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From Commitment to Institutionalization: Healthcare Organization Leaders' Perspectives on Diversity, Equity, Inclusion, and Belonging in Southern California — A Qualitative Study

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Abstract

Background

Public health and health-oriented non-profit organizations increasingly implement diversity, equity, inclusion, and belonging (DEIB) initiatives to strengthen organizational culture and reduce health inequities. However, translating DEIB commitments into sustainable, structural change remains a significant challenge. Existing literature offers limited insight into how organizational leaders distinguish between symbolic and transformative implementation strategies. This qualitative study explored leaders' and facilitators' perspectives on DEIB institutionalization.

Methods

Using a qualitative study design, semi-structured virtual interviews were conducted with 15 organizational leaders and DEIB facilitators across nine public health and health-oriented non-profit organizations in Southern California, USA. Participants were selected based on leadership roles or direct DEIB implementation experience. Data were analyzed using reflexive thematic analysis, guided by Inclusive Leadership Theory and Systems Theory. Trustworthiness was established through member checking, reflexive journaling, and audit trails.

Results

Five primary themes emerged: (1) leadership commitment as the central driver; (2) systemic integration over isolated initiatives; (3) authentic community engagement; (4) robust accountability and measurement; and (5) adaptive leadership resilience. Importantly, participants distinguished between performative DEIB – marked by symbolic actions and superficial structural change – and restorative DEIB, an approach focused on repairing historical inequities, rebuilding trust, fostering belonging, and embedding equity into governance, policies, and daily practice.

Conclusions

Achieving meaningful DEIB requires moving beyond representation and compliance toward organization-wide transformation. We propose restorative DEIB as an emerging conceptual framework to shift healthcare organizations from symbolic commitment to sustained systems change. This framework provides a practical pathway for embedding equity into organizational culture, decision-making, and continuous improvement, ultimately supporting workforce inclusion and equitable outcomes.

Introduction

Although public health and health-oriented non-profit organizations (collectively referred to as healthcare organizations) strive to deliver safe, high-quality, population and patient-centered services and care, substantial disparities in healthcare access, quality, and outcomes persist across demographic, socioeconomic, and geographic lines [1–3]. Despite ongoing policy reforms across the world, particularly in the United States, and healthcare organizations' stated commitment to equity, internal performance metrics reveal ongoing disparities in program reach, service delivery, and resource investment across demographic, socioeconomic, and geographic populations. Consequently, eliminating preventable health inequities remains a persistent challenge [4, 5]. Over the past decade, diversity, equity, inclusion, and belonging (DEIB) has emerged as an essential framework for addressing structural health inequities. While interrelated, DEIB encompasses distinct constructs: diversity concerns representation across demographic and experiential backgrounds; equity addresses fairness by tailoring resources to unique needs; inclusion creates environments where diverse individuals are valued and engaged; and belonging ensures psychological safety and authentic participation [2, 3, 6].

Within healthcare organizations, DEIB has evolved from isolated workforce diversity initiatives into a comprehensive strategy for optimizing organizational performance, patient safety, workforce engagement, and community trust [7, 8]. The COVID-19 pandemic further exposed how structural and institutional factors within healthcare organizations disproportionately burden marginalized populations [1, 4, 5], accelerating a shift toward systemic approaches targeting organizational culture, governance, and leadership accountability. Substantial evidence indicates that inclusive organizational cultures yield significant benefits, including higher employee retention, enhanced psychological safety, improved patient satisfaction, and stronger health equity outcomes [2, 6, 9].

Nevertheless, healthcare organizations face substantial barriers to translating DEIB principles into sustained organizational change. Common implementation hurdles include inconsistent leadership commitment, resource constraints, resistance, inadequate accountability systems, and an overreliance on process-based metrics rather than meaningful outcome evaluations [10–12]. Overcoming these barriers depends heavily on inclusive leadership to align vision, allocate resources, and embed equity into operational processes [13, 14]. Since healthcare organizations function as complex adaptive systems, achieving sustainable equity requires coordinated structural changes across multiple organizational levels [15, 16]. Together, Inclusive Leadership Theory and Systems Theory provide a robust framework for understanding how leaders influence systemic DEIB implementation and sustainability [14–16].

While literature on DEIB policies and workforce programs continues to expand, few qualitative studies examine how organizational leaders and implementation facilitators navigate their roles across both internal (employees, leadership, governing boards) and external (patients, communities) stakeholders. Addressing this gap, the present study explores the perspectives of organizational leaders and DEIB facilitators across public health and non-

profit healthcare organizations in Southern California, USA. Guided by Inclusive Leadership and Systems Theories, this study investigates leadership influence, implementation barriers, evaluation approaches, and strategies for advancing sustainable, system-level equity.

Methods

Study Design and Philosophical Orientation

This study employed a basic qualitative research design grounded in constructivism to explore organizational leaders' and DEIB facilitators' perspectives regarding the implementation, impact, and future of DEIB initiatives within healthcare and public-serving organizations. A qualitative paradigm was selected because it enables an in-depth understanding of participants' experiences, perceptions, and interpretations of complex organizational processes that cannot be adequately captured using quantitative methods [17, 18]. Constructivism posits that individuals generate meaning from their professional experiences and organizational contexts; thus, this study prioritized understanding how organizational leaders perceive their roles in advancing meaningful DEIB initiatives and how these perceptions influence organizational practices [17, 18].

Theoretical Frameworks

The study was guided by two complementary theoretical perspectives: Inclusive Leadership Theory and Systems Theory. Inclusive Leadership Theory provided the conceptual lens for examining how leaders create environments characterized by equity, psychological safety, participation, and belonging [14]. Systems Theory facilitated the conceptualization of DEIB as an organizational phenomenon influenced by interconnected structures, policies, internal and external stakeholders, and broader political-economic environments [15].

Study Setting and Population

The study was conducted among public sector and non-profit organizations located across four counties in Southern California, United States. Participating agencies represented multiple sectors, including county public health departments, non-profit organizations, managed care organizations, and a regional alliance responsible for advancing health equity and community well-being. These settings were purposefully selected due to their demonstrated engagement in DEIB or health equity initiatives and their service to culturally and socioeconomically diverse populations.

Sampling and Recruitment

Purposive sampling was used to recruit participants with substantial knowledge of organizational DEIB efforts across executive leadership and operational implementation roles. Eligible participants met one or more criteria: occupying executive or senior leadership positions within public or non-profit organizations; directing or coordinating DEIB, health equity, accessibility, or related initiatives; possessing responsibility for organizational decision-making related to DEIB; or having extensive professional experience implementing or overseeing equity-related programs. Fifteen participants from nine organizations were interviewed, including executive directors, public health leaders, health equity directors, DEIB practitioners, and program managers. Recruitment continued until thematic saturation was achieved. This was defined as the point at which additional interviews yielded minimal new conceptual insights, aligning with sample size recommendations for qualitative studies exploring professional populations [19].

Ethical Considerations and Informed Consent

Ethical approval

was granted by the Institutional Review Board (IRB) of the American College of Education on 14 November 2024 (ACE IRB-FY2024 2207119555). Formal organizational site permissions were secured from participating agencies prior to recruitment. Potential participants received an electronic invitation detailing study aims, voluntary participation, confidentiality protections, and informed consent procedures (*Supplement 1*). Interested individuals completed an electronic written informed consent form prior to participation, explicitly consenting to audio recording, verbatim transcription, publication of anonymized direct quotes, and confidential data storage on encrypted, password-protected cloud drives behind secure institutional firewalls accessible exclusively to the research team. Participants retained the right to decline answering any question or withdraw from the study at any time without penalty or impact on professional standing.

Data Collection and Instrumentation

Data were collected through individual semi-structured interviews conducted via Zoom between November and December 2024 by the principal investigator, using a standard structured questionnaire developed for this study *(Supplement 2*). Utilizing a single interviewer ensured procedural consistency across sessions while offering flexibility to explore unique organizational contexts. An interview guide developed from the literature, Inclusive Leadership Theory, and Systems Theory facilitated discussion across six key domains: current DEIB initiatives, leadership roles and governance, organizational facilitators and barriers, perceived impacts, evaluation approaches, and future sustainability. Interviews lasted between 56 and 78 minutes (mean duration of 62 minutes), were audio-recorded, transcribed verbatim using Otter.ai (https://otter.ai/), audited line-by-line against original recordings for accuracy, and offered to participants for member checking to enhance data credibility.

Data Analysis

Data were analyzed using Braun and Clarke's six-phase reflexive thematic analysis framework [20], supported by Microsoft Excel (https://www.microsoft.com/en-us) for matrix organization and ChatGPT (OpenAI) (https://chatgpt.com/) as an exploratory tool for code organization and brainstorming. Analysis occurred concurrently with data collection to iteratively inform interview probing. The six analytical phases comprised familiarization through transcript reading and audio review; systematic line-by-line coding of explicit and latent meanings; grouping related codes into candidate categories; reviewing candidate themes against the full dataset; defining and naming final thematic structures; and producing the report with illustrative narrative extracts. Two analysts (PO-O and OOO) independently coded thirty percent of the transcripts and met regularly to compare code applications, resolve discrepancies, and maintain constant comparison across participant roles and organizational types.

Researcher Reflexivity

The principal investigator (PO-O: MS in Health Policy, MBA in Non-profit Management, EdD in Public and Non-profit – policy analyst, advocate, and strategist) possessed a professional background in public health leadership and health equity advocacy, thereby providing contextual understanding of public sector health systems. To minimize potential bias and prevent prior experience from unduly influencing data interpretation, several reflexive strategies were employed: maintaining reflexive notes throughout data collection and analysis; strictly adhering to a standardized interview guide; engaging in continuous comparison across interviews; documenting analytic decisions through an audit trail; and grounding all interpretations directly in participants' verbatim accounts rather than preconceived assumptions.

Methodological Rigor and Trustworthiness

Trustworthiness was established using Norris and Walker's criteria of credibility, transferability, dependability, and confirmability [21]. Credibility was enhanced through prolonged engagement with the data, member checking of transcripts, investigator triangulation between independent coders, and role triangulation across executive leaders and operational facilitators. Transferability was supported by detailed descriptions of participant characteristics, organizational settings, and regional contexts. Dependability was maintained through a detailed audit trail documenting raw data, transcription revisions, coding schemes, analytical memos, and methodological decisions throughout the study lifecycle. Confirmability was strengthened through reflexive journaling, preservation of coding matrices, and ensuring findings reflected participant narratives. This study was prepared and reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines [22].

Results

Participant Characteristics

Fifteen participants representing nine public sector and non-profit organizations in Southern California completed the study. Participants occupied positions across executive, senior management, and program leadership levels, maintaining direct responsibility for organizational strategy, policy development, or the operational implementation of DEIB and health equity initiatives. Participating organizations included county public health departments, community-based health non-profits, healthcare partnerships, and regional population health agencies.

Participants demonstrated extensive professional expertise, with most possessing over ten years – and several over two decades – of management experience in public health, healthcare administration, and health equity. Educational backgrounds were similarly advanced, with nearly all participants holding graduate degrees (e.g., MPH, MHA, MBA) and several possessing or pursuing doctoral degrees. The sample reflected broad demographic diversity across racial and ethnic identities (African American, Caribbean, Hispanic/Latino, White, Asian American, Vietnamese American, Middle Eastern/Persian American, and multiracial), gender, age (late 30s to over 60), and lived experience, including backgrounds as immigrants, children of refugees, first-generation college graduates, and community advocates **(**Tables 1 & 2**)**.

Table 1
Demographic Characteristics of Participants (N = 15).

Description	Frequency (%)
Gender	
Female	9 (60)
Male	6 (40)
Other	0 (0)
Age Group	
35–44 years	5 (33.3)
45–54 years	6 (40)
≥ 55 years	4 (26.7)
Race/Ethnicity	
White	3 (20)
African American/Black	3 (20)
Hispanic/Latino	3 (20)
Asian/Vietnamese American	2 (13.3)
Middle Eastern/Persian American	1 (6.7)
Multiracial	2 (13.3)
Other	1 (6.7)
Highest Education	
Master's degree	10 (66.7)
Doctoral candidate	2 (13.3)
Doctoral degree	3 (20)
Organization Type	
County Public Health Department	8 (53.3)
Non-profit Organization	7 (46.7)
Primary Leadership Role	
Executive Leadership	6 (40)
Senior Management	4 (26.7)
Health Equity/DEIB Director	5 (33.3)

Table 2
Professional Backgrounds and Diversity of Participants.

Professional Background of Participants	
Average years of professional experience	> 15 years
Primary sectors represented	Public health, non-profit organizations, healthcare administration, community organizations, etc.
Areas of expertise	Health equity, DEIB, organizational leadership, epidemiology, community engagement, workforce development, healthcare administration, public policy
Leadership responsibilities	Executive leadership, strategic planning, organizational governance, health equity implementation, workforce management, community partnerships
Geographic representation	Four Southern California counties
Diversity of Participant Perspectives	
Professional identity	Public health leader, executive director, epidemiologist, DEIB director, community health leader
Personal identity	Parent, immigrant, child of refugees, first-generation college graduate, veteran, advocate
Cultural perspectives	African American, Latino, Vietnamese American, Persian American, White, multiracial
Leadership perspectives	Systems thinking, servant leadership, inclusive leadership, collaborative leadership, equity-centered leadership
Community focus	Health equity, community engagement, social justice, accessibility, language justice, organizational belonging

Thematic Analysis

Across all 15 interviews, participants framed DEIB not as a peripheral human resources function, but as a systems-level leadership strategy. Analysis revealed five primary interconnected themes explaining how leaders conceptualize, implement, and sustain organizational equity initiatives.

Theme 1: Leadership Commitment Drives Organizational DEIB

Leadership commitment emerged as the single most critical determinant of whether DEIB efforts achieve structural integration or remain symbolic and episodic. Participants emphasized that workforce members evaluate executive intent through concrete resource allocation, policy decisions, and daily behaviors rather than formal statements. As one participant