% | 22.5% | 27.7% | 23.4% |
| | 3.00 | Count | 76 | 163 | 56 | 295 |
| | | % | 73.1% | 71.8% | 67.5% | 71.3% |
| Total | | Count | 104 | 227 | 83 | 414 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**26. I can promote promising practices that will aid in fair service delivery.**

**A. PROFICIENCY by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q26AR | 1.00 | Count | 46 | 83 | 24 | 153 |
| | | % | 44.2% | 35.9% | 28.9% | 36.6% |
| | 2.00 | Count | 37 | 79 | 29 | 145 |
| | | % | 35.6% | 34.2% | 34.9% | 34.7% |
| | 3.00 | Count | 21 | 69 | 30 | 120 |
| | | % | 20.2% | 29.9% | 36.1% | 28.7% |
| Total | | Count | 104 | 231 | 83 | 418 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**B. IMPORTANCE by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q26BR | 1.00 | Count | 3 | 11 | 3 | 17 |
| | | % | 2.9% | 4.9% | 3.6% | 4.1% |
| | 2.00 | Count | 25 | 64 | 22 | 111 |
| | | % | 24.3% | 28.3% | 26.5% | 26.9% |
| | 3.00 | Count | 75 | 151 | 58 | 284 |
| | | % | 72.8% | 66.8% | 69.9% | 68.9% |
| Total | | Count | 103 | 226 | 83 | 412 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**27. I can identify the policies and systems of institutionalized racism.**
**A. PROFICIENCY**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q27AR | 1.00 | Count | 61 | 135 | 42 | 238 |
| | | % | 59.2% | 58.7% | 50.6% | 57.2% |
| | 2.00 | Count | 24 | 50 | 23 | 97 |
| | | % | 23.3% | 21.7% | 27.7% | 23.3% |
| | 3.00 | Count | 18 | 45 | 18 | 81 |
| | | % | 17.5% | 19.6% | 21.7% | 19.5% |
| Total | | Count | 103 | 230 | 83 | 416 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**B. IMPORTANCE**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q27BR | 1.00 | Count | 7 | 19 | 6 | 32 |
| | | % | 6.8% | 8.3% | 7.2% | 7.7% |
| | 2.00 | Count | 20 | 66 | 23 | 109 |
| | | % | 19.4% | 28.7% | 27.7% | 26.2% |
| | 3.00 | Count | 76 | 145 | 54 | 275 |
| | | % | 73.8% | 63.0% | 65.1% | 66.1% |
| Total | | Count | 103 | 230 | 83 | 416 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**28. I can to identify the policies and systems of institutionalized discrimination.**
**A. PROFICIENCY by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q28AR | 1.00 | Count | 64 | 122 | 40 | 226 |
| | | % | 62.1% | 53.3% | 48.2% | 54.5% |
| | 2.00 | Count | 20 | 64 | 21 | 105 |
| | | % | 19.4% | 27.9% | 25.3% | 25.3% |
| | 3.00 | Count | 19 | 43 | 22 | 84 |
| | | % | 18.4% | 18.8% | 26.5% | 20.2% |
| Total | | Count | 103 | 229 | 83 | 415 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**B. IMPORTANCE**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q28BR | 1.00 | Count | 7 | 15 | 6 | 28 |
| | | % | 6.9% | 6.6% | 7.2% | 6.8% |
| | 2.00 | Count | 21 | 69 | 24 | 114 |
| | | % | 20.6% | 30.1% | 28.9% | 27.5% |
| | 3.00 | Count | 74 | 145 | 53 | 272 |
| | | % | 72.5% | 63.3% | 63.9% | 65.7% |
| Total | | Count | 102 | 229 | 83 | 414 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**29. I can develop policies that will affect the social determinants of health and improve health equity.**

**A. PROFICIENCY by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q29AR | 1.00 | Count | 64 | 107 | 38 | 209 |
| | | % | 61.5% | 46.1% | 46.3% | 50.0% |
| | 2.00 | Count | 24 | 82 | 27 | 133 |
| | | % | 23.1% | 35.3% | 32.9% | 31.8% |
| | 3.00 | Count | 16 | 43 | 17 | 76 |
| | | % | 15.4% | 18.5% | 20.7% | 18.2% |
| Total | | Count | 104 | 232 | 82 | 418 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**B. IMPORTANCE by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q29BR | 1.00 | Count | 3 | 9 | 5 | 17 |
| | | % | 2.9% | 4.0% | 6.0% | 4.1% |
| | 2.00 | Count | 22 | 61 | 23 | 106 |
| | | % | 21.4% | 26.9% | 27.7% | 25.7% |
| | 3.00 | Count | 78 | 157 | 55 | 290 |
| | | % | 75.7% | 69.2% | 66.3% | 70.2% |
| Total | | Count | 103 | 227 | 83 | 413 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**30. I can convert policies into programs that improve fair service delivery.**
**A. PROFICIENCY by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q30AR | 1.00 | Count | 65 | 115 | 38 | 218 |
| | | % | 62.5% | 50.4% | 45.8% | 52.5% |
| | 2.00 | Count | 29 | 70 | 26 | 125 |
| | | % | 27.9% | 30.7% | 31.3% | 30.1% |
| | 3.00 | Count | 10 | 43 | 19 | 72 |
| | | % | 9.6% | 18.9% | 22.9% | 17.3% |
| Total | | Count | 104 | 228 | 83 | 415 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

**B. IMPORTANCE by**

**Number of years in Public Health: Cross tabulation**

| | | | Years in public health | | | |
|---|---|---|---|---|---|---|
| | | | 0-5 yrs | 6-20 yrs | >21 yrs | Total |
| Q30BR | 1.00 | Count | 3 | 10 | 5 | 18 |
| | | % | 2.9% | 4.3% | 6.1% | 4.3% |
| | 2.00 | Count | 21 | 68 | 22 | 111 |
| | | % | 20.6% | 29.6% | 26.8% | 26.8% |
| | 3.00 | Count | 78 | 152 | 55 | 285 |
| | | % | 76.5% | 66.1% | 67.1% | 68.8% |
| Total | | Count | 102 | 230 | 82 | 414 |
| | | % | 100.0% | 100.0% | 100.0% | 100.0% |

## Appendix H. Summary
## Summary of Responses to Survey Open-ended Questions

There were three open ended questions posed to respondents at the end of the tool asking survey participants to provide information on skills that were not covered in the survey, other ways besides training to increase skills, and any other additional comments on the skills sets covered in the survey. The tables below summarize the responses to the three open-ended questions and the suggestions/comments provided by participants. Please note that suggestions included in the tables are those that reflected a minimum of three individual responses.

1. Are there any skill sets not covered in the survey that are essential to health equity and social determinants of health issues? Please describe.

**Summary of Responses (N=81)**

| | Frequency | Percentage |
|---|---|---|
| **Suggestions for additional skills** | 60 | 74% |
| **No, there are no additional skill sets not covered in the survey** | 18 | 22% |
| **Don't know or N/A if there are additional skills sets not covered in the survey** | 3 | 4% |
| **TOTAL RESPONSES** | 81 | 100 % |

**Summary of Suggested Recommendations/Comments (N=60)**

| Suggestion/Recommendation | Frequency |
|---|---|
| **Partnerships/collaboration (community, interagency, elected officials, diverse populations)** | 8 |
| **Communication skills** | 6 |
| **Skills in addressing health literacy** | 4 |
| **Skills in community assessment and developing/organizing community. Developing community based coalitions and programming.** | 4 |
| **Research; measuring and evaluating disparities in health and translating data into usable concepts or maps.** | 4 |
| **Developing, and implementing language access policies** | 4 |
| **Using plain talk in policies, translating policy for the public** | 4 |

| | |
|---|---|
| **Program and outcome evaluation** | 4 |
| **Comfort level, respect in working with diverse populations** | 4 |
| **Understanding oppression and power in social constructs** | 3 |
| **Designing and developing public health programs** | 3 |
| **Assessing personal thinking/beliefs and interaction with culture/diverse populations** | 3 |
| **Listening, empathy, and compassion** | 3 |
| **Addressing internal institutional policies first (Ex. institutional racism) or create a tool to assess organizations (like CDC)** | 3 |
| **Culturally appropriate or competent** | 3 |
| **Legislative skills, educating legislators, and political strategy** | 3 |
| **Program administration, management and strategic planning** | 3 |
| **Effectively working with, mobilizing, and engaging community and diverse populations** | 3 |

Other areas brought up in responses (by more than one participant): Skills in fostering relationships, overcoming barriers with managers/leadership and communicating the importance of the social determinants effectively with these individuals, public health finance and relating the social determinants of health to costs-savings, increase of knowledge of the terms used in health equity work, advocacy skills, facilitating discussions around poverty, discrimination and racism, personal experience with minority groups and ability to work with diversity and differences.

2. What are some ways to increase skills around health equity, the social determinants of health and cultural competency, other typical training sessions?

**Summary of Responses (N=140)**

| | Frequency | Percentage |
|---|---|---|
| **Suggestions/Comments** | 136 | 97% |
| **None or N/A** | 4 | 3% |
| **TOTAL RESPONSES** | 140 | 100% |

**Summary of Topics Occurring in Respondents Comments/Suggestions (N=136)**

| Suggestion/Comment | Frequency |
|---|---|
| **Examples of what has worked, utilizing case studies, sharing promising practices and evidence based practice** | 18 |
| **Mentor staff, provide mentorship opportunities** | 12 |
| **Provide web resources, web-based training** | 10 |
| **Provide access and encourage staff to read journal articles, reports and current research** | 10 |
| **Use testimonies and stories of those experiencing negative health effects** | 9 |
| **Do self-study exercises with staff, identify own culture/values, discuss racism and empathy** | 7 |
| **Review policies, discuss ways to go about policy change** | 7 |
| **Hands-on learning and interactions** | 6 |
| **Exposure to and immersion within diverse cultures/groups** | 6 |
| **Incorporate health equity competencies into job descriptions, performance evaluations, hire competent and diverse staff** | 6 |
| **Use 'Unnatural Causes' series** | 6 |
| **Partner with community** | 6 |
| **On the job experience or job shadowing** | 5 |
| **Attend (skill-building, mandatory with funding) training** | 5 |
| **Facilitate group staff discussions on the SDOH/equity** | 5 |

| | |
|---|---|
| **Use media in training (internet, video)** | 6 |
| **Attend on-going training** | 4 |
| **Provide/receive technical assistance and follow-up** | 4 |
| **Incorporate health equity principles/skill building into higher education system** | 3 |
| **Cultural competency (training, assess agencies)** | 5 |
| **Brown bag meetings with community** | 3 |
| **Community service learning/volunteering at community organizations** | 4 |

Other areas brought up in responses (by more than one participant): Role play, funding health equity work and the community, build training into contracts and funding opportunities, provide a tool-kit, utilize research and data, provide literacy level appropriate training.

3. Please enter any comments you may have on the skills statements included in this survey.

**Summary of Responses (N=68)**

| | Frequency | Percentage |
|---|---|---|
| **Suggestions or negative comments** | 51 | 75% |
| **Positive comments or no recommendations** | 11 | 16% |
| **Responded no comment or n/a** | 6 | 9% |
| **TOTAL RESPONSES** | **68** | **100%** |

**Summary of Topics Occurring in Respondents Comments/Suggestions (N=51)**

| Suggestion/Topic Area | Frequency |
|---|---|
| **Responses were affected by their job function/role or survey did not apply to their job role** | 8 |
| **Didn't understand the questions, statements were unclear, suggested survey is written more generally, or use plain language** | 7 |
| **Participant mentioned barriers or inability to use skills (ex. Organization** | 7 |

| | |
|---|---|
| **policies/laws, leadership/management support, too little resources or training) and/or recommended adding question about barriers** | |
| **Concerns/issues with the importance scale** | 4 |
| **Recommendations in leaderships development, or addressing leadership needs** | 3 |
| **Suggestion that questions are asked based on work done in teams or in collaboration instead of as an individual** | 3 |

Other areas brought up in responses (by more than one participant): need to focus attention on individual behavior change, increase awareness of social determinants of health, need to work and collaborate with researchers or have access to more training in research, concerns with the proficiency scale, and make a grammatical error correction in Question 2.

## Appendix I. Summary of Focus Group Responses

### Methodology

The Team conducted focus group interviews of respondents to the health equity skills assessment in order to improve the health equity skills assessment survey tool.

Survey respondents opted into the focus groups via a field at the end of the survey. By the end of the pilot period, a total of 34 participants indicated willingness to provide feedback on the tool. Of these 29 were either interviewed as part of a focus group teleconference calls, or answered the same questions asked during the focus groups by email. Most focus groups were about one hour and had between two and four participants. Participants included individuals from Alaska, South Carolina, Rhode Island, New York, Iowa, Michigan, West Virginia, Washington, Oklahoma, Puerto Rico, Wyoming, Ohio, and Maryland. Of the information collected/shared regarding their organization and job, most respondents were from state health departments and worked in a range of categorical programs including cancer prevention, obesity prevention, maternal and child health, cardiovascular health, and tobacco prevention. In addition, several respondents worked in offices of minority health or focused specifically on reducing health disparities. Most participants identified themselves as epidemiologists, coordinators or managers.

### Summary of Results

Focus Group participants provided feedback on the length of time it took for them to complete the survey, the skills statements, definitions of terms provided in the survey, survey layout, and the scales. Most participants were at the state-level and gave recommendations based on their expertise and experience in their current position. Participants complimented the NACDD-NACDD-HEC for the overall design and synthesis of a vast set of competences into the skill statements on the survey and were interested in how they could become more involved, where to locate resources pertaining to the skills, and what the next steps of the survey entailed. Others mentioned that the skills statements and definitions helped them clarify and identify the skills needed in health equity work and some mentioned that they kept the definitions of terms to use for future reference.

### Recommendations

Recommendations for improving the survey included modifying the scales used to rate the skills statements, skill wording, adding or modifying key definitions, and adding additional resources on the topic to the end of the survey. Interviewees overwhelming responded that they would like to have an opportunity to respond on barriers and successes they might encounter while using the skills addressed in the survey. There were recommendations to add additional skill statements pertaining to collaboration and partnering, data, cultural competency, and leadership.

The focus group interviews provided an excellent opportunity for the NACDD-NACDD-HEC to understand more about the participants experience while completing the Assessment and to identify ways to strengthen the survey design.

## Appendix J. Sample Survey REVISED[11]

**INTRODUCTION**

**Health Equity Skills for Public Health Professionals**

**We need your help!**

Your expertise is needed as we search for information about health equity in public health practice. You will help identify training needs for health equity, the social determinants of health and cultural competency!

The National Association of Chronic Disease Directors (NACDD) Health Equity Council (HEC) and the Centers for Disease Control and Prevention (CDC) want to assist you in achieving health equity expertise. Your responses to this questionnaire are greatly needed. The survey will take approximately 20 minutes. It was developed specifically for chronic disease public health professionals; however others are welcome to use it.

Thank you for your participation!

Please follow screen instructions by clicking on NEXT PAGE or PREVIOUS PAGE to navigate through the survey and click SUBMIT when you are finished. You may save and exit the program at any time by clicking on SAVE AND RETURN LATER.

Participation in this survey is voluntary and confidential. If you would prefer to respond by mail, please print the survey and send it to:

Attention: Health Equity Survey
NACDD Heath Equity Council
2872 Woodcock Blvd Ste 220
Atlanta, GA 30341

**NEXT PAGE**

***(Page 2)***

**DEFINITION OF TERMS**

**Health disparities** are differences in the rates of disease and health status among groups of people. Most **health disparities** impact populations defined by socioeconomic status, age, race or ethnicity, sexual orientation, gender, gender identity, disability status, geographic location or a combination of these factors.

**Health inequities** result when the disparities, or differences, are combined with conditions that are unfair, unjust and avoidable.

Where we are born, grow, live, work, and play define the **social determinants of health**. These include adequate income; secure employment and good working conditions; quality

[11] The sample has a different appearance once transferred into the on-line survey instrument.

education; safe neighborhoods and housing; food security; access to social support networks; good health care services and freedom from racism and other forms of discrimination.

**Health equity** is achieved when no one is limited in achieving good health because of his or her social position or any other social determinant of health.

The ongoing effort to respond respectfully and effectively to all people is called **cultural competence**. Affirming the value and worth of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, sexual orientations and other diversity factors is essential for success.

**Fair service delivery** is an important component in achieving health equity. For the purpose of this survey, 'fail' refers to the just of right action – giving to each according to need.

**Institutionalized racism** is caused by policies and practices integrated into government and organizations. These policies and practices are based on race and result in unequal access to education, opportunities, power and influence, which continues an inherited disadvantage to certain racial groups of people. Examples: Unpaved streets and roads in certain neighborhoods; Standardized tests prepared for the majority population, Use of stereotypical caricatures, such as "Indian" sports mascots.

**Institutionalized discrimination** results in differences in the treatment of certain population groups, including those based on age, ability, gender, gender identity, sexual orientation, class, ethnicity or socio-economic status. It is caused by a system of policies and practices that have been accepted as normal in today's society.

Techniques or a method that, through experience or research, have shown successes are called **promising practices.**

For the purposes of this survey, a **skill** is the ability, acquired through knowledge, training or experience, to do something well.

**NEXT PAGE**

***(Page 3)***

**SURVEY QUESTIONS**

**Health Equity Skills for Public Health Professionals**

**For the survey statements, please:**

- Indicate your level of proficiency for the skill described in the statement, using the scale 1 through 5, with 1 being "Unaware" and 5 being "Expert". You may want a copy of this scale and explanation while completing the survey.

| Scale | Explanation of Scale |
|---|---|
| **1**<br>**Unaware** | I have no knowledge or awareness of this skill<br>*(I have never heard of this concept)*<br>Example: I have never heard of policy analysis. |
| **2**<br>**Aware** | I am aware of this skill but have not used it in my public health practice<br>*(I was exposed to this skill in training but haven't used it)*<br>Example: I took a class or training in policy analysis, but I have not analyzed policy as a paid employee of a public health authority. |
| **3**<br>**Functional** | I can apply this skill but occasionally require assistance<br>*(I can do this but sometimes need to ask for help)*<br>Example: I can analyze policy, but like to have guidance from a more experienced colleague. |
| **4**<br>**Proficient** | I can execute this skill in complex situations without guidance<br>*(I have lots of experience with this skill)*<br>Example: I analyze policy frequently and regularly. |
| **5**<br>**Expert** | I can execute this skill in complex situations and have the expertise to coach and support others<br>*(I have done this so much that I am comfortable offering my expertise to others)*<br>Example: I analyze policy frequently and regularly and offer guidance to colleagues upon request. |

**Then:**

- Compare the five statements in each separate category and rate the relative importance of each against the other four. Decide how important the skill is to achieving expertise in health equity and the social determinants of health in comparison to the other four skills statements in that section. Use the scale 1 through 5, with 1 being "Least Important" and 5 being "Most Important". You are asked to do this for each of the six topic areas, **A) Communications, B) Cultural Competence, C) Program Planning and Development, D) Analytic Assessment E) Community Practice and F) Leadership and Systems Thinking.**

### A) COMMUNICATIONS

Communications are relevant to health equity and the social determinants of health. Your responses to the following five statements will provide information about training needs to increase proficiency in this area. Please think about Communications when responding to each statement in this section.

1. **I can explain the difference between health equity, health inequities and health disparities.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

2. **I can describe the social determinants of health and their effect on health equity for specific populations in my state.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

3. **I can describe the effects that policies may have on health equity.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

4. **I can focus policy maker attention on improving social and economic conditions instead of trying to change individual behaviors.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

5. **I can use television, radio and print media to describe the costs connected to the social determinants of health.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

**RATE HOW IMPORTANT EACH COMMUNICATION SKILLS STATEMENT IS IN COMPARISON TO THE OTHERS IN THIS CATEGORY. MARK THE LEAST IMPORTANT SKILL AS "1" AND THE MOST IMPORTANT SKILL AS "5".**

— **I can explain the difference between health equity, health inequities and health disparities.**
— **I can describe the effects that the social determinants of health have on health equity for specific populations in my state.**
— **I can describe the effects that policies may have on health equity.**
— **I can focus policy maker attention on improving social and economic conditions instead of trying to change individual behaviors.**
— **I can use television, radio and print media to describe the costs connected to the social determinants of health.**

**B) CULTURAL COMPETENCE**

One of the intents of this survey is to assess the Cultural Competence skills levels of public health professionals and to determine how important each skill is to health equity and the social determinants of health. Please think about Cultural Competence when responding to the five statements in this section.

6. **I can identify the effects of cultural factors on public health services.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

7. **I can describe the cultural differences among the populations we serve.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

**8. I can provide cultural competency training to improve staff skills in working with diverse populations.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

**9. I can use my knowledge about cultural differences (values, beliefs and behaviors) in public health planning.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

**10. I have the skills to recruit a diverse staff that reflects the populations we serve.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

**RATE HOW IMPORTANT EACH CULTURAL COMPETENCE SKILLS STATEMENT IS IN COMPARISON TO THE OTHERS IN THIS CATEGORY. MARK THE LEAST IMPORTANT SKILL AS "1" AND THE MOST IMPORTANT SKILL AS "5".**

— **I can identify the effects of cultural factors on public health services.**
— **I can describe the cultural differences among the populations we serve.**
— **I can provide cultural competency training to improve staff skills in working with diverse populations.**
— **I can use my knowledge about cultural differences (values, beliefs and behaviors) in public health planning.**
— **I have the skills to recruit a diverse staff that reflects the populations we serve.**

### C) PROGRAM PLANNING AND DEVELOPMENT

Many public health competencies are associated with Program Planning and Development. The following five statements are designed to measure how proficient public health workers are in the area of Program Planning and Development and how important each skill is to public health practice. Please think about Program Planning and Development when responding to each statement in this section.

**11. I can draft job descriptions to include health equity expertise requirements.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

**12. I can implement ongoing health equity and social determinants of health trainings for staff.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

**13. I can adapt public health programs to take into account the differences among populations.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

**14. I can add the social determinants of health and health equity into public health policies and actions.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

**15. I can partner with other organizations to develop strategies to improve health equity.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

**RATE HOW IMPORTANT EACH PROGRAM PLANNING AND DEVELOPMENT SKILLS STATEMENT IS IN COMPARISON TO THE OTHERS IN THIS CATEGORY. MARK THE LEAST IMPORTANT SKILL AS "1" AND THE MOST IMPORTANT SKILL AS "5".**

- **I can include the use of health equity skills into job descriptions.**
- **I can implement ongoing health equity and social determinants of health trainings for staff.**
- **I can adapt public health programs to take into account the differences among populations.**
- **I can add the social determinants of health and health equity into public health policies and actions.**
- **I can partner with other organizations to develop strategies to improve health equity.**

### D) Analytic Assessment

Analytic Assessment is the fourth category to be evaluated by this skills survey. The following five statements are used to identify important areas of Analytic Assessment and to give training development experts an idea of current skills levels. Please think about Analytic Assessment when responding to the five statements in this section.

**16. I can use data that identify health inequities.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

**17. I can explain social determinants of health data and identify health equity issues.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

**18. I can evaluate an organization's readiness to work on the social determinants of health that effect health equity.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

**19. I can analyze policies intended to improve the social determinants of health and health equity.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

**20. I can identify the evidence linking discrimination and health outcomes.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

**RATE HOW IMPORTANT EACH ANALYTIC ASSESSMENT SKILLS STATEMENT IS IN COMPARISON TO THE OTHERS IN THIS CATEGORY. MARK THE LEAST IMPORTANT SKILL AS "1" AND THE MOST IMPORTANT SKILL AS "5".**

— **I can use data that identify health inequities.**
— **I can explain social determinants of health data and identify health equity issues.**
— **I can evaluate an organization's readiness to work on the social determinants of health that effect health equity.**
— **I can analyze policies intended to improve the social determinants of health and health equity.**
— **I can identify the evidence linking discrimination and health outcomes.**

### E) COMMUNITY PRACTICE

Community Practice is a category of public health competency of importance to health equity and the social determinants of health. Your responses to the following five statements will provide information about the level of importance and what proficiency currently exists. Please think about Community Practice when responding to each statement in this section.

**21. I can engage communities to work on the social determinants of health and health equity.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

**22. I can use community-based research to affect the social determinants of health and improve health equity.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

**23. I can develop community leaders within populations negatively affected by the social determinants of health.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

**24. I can provide communities with data on health, the social determinants of health and health equity status.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

**25. I can advocate for community investments that improve the social determinants of health and health equity.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

**RATE HOW IMPORTANT EACH COMMUNITY PRACTICE SKILLS STATEMENT IS IN COMPARISON TO THE OTHERS IN THIS CATEGORY. MARK THE LEAST IMPORTANT SKILL AS "1" AND THE MOST IMPORTANT SKILL AS "5".**

— **I can engage communities to work on the social determinants of health and health equity.**
— **I can use community-based research to affect the social determinants of health and improve health equity.**
— **I can develop community leaders within populations negatively affected by the social determinants of health.**
— **I can provide communities with data on health, the social determinants of health and health equity status.**
— **I can advocate for community investments that improve the social determinants of health and health equity.**

### F) LEADERSHIP AND SYSTEMS THINKING

In this sixth and last category of competency, Leadership and Systems Thinking, your responses will help determine how important each skill is and what level of proficiency exists.

Please think about Leadership and Systems Thinking when responding to each statement in this section.

**26. I can promote promising practices that will aid in fair service delivery.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

**27. I can identify the policies and systems of institutionalized racism.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

**28. I can identify the policies and systems of institutionalized discrimination.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

**29. I can develop policies that will affect the social determinants of health and improve health equity.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

**30. I can convert policies into programs that improve fair service delivery.**

My level of proficiency for this skill is:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Unaware | Aware | Functional | Proficient | Expert |

**RATE HOW IMPORTANT EACH LEADERSHIP AND SYSTEMS THINKING SKILLS STATEMENT IS IN COMPARISON TO THE OTHERS IN THIS CATEGORY. MARK THE LEAST IMPORTANT SKILL AS "1" AND THE MOST IMPORTANT SKILL AS "5".**

— **I can promote promising practices that will aid in fair service delivery.**
— **I can identify the policies and systems of institutionalized racism.**
— **I can identify the policies and systems of institutionalized discrimination.**
— **I can develop policies that will affect the social determinants of health and improve health equity.**
— **I can convert policies into programs that improve fair service delivery.**

**Are there skill sets not covered in the survey that are essential to health equity and social determinants of health issues? Please describe.**

**What are some ways to increase skills around health equity, the social determinants of health and cultural competency, other than typical training sessions?**

**Do you experience barriers surrounding issues concerning health equity and the social determinants of health? If yes, please briefly describe the barriers.**

**Please enter any comments you may have on the skills statements included in this survey.**

**ENTER DEMOGRAPHICS**

**Your state or territory** (drop down box)

**Your organization**

Government, federal

Government, state

Other (please specify)

**Your position** (you can choose more than one):

| | | |
|---|---|---|
| | Senior Manager | Manages/directs a department, agency or division |
| | Program Manager | Manages/directs one or more programs |
| | Program Coordinator | Administers one or more programs |
| | Epidemiologist/Research Analyst | Provides epidemiology and/or surveillance expertise |
| | Operational Support | Performs/coordinates administrative support to program(s) |

**Number of years in Public Health**:

0-5

6-20

21 and up

**Age:**

Under 30

30 to 44

45 to 59

60 and over

**Race/Ethnicity:**

American Indian/Alaska Native

Black or African American

Asian

Hispanic or Latino

Non-Hispanic White

More than one _____

**Gender:**

Male

Female

Transgender

**Sexual Orientation**

Heterosexual

Gay

Lesbian

Bisexual

Other _____

**Disability:**

Yes

No

**List of Helpful Resources**

- 
- 
- 

**SURVEY WRAP UP – LAST PAGE**

The NACDD HEC and the CDC appreciate your time and effort in responding to this survey. Clicking on the icon below will take you to a separate site to enter your contact information and any comments you may have regarding the assessment. This is **OPTIONAL**

Please enter the following:

Name _____

Phone _____

E-mail address_____

Comments/questions regarding the survey: