AISP Working Paper:

Addressing Racial and Ethnic Inequities in Human Service Provision

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Introduction

Equity assessments, like those described in this working paper, have historical roots in the Civil Rights movement. As part of demands for equitable access to jobs, resources, and services, communities of color and Civil Rights advocates pressed public and private institutions to document the representation of racial and ethnic groups (National Archives, 2016). Corrective action plans were used to develop clear strategies to redress inequities and hold institutions accountable to change. Affirmative action policies reinforced these strategies by requiring certain groups, such as federal contractors, to develop numerical targets and timelines to correct for underutilization of services by marginalized groups (Legal Information Institute, n.d.).

Human service agencies are now being called upon once again to address inequities within their programs. In January 2021, President Biden signed the *Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government*, which requires federal agencies to identify methods for assessing equity within federal programs and to engage communities historically underserved or discriminated against in these programs (Exec. Order No. 13985, 2021). This working paper strives to build upon the aims of the Civil Rights movement to help human service agencies estimate and respond to racial and ethnic inequities in their service provision. The urgency of this work is underscored not only by the executive order, but also by the long overdue social unrest around racialized violence and inequity in the U.S. and the stark racial disparities in experience and outcomes of the COVID-19 pandemic.

The following sections of this paper outline three phases of work—performing a gaps analysis (measuring gaps between need for and current availability of services), interpreting the gaps analysis (assessing root causes of the problem and strategizing responses), and co-creating an equity plan (determining next steps and implementing strategies to correct for inequities). Importantly, community organizations and those with lived experiences of the systems under consideration need to be engaged throughout this entire process. See *A Toolkit for Centering Racial Equity Throughout Data Integration* for more (Hawn Nelson et al., 2020a). In addition, the general process provided here will need to be customized based on the social issue of interest, local context, available data, and resource constraints. Drawing upon multiple data sources, types of expertise, and stakeholder perspectives is highly recommended in order to robustly assess and respond to inequities in service provision. Altogether, these methods can inform social policymaking and support human service agencies in more equitable resource allocation and service provision.

Convening Stakeholders

Before undergoing any analysis, it is crucial to identify and convene stakeholders. Stakeholders typically include three key groups: the desired population of the program (e.g., families receiving SNAP benefits, parents of children in child care, older adults experiencing homelessness); key informants who have expert knowledge on the program (e.g., community advocates, program administrators, service providers, researchers); and the broader community (e.g., residents of a neighborhood where a community health center will be built) (Tutty & Rothery, 2001). Each of these groups should be brought to the table early, often, and consistently, as they can all provide unique perspectives on the framing and results of the gaps analysis, the interpretation of root causes for identified gaps in services, and the co-creation of a plan to correct for historical inequities. Though it can be time- and resource- intensive, inviting stakeholders to help plan the gaps analysis and serve as members of the research team is highly recommended. See Ozer (2015) for guidance on conducting community participatory action research.

There are numerous ways to convene stakeholders—virtual or in-person meetings, an ongoing taskforce, townhalls, surveys, focus groups, interviews, mini publics (Escobar & Elstub, 2017), etc.—that can be molded to the context. It is imperative that the chosen strategies facilitate authentic stakeholder engagement and not merely "token" representation. This means that stakeholder input is valued and used to drive change, that stakeholders have voting or other decision-making power, and that one person is not tasked with representing the voice of all stakeholders from a specific group or demographic. Furthermore, agencies convening stakeholders should be upfront about policy and practice decisions that are potentially available as part of the equity assessment process—this gives stakeholders clarity about their power to influence action. Finally, agencies should budget for compensating stakeholders (e.g., an honorarium, stipend, gift card) and ensure that participation is accessible (e.g., accommodations for those with disabilities, transportation passes or reimbursement, child care provided, meeting times that consider non-traditional work schedules). For more on how to identify and engage stakeholders, see *Nothing to Hide: Tools for Talking (and Listening) About Data Privacy for Integrated Data Systems (*Actionable Intelligence for Social Policy & Future of Privacy Forum, 2018).

Guiding Questions

The guiding questions included throughout this working paper aim to highlight key points and help readers apply them to their unique context. These questions are not comprehensive; rather, they serve as a starting point for those conducting equity needs assessments.

- Who are the relevant stakeholders that should be brought to the table:
  - ➤ Desired population of the program (e.g., service participants and families)?
  - ➤ Key informants (e.g., community advocates, frontline staff, program administrators, outside experts, legislative representatives, executive leadership)?
  - ➤ Broader community that may be impacted by the program?
- What strategies for engaging stakeholders have worked in the past, if any? What new strategies could be explored? Who has relationships with stakeholders that can be leveraged?
- What is the available budget to compensate stakeholders?
- What accommodations could make stakeholder participation more accessible?

Phase 1: Perform a Gaps Analysis

The first analytical step is performing a gaps analysis. At a high level, a gaps analysis estimates the need for human service programs and their availability. For example, a gaps analysis of publicly funded child care might seek to measure the number of slots (availability) against the number of children in need of child care (need) in a given jurisdiction. The difference between the availability of child care slots and the need for child care is the gap in services. That gap can also be thought of as the difference between the real and ideal circumstances, the observed and expected demand for a particular service, or the supply and demand (Tutty and Rothery, 2001). Gaps analyses can also be disaggregated (e.g., by race, ethnicity, gender, neighborhood, intersecting identities) to understand if and how gaps are disproportionately distributed.

Gaps can exist in terms of access to services, quality of services, and outcomes of services. Drawing on the child care example, one might ask—how many children in need of child care have *access* to a child care provider? How many of these children have access to a *high-quality* child care provider? Are there differences in key early childhood *outcomes* based on program access and quality? It is important to underscore that the terms access, quality, and outcomes will likely have different meanings across stakeholder groups and jurisdictions. Therefore, drawing on multiple stakeholder perspectives to establish clear definitions from the outset is recommended to build a strong foundation for the gaps analysis.

Guiding Questions

Before analyzing any data, identify and reflect upon the program or service of interest and potential gaps that may lead to inequity, using the following questions as a guideline.

- What is the program/service?
- What jurisdictions or populations are or will be served?
- What are the goals of the program/service?
- What would ideal program/service provision look like in terms of access, quality, and outcomes? How might this differ by jurisdiction and by stakeholder perspective?
- Where and how might inequities in service provision appear?

Estimating Need for Services

A gaps analysis begins by estimating the level of need for a program through direct or indirect measurements. Again, this can also be thought of as reflecting the ideal population coverage.

Direct measurement relies on data sources that explicitly measure the level of need for a particular service. Direct measurement data often come from the census, surveys (e.g., American Community Survey, Current Population Survey, New York City Community Health Survey), service utilization data (commonly referred to as "rates under treatment" in health care), surveillance data (e.g., disease registries, Youth Risk Behavior Surveillance System), or other administrative datasets (e.g., admission and discharge records, program spending, benefits receipt).

Going back to the child care example, the simplest way to directly measure need is by tabulating the population of children under age five. However, this measurement is not likely to be sufficiently nuanced for understanding the distribution of need across a jurisdiction and planning child care services accordingly. To further tease out need for child care, population characteristics from the census or other surveys could be used to estimate the relative number of children by age, race, ethnicity, income level, or other demographics that the agency would expect to see participating in services. Labor market participation rates can help to further estimate how many children under five have working parents and likely need formal child care. Similarly, service utilization and other administrative datasets may provide further insight about how certain subgroups of the population or geographic regions have historically used services, which can inform the planning and siting of programs. Consider the various nuances that shape service needs and seek out the available data sources to support direct measurement.

In health care, a common way to directly measure need is through measures of prevalence (i.e., total cases) and incidence (i.e., new cases). These measures can also be used in human service settings. For example, a gaps analysis of food insecurity might start by tabulating the total number of adults and children reporting food insecurity (prevalence), or alternatively, by estimating the number of households that became food insecure following a recession or natural disaster (incidence). Incidence can be tricky to measure because the need for human service programs is often not clearly fixed to a date of "onset," making it difficult to specify a meaningful starting point from which to measure new cases. Service utilization and other direct measures are also sometimes unavailable, particularly when services are targeted to entire communities and not tracked at the individual level (e.g., libraries, parks, recreation areas) or when planning a new program without historical data. In these instances, proxy data are needed.

Indirect measurement relies on proxy data to model the risk of a particular condition or need within a given jurisdiction. Indirect measurement is useful when there is an absence of data or when the coverage of available administrative data is incomplete or missing non-service users. For example, mental health services often have a shortage of inpatient beds, crisis response units, coverage in rural regions, and other services to meet the needs of everyone in a jurisdiction. This means that the available service utilization data will not provide an accurate estimate of need for mental health services (rather, it is a better measure of availability, as discussed later), so indirect measurement may be used instead.

There are two key ways to indirectly measure service needs. The first way is to look for large epidemiological studies where population-specific rates have been determined through surveys (e.g., Epidemiological Catchment Area Survey of Mental Disorders) and use either their total national multipliers or multipliers from the localities that most closely resemble the jurisdiction of interest. These multipliers are typically available by race, sex, age, and poverty status subgroupings. For example, a jurisdiction strategizing where to site vaccination clinics to promote more equitable distribution might look at vaccination rates by race and age group for a similar jurisdiction that has these data. Vaccination rates can then be applied to the jurisdiction of interest to estimate how many people by race and age are unvaccinated—which can then inform where clinics are sited to be most accessible to groups with lower vaccination rates. Using epidemiological data from comparable jurisdictions is the ideal way to conduct indirect measurement because it relies on comprehensive, population-based data. Keep in mind that if there is relevant epidemiological data for the jurisdiction of interest, this would be a direct measurement.

A second way to indirectly measure need is through a synthetic estimate (Kamis-Gould & Minsky, 1995). This multistep method estimates proportional need across a jurisdiction and within subareas or subgroups in the jurisdiction (e.g., County A accounts for 25% of the state's need for mental health services, County B accounts for 10% of the need, etc. until adding up to 100%). Importantly, this method does not provide an estimate of the total number of people in need but rather an estimate of how need is distributed across a jurisdiction so that resources can be allocated proportionately. This process starts by developing consensus as to the factors associated with a particular condition and their relative weights, based on expert input (including experts through lived experience), research evidence, and readily available data (e.g., census, open data, public reports). See Work in Action: Synthetic Estimation of Need for an extended example of this method.

Guiding Questions

- What data sources are currently available to estimate need, demand, or ideal population coverage for the service of interest?

- Do these sources provide direct measurements of need (e.g., population-based surveys, service utilization data, surveillance data)?

- If no direct measurements are available, are there epidemiological studies from comparable jurisdictions that could be used for indirect measurement? If not, what resources and data are available to perform a synthetic estimate of need (e.g., experts, research evidence, public datasets on the service of interest)?

- Who could provide guidance on deciding which data sources and methods would be best for estimating need (e.g., research experts, practitioners, program data managers)?

- What is not covered by existing data sources?

- How might available estimates of need introduce bias (e.g., systematically undercounting certain groups or underestimating need)? What additional data or steps could help mitigate the potential for bias?

Estimating Availability of Services/Resources

After developing an estimate of need, the next step is to estimate the current availability of the program or service (or "supply"). A common method for estimating availability is analyzing spending for the program of interest (e.g., what was the city's annual spending on community swimming pools? How much money is allocated to the state in the TANF block grant? How many staff are allocated to provide outpatient therapy? How many domestic violence shelter beds exist in the community?). For grant-funded programs this analysis is often straightforward since the allocation to particular programs or regions is known by the agency providing services. Service utilization data can also provide an estimate of supply (e.g., how many people were served by a community health center in a given timeframe?). However, calculating available services can quickly become complex when the same service is provided by numerous agencies and/or disparate funding streams. This is where sharing and linking data across different providers and programs can greatly enhance agency capacity for conducting holistic assessment of need. For more on this important topic, see an Introduction to Data Sharing and Integration (Hawn Nelson et al., 2020b).

Issues of access and quality are particularly pertinent when estimating supply, as the mere number of available providers, service beds, or other units does not indicate if the available supply is accessible or of high-quality. For instance, an analysis of skilled nursing facilities could find that there are enough beds across the state to meet the projected need for nursing beds. However, further analyzing the accessibility of these beds could surface insights about which counties or subpopulations do not have sufficient nursing beds in their local community or which regions are lacking high-quality providers. Furthermore, even if the nursing facilities in a given region are rated as high quality by their overseeing regulatory agency, there may still be quality issues from the client and family perspective that need to be addressed to enhance equitable service delivery.

Therefore, when assessing equity it is critical to analyze who has (and does not have) access to higher quality programs, and how quality and access are defined by different stakeholders. Some programs will have publicly available quality data at the provider level from state or federal regulatory agencies (e.g., child care facilities, hospitals, public schools). Collecting data directly from service users regarding program quality is also highly recommended given that the metrics used in quality rating systems may not reflect the elements of quality that are most important to clients. Consider a child care facility that ranks highly in terms of safety, curriculum, and provider qualifications—all metrics that seem universally important and are often rated by state agencies. However, these metrics do not indicate if there are strong relationships and trust between parents and providers, if the curriculum is culturally nurturing for children of different backgrounds, or if important communications are provided in ways that are accessible to parents. In some instances, funding may be used as a proxy for quality. For example, differences in school spending between districts could indicate potential disparities in school quality based on geographic location. Keep in mind that each program will have a variety of dimensions of quality to consider and varying definitions of quality across stakeholder groups.

Another dimension of equity within the supply of service providers is the relative representation of clients and staff by race, ethnicity, sex, or other demographic characteristics. If the characteristics of service recipients are not reflected in the direct care staff, administrators, or board members of an organization, this may point to a need to improve staff and leadership recruitment practices. Representation may also impact dynamics that are hard to measure quantitatively, like the influence of social networks, microaggressions, and other subtle forms of racism. Integrating qualitative data from community stakeholders can often help uncover these dynamics, which is discussed more in Phase 2.

Guiding Questions

- What data sources are currently available to estimate the supply of resources available to address a given need (e.g., program spending, funding allocations, service utilization data)?

- How could program access be measured with the available data sources?

- Is there quality rating data available for the program of interest? If not, could funding data serve as a proxy measure for disparity in access to quality programs?

- Are there data sources that measure program access and quality based on participant voice/experience? If not, how could these data be collected in the future?

- What is currently known about the demographic makeup of those providing services (i.e., staff, administrators, board members) compared to those receiving services?

Putting It All Together

After estimating the distribution of need and available supply, the gap between these can be identified. Again, this gap can also be thought of as the difference between the ideal and actual state of service provision or as the difference between the expected and observed level of service use.

Homelessness services provides a helpful example. Homelessness is a function of poverty, and reliable data exists for the distribution of poverty by race, ethnicity, sex, age, and other demographic factors (i.e., a proxy for proportional need for homeless services). The distribution of poverty can be measured against administrative data on homeless service provision to compare the proportion of people receiving these services to what is expected based on the well-known demographic distribution of poverty. In Philadelphia, community advocates were concerned that Latinx people were not being adequately served by the city's homeless services, and requested a gaps analysis to quantify the potential gap (Culhane et al., 2019). Although Latinx people made up 23.5% of the population living in poverty in Philadelphia, this group was only receiving around 10% of the city's homeless services. When looking further at representation within specific service types, the research team found that White people were overrepresented in street outreach receipt and Black people were overrepresented in shelter use, while Latinx people were underrepresented across both service types. From here, the research team sought to

further understand these patterns by engaging stakeholders to interpret the gaps analysis (see Phase 2 of this working paper for more detail).

While this example focuses on identifying gaps in access to services, other analyses might focus on gaps in quality or outcomes. For instance, housing subsidies are considered the highest quality homelessness intervention available. A gaps analysis of housing subsidies might ask if such services are disproportionately provided to one race or ethnic group. A similar analysis could be performed to understand which communities have access to higher versus lower quality child care providers. In terms of outcomes, a gaps analysis could be used to look at the differential distribution of standardized testing scores or school suspensions, disease survival rates in health care settings, rehospitalizations, recidivism, employment and earnings, or any other number of meaningful outcomes for the respective system of interest.

To further assess inequities *within* service provision, **data on needs and availability must be disaggregated by relevant subgroups and intersections thereof**. Data can be disaggregated by race, ethnicity, sex, sexual orientation and gender identity and expression (SOGIE) (Delpercio & Murchison, 2017), income or poverty level, or any other characteristic for which reliable data exist. Data can also be disaggregated by multiple, intersecting identities (e.g., trans* multiracial youth, Black men with intellectual or developmental disabilities, older adults living in poverty). This type of disaggregation can generate meaningful insights about equity, though the ability to access and link the necessary data is a common challenge, especially when relying on administrative data for analysis. Disaggregating data can help surface inequities that have previously been overlooked or obscured (e.g., do certain racial groups have a disproportional gap in access to high-quality child care providers? How do mental health services outcomes vary by household income level or form of health insurance?). Disaggregating data is, essentially, breaking down the estimated gap between need and service availability into relevant intersections of population groups.

While the presence of race and ethnicity data provides the most straightforward way to disaggregate data for racial and ethnic groups, sometimes these data are unavailable and may need to be imputed. See Brown et al. (2021) for guidance on Ethics and Empathy in Using Imputation to Disaggregate Data for Racial Equity. Neighborhood data can often proxy for these demographics. Even if race and ethnicity data are available, it may still be important to disaggregate data by neighborhood since where people live is connected to housing markets, school quality, poverty concentration, and the cumulative historical effects of systemic racism and discrimination within these areas (Sharkey, 2016). In this way, disaggregating data by neighborhood or other meaningful spatial units is both complementary to a population-wide gaps analysis and also can be used as a proxy for missing data. However, it is important to keep in mind that using a proxy is always going to be speculative and imperfect. It will be helpful to have Geographic Information Systems (GIS) mapping skills to graphically visualize these data and use these insights to inform the siting of new programs or services to address neighborhood gaps in service access, quality, or outcomes.

While disaggregating data by subgroups can expose inequities and help guide meaningful programmatic changes, also consider the risk of over-surveillance that may emerge from disaggregated data by subgroups (Hawn Nelson et al., 2020a). How disaggregated data are

presented also matters—for example, visuals where red is equated to "bad" access, quality, or outcomes can feed deficit narratives about communities and overshadow potential areas of community strength. To balance these concerns, start with a clear purpose for the data you will use and seek critical feedback as to the risks and benefits before deciding which data you will use for disaggregation and how you will communicate about it (Hawn Nelson et al., 2020a).

> **"Disaggregation of data is also a series of tradeoffs. Without disaggregating data by subgroup, analysis can unintentionally gloss over inequity and lead to invisible experiences. On the other hand, when analysts create a subgroup, they may be shifting the focus of analysis to a specific population that is likely already over-surveilled."** (Hawn Nelson et al., 2020a, p.28)

Guiding Questions

- Which subgroups might be relevant to disaggregate by for analysis (e.g., race, ethnicity, sex, SOGIE, income or poverty level, intersecting identities)?

- Are location data available to disaggregate by neighborhood or other relevant spatial units?

- What are the risks and benefits of disaggregating data by the relevant subgroups and neighborhoods for this analysis?

- What data sources are currently available that could be used for disaggregation?

Work in Action: Synthetic Estimation of Need

In the area of mental health, Kamis-Gould and Minsky (1995) provide an example of synthetic estimates of need and the five key steps involved, based on a method developed for state mental health agencies who must submit equitable allocation plans in their annual federal block grant applications. The table below lists these steps and an example adapted from their work.

It is important to note that this method of indirect measurement is only as accurate as the underlying data and expertise that is used to formulate the weighted factors. Issues of bias, data quality, and historical patterns of funding should be assessed as part of any data analysis project, whether using direct or indirect measurements. This synthetic estimation method can be particularly helpful for determining how to apportion funds from a block grant. The process may surface large discrepancies in how funds have historically been allocated versus how they might ideally be allocated based on need. In the problem assessment phase, seek to understand why such discrepancies exist (e.g., does it reflect racial or socioeconomic disproportionality?).

Steps for Synthetic Estimate of Need	Example
Step 1: Develop a comprehensive list of indicators for a particular condition or need based on expert input, research evidence, and readily available data.	In this example, a state wants to understand the distribution of severe and persistent mental illness (SPMI) by county in order to inform mental health funding allocations. The first step is to convene experts (e.g., program administrators, researchers), discuss existing data and research evidence on SPMI, and generate consensus as to the indicators of SPMI that are relevant for the state.
Step 2: Perform a factor analysis, which will reduce the comprehensive list of indicators to a simplified group of factors. The factor analysis will also show how much of the variance in the condition can be explained by each factor. See Cudeck (2000) and Kline (1994) for more on factor analysis methods.	A factor analysis of indicators for SPMI might result in three factors contributing to the distribution of need for treatment: poverty, social isolation, and housing instability.
Step 3: Perform a correlation analysis between the factor scores developed in Step 2 and any existing proxy measures of prevalence for the condition.	The factor scores for poverty, social isolation, and housing instability can then be correlated with the best available proxy measure of SPMI prevalence (e.g., admissions to psychiatric treatment, caseloads among psychiatric service providers, or other service utilization measures). Let's say the following correlations were produced between each factor and the chosen proxy measure: - Poverty: r=0.5 - Social isolation: r=0.3 - Housing stability: r=0.25
Step 4: Apply the beta coefficients for each factor produced in Step 3 to the actual characteristics of each service area in a linear regression model to produce a score per service area. This score represents an indirect measurement of prevalence of the condition.	These coefficients can be combined with the actual measures of poverty, social isolation, and housing instability from each county to produce a score. Need for SPMI Treatment in County B = (County B Poverty x 0.5) + (County B Social Isolation x 0.3) + (County B Housing Instability x 0.25)
Step 5: Standardize each service area's score by transforming to a T-score, which will allow for mathematical manipulation.	The model shown in the previous step produces a score for each county (or other geographic subunit) that is then transformed into a T score.
Step 6: Use the T-scores to inform decisions about service provision and funding allocation.	The T-score can be used to understand the theoretical apportionment of need for mental health services across a state. For example, if County B is found to make up 10% of the total need scores for the state, then it might follow that 10% of funding for mental health services should be allocated to County B.

Phase 2: Interpret the Gaps Analysis and Identify Root Causes of Inequity

This phase centers around convening relevant stakeholders who can bring contextual expertise, experience, and insights to the interpretation of data produced by the gaps analysis. The main goal of this phase is to better understand and explain the root causes of gaps in services uncovered in Phase 1, particularly the gaps resulting in any disproportional or inequitable distribution of services. There may also be a need to gather additional information and develop follow-up analysis questions at this point. This process is iterative and nonlinear, so the steps discussed below are meant to be customized to the local context and repeated as necessary throughout the project.

Assessing Underlying Sources of Disparities in Service Provision

Stakeholders can help elevate and honor divergent perspectives on the path to consensus regarding the underlying sources of disparities in service provision surfaced by the gaps analysis as well as develop plans for correcting them (discussed further in Phase 3). It may be helpful to start by presenting the results of the gaps analysis and asking stakeholders for their initial reactions and interpretations. This step—often referred to as a "data walk"—can lead to further discussion of why stakeholders think certain gaps in service provision exist (Stokes-Hudson, 2018). For more on data walks, see *Data Walks: Community-Engaged Advocacy*.

The Convening Stakeholders section of this working paper highlights additional ways to bring stakeholders together to elicit qualitative information on the interpretation of gaps. During this process, stakeholders may consider many potential root causes, but broadly they can be summarized in four categories:

- **Risk and protective factors**: What individual, family, community, or societal level factors might contribute to increased risk for a condition or need? What factors might shield people from this risk? For example, parental substance use, poverty, and exposure to environmental toxins are commonly cited as risk factors for child abuse and neglect, while adequate housing, access to health care, and family support may be protective factors (Child Welfare Information Gateway, 2004). Stakeholders can help identify lesser known or community-specific risk and protective factors that are not often visible in administrative data (e.g., mutual aid among immigrant communities, informal support systems, spiritual or religious connections).

- **Barriers and facilitators to accessing services**: Access issues are often subtle and difficult to measure but highly important to revealing biases in service provision.

Stakeholders can help surface explanations as to why some people or communities may not be able to access a service at all and are therefore not present in the data. For example, inadequate interpreter options, long commutes to the service site, and lack of child care may prevent immigrant parents in a particular neighborhood from attending parenting skills classes. Meanwhile, sites that provide interpreters, are on an easily accessible transit route, and provide child care during classes may facilitate easier access.

- **Historical patterns**: Consider how prior policies, spending allocations, the location of services, or other structural factors influence today's service provision. For instance, have the loudest advocate voices typically determined where new homeless services are located, rather than analyses of where such services could be most impactful to those experiencing homelessness? Has the funding allocation formula remained the same for a decade, despite major changes to the economy or migration patterns in the state? Stakeholders will have important insights to contribute to this discussion and it may also require that agency staff carry out additional research.

- **Potential for discrimination**: Inequity is often distributed by historical patterns of discrimination in housing markets, education quality, and access to services. For example, neighborhoods that still experience high rates of poverty and education achievement gaps often align closely with neighborhoods that were redlined since the 1930s (Rothstein, 2017). While legacies of racism continue to impact today's systems, there are also more nuanced ways in which discrimination can appear in service provision. For example, multiple studies have shown that homelessness assessment instruments disproportionately rate White people as having higher need, which makes them more likely to receive high-quality housing assistance (Cronley, 2020). Discrimination can occur even when intentions are good, meaning that no institution is exempt from critically examining the potential influence of discriminatory practices. In addition to engaging stakeholders on this topic, analyzing data by address can show if service access, quality, or outcomes differ significantly based on neighborhood, school district, county, police district, or any other meaningful spatial unit.

Qualitative data gathered in stakeholder convenings can help triangulate quantitative findings from the gaps analysis and also unearth underlying sources of disparity not captured in administrative data or other sources used in the gaps analysis. Where a gaps analysis typically addresses questions of "what," qualitative analysis answers questions about "how" or "why." This process can also surface conflicting findings or disagreement, and while this may be frustrating, it is an important part of making meaning of the data. Conflict often points to areas where additional data analysis, stakeholder input, or examination of existing policies may be necessary in order to generate consensus and move forward. Try to help people arrive at consensus on the major issues and prioritize focus areas. Additional information may need to be gathered to develop follow-up questions and analysis at this point, as this process is iterative and nonlinear. This type of mixed methods approach to analyzing data requires a shift from traditional ideas of academic rigor to the notion of holistic rigor, which "balances the multiple ways of knowing and constellation of perspectives" (Beriont, 2021, para.10). Ultimately, this type of approach can provide more robust analyses and authentic stakeholder engagement.

Guiding Questions

- What can be learned from stakeholders regarding root causes, including:

  Risk and protective factors for the condition or need of interest?

  Barriers and facilitators to accessing the service of interest?

  Potential for discrimination in how services are distributed?

  Historical patterns that may influence service provision?

  Other root causes not listed here?

- How does stakeholder input help move from the 'what' to the 'how' and 'why'? How does this input deepen understanding of the gaps analysis? Does what stakeholders say change interpretations of the gaps analysis from Phase 1?

- Are any additional analyses and/or perspectives needed to move forward?

Work in Action: Assessing Barriers to Homeless Services Access in Philadelphia's Latinx Population

After a gaps analysis surfaced insights about the underuse of homeless services by Philadelphia's Latinx community (see **Figure 1**), stakeholders were brought to the table to help understand why (Culhane et al., 2019). The research team organized focus groups with Latinx individuals who had experienced homelessness or housing instability, frontline service providers, and leaders from nonprofits serving Latinx populations. Focus groups discussed potential barriers to accessing services and community protective factors that may have mitigated use of homeless services among Latinx communities.

Several explanations for disproportional service use emerged from the focus groups. For one, negative perceptions of homeless services deterred Latinx Philadelphians from engaging in the City's services. A lack of Spanish-speaking staff made it particularly difficult and intimidating to navigate services. Service sites were also located in unfamiliar neighborhoods where those in need of services did not feel comfortable going. In addition, focus group participants noted the role of formal and informal support systems in preventing housing loss from those imminently at risk of homelessness. For example, other social service agencies that were more well-known, trusted, and conveniently located in predominantly Latinx neighborhoods, provided benefits that could mitigate housing loss (e.g., emergency cash assistance, service referrals). However, these agencies were not equipped to offer targeted homeless programming.

Integrating findings from the gaps analysis with insights generated via focus groups was crucial for creating shared understanding of the underlying reasons for disproportional service use, which has since informed strategies to correct for inequities in service provision. Although City personnel had previously invited

requests for funding proposals from community organizations, this effort was largely unsuccessful given the lack of clarity around which types of services could reduce disparities. The process of the study revealed two key areas where funding is now being strategically directed: 1) the creation of a new intake site with Latinx providers and more conveniently located in a predominantly Latinx neighborhood, and 2) support for a rapid rehousing program for those leaving shelter. Advocates have also been exploring temporary shelter options in Latinx communities (e.g., a church rectory) that could serve as a stopgap while people wait to get into housing. Altogether, this example demonstrates how stakeholder input can deepen understanding of the gaps analysis by understanding why such gaps exist and allow for actionable solutions to emerge.

Figure 1:

Table 1 – Philadelphia Population Size, by Race/Ethnicity, Sex and Age Group

	Philadelphia Population (2011-2015)		Philadelphia Poverty Population (2011-2015)		Emergency Shelter/Transitional Housing Population (2018)		Outreach Services Population (2018)	
	N	%	N	%	N	%	N	%
Total Population	1,372,808	100	359,760	100	13,052	100	8,348	100
Race/Ethnicity								
Latinx	204,012	14.9	84,496	23.5	1,183	9.1	864	10.3
Black	632,951	46.1	195,598	54.4	10,143	77.7	4,780	57.3
White	535,845	39.0	79,666	22.1	1,726	13.2	2,704	32.4
Sex								
Male	646,415	47.1	160,249	44.5	7,433	56.9	5,829	69.8
Female	726,393	52.9	199,511	55.5	5,829	44.7	2,519	30.2
Age Groups								
0-5	112,033	8.2	42,059	11.7	1,554	11.9	22	0.3
6-17	194,494	14.2	73,508	20.4	1,632	12.5	-	0.0
18-24	143,792	10.5	53,180	14.8	1,134	8.7	322	3.9
24-34	242,042	17.6	52,351	14.6	2,439	18.7	1,429	17.1
35-44	169,681	12.4	35,931	10.0	1,967	15.1	1,616	19.4
45-54	176,386	12.8	39,846	11.1	2,126	16.3	1,764	21.1
55-64	159,962	11.7	33,700	9.4	1,634	12.5	1,392	16.7
65+	174,418	12.7	29,185	8.1	441	3.4	429	5.1

Notes: 1) All Philadelphia populations include only those in the three largest racial/ethnic groups, as the homeless numbers (emergency shelter/transitional housing and outreach services) for the other groups were too small for analysis.
2) Philadelphia overall and poverty population numbers come from the American Community Survey; emergency shelter/transitional housing numbers provided by the City of Philadelphia Office of Homeless Services, and outreach services numbers provided by the City of Philadelphia Office of Behavioral Health and disAbility Services.
3) Percentages in the age categories for the homeless data do not add up to 100 due to missing data.
4) Numbers for White and Black races do not include those with Latinx ethnicity; numbers for Latinx are inclusive of all (including unknown and multiracial) race.

Phase 3: Co-Create an Equity Plan

In this phase, stakeholders and research team members co-create an equity plan drawing on insights from the gaps analysis and stakeholder engagement around root causes. This process aims to not only correct for historical inequities in service provision, but also to reimagine and plan for the future. Like a corrective action plan, the core goal of an equity plan is to create concrete next steps to redress inequities and ensure accountability along the way. Stakeholders should be reconvened to discuss the proposed plan, provide feedback, and develop consensus for implementing it. A common challenge at this point is prioritizing strategies to redress inequity within resource constraints while also balancing diverse stakeholder perspectives. The example at the end of this section illustrates this through an effort to allocate limited preschool funding to the most high-need areas.

Potential corrective actions to consider include:

- Expanding services and eligibility
- Developing more culturally appropriate service options or touchpoints
- Reallocating funds according to need
- Dedicating new funding streams to address need
- Ceasing programs or policies found to be discriminatory and/or harmful
- Choosing where to site a program based on geographic distribution of need
- Renegotiating program improvement goals in provider contracts
- Changing the way programs can be accessed
- Revising staff and leadership recruitment practices

An equity plan connects findings from Phase 1 and Phase 2 to create a clear plan of action. It should include measurable goals, deliverables, deadlines, roles, and responsibilities. This also includes developing mechanisms to track and evaluate progress towards goals and communicate results to stakeholders, advisory groups, the public, or any other entity that should be kept abreast of the plan. The team that conducted the gaps analysis or a newly configured team may assume this role. Ultimately, a gaps analysis is a strategy for measuring and holding up unmet need, disparity in service provision, or other inequities. It is critical that the insights surfaced from this process are used to drive action or change that benefits the community and remedies prior gaps in service provision.
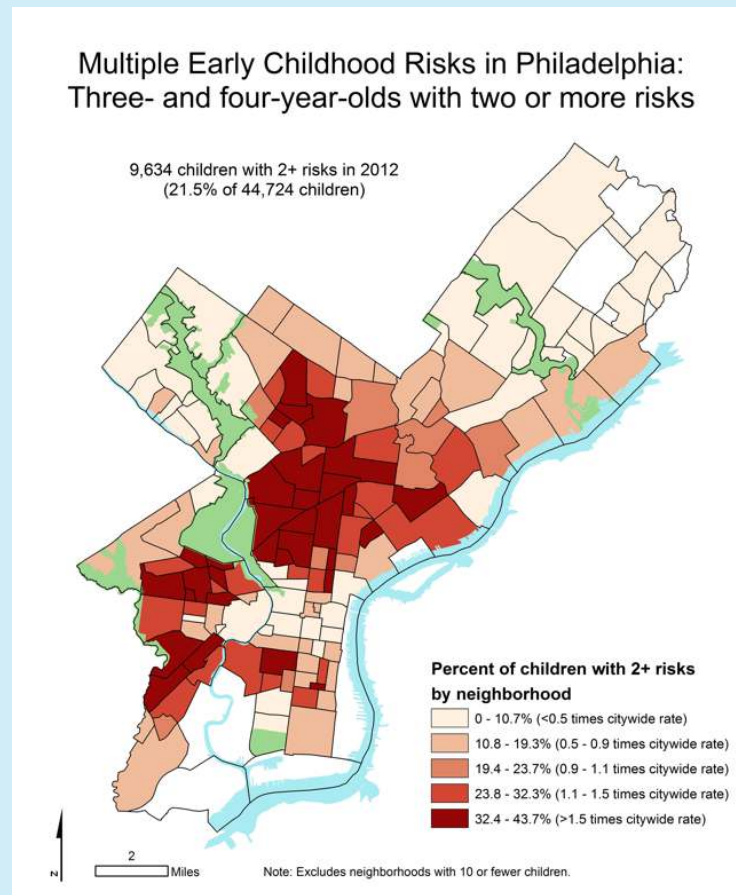
Guiding Questions

- What resources are available to redress inequities in the program of interest?
- Which corrective action(s) are plausible within the local context and available resources?
- Where do stakeholders align on how to approach corrective action? Where do they diverge? How might differing perspectives be balanced in carrying out the equity plan?
- What mechanisms can ensure accountability to carrying out the equity plan? How will equity continue to be evaluated as the plan is implemented?
- Do corrective actions address root causes and considerations uplifted by stakeholders as well as findings from the gaps analysis?

Work in Action: Mapping Risk Indicators to Inform Equitable Expansion of Philadelphia Pre-K

A second example from Philadelphia demonstrates how insights about disparities in access to high quality pre-k programs informed a strategic plan to expand offerings and improve equity (LeBoeuf et al., 2017). A team of researchers from the Penn Child Research Center partnered with the Mayor's Universal Pre-K Commission to inform how to allocate available funding for this effort to neighborhoods that could most benefit from additional high-quality pre-k slots. Importantly, the Commission included parents and providers, so that the voices of those who would be most impacted by this effort were represented. The research team relied on administrative data housed in the city's integrated data system to estimate neighborhood-level need by mapping cumulative risks to children based on evidence-based indicators (lead exposure, child maltreatment, homelessness, low birth weight, inadequate prenatal care, low maternal education, and teen pregnancy). The team then mapped the availability of existing quality pre-k slots and overlayed this with the cumulative risk maps to identify areas where pre-k expansion would have the most impact. See **Figure 2** for the map summarizing this analysis.

In the corrective action planning phase, the City used these insights to inform their process for selecting providers to receive pre-k expansion funding. For example, three high-quality pre-k providers in Kingsessing received expansion funds, which added 68 slots to this neighborhood identified as high-risk/low-supply. The corrective action plan also included outreach efforts to neighborhoods with higher concentrations of risk to encourage children who could most benefit from high-quality pre-k to fill the new slots and flags on case records for individual children to encourage referral to the program. The corrective action phase was critical to figuring out how to expand pre-k access equitably and realistically in a resource-constrained environment.

Figure 2:

Multiple Early Childhood Risks in Philadelphia:
Three- and four-year-olds with two or more risks

9,634 children with 2+ risks in 2012
(21.5% of 44,724 children)

Percent of children with 2+ risks
by neighborhood

- 0 - 10.7% (<0.5 times citywide rate)
- 10.8 - 19.3% (0.5 - 0.9 times citywide rate)
- 19.4 - 23.7% (0.9 - 1.1 times citywide rate)
- 23.8 - 32.3% (1.1 - 1.5 times citywide rate)
- 32.4 - 43.7% (>1.5 times citywide rate)

Note: Excludes neighborhoods with 10 or fewer children.

Conclusion

Human service agencies are being called upon to assess equity within their programs and redress historical inequities. The three phases of work outlined in this working paper strive to build upon the aims of the Civil Rights movement to help agencies analyze their gaps in services, engage community stakeholders to interpret identified gaps, and co-create equity plans that support more equitable distribution of programs and services. This is a complex and difficult undertaking for human service agencies and their partners. However, numerous organizations and tools exist to support these efforts in addition to this working paper. The Government Alliance on Race and Equity (GARE) has publicly available resources and examples of how this work has been enacted by city and county governments. Additionally, the Office of Management and Budget (OMB) compiled methodological tools for equity assessments in a 2021 report to President Biden (OMB, 2021).

The important thing to remember is that there's something everyone and every agency can do, starting today, to adopt an equity lens—whether it's bringing this lens to existing needs assessment efforts; planning new needs assessments in response to community feedback; engaging stakeholders in new ways; learning about the role of historical policies and structural racism in service provision; or taking action to ensure access to high quality services is more equitably distributed in the future. The need for this work is not new, but it is now more urgent than ever. We hope you will join us!

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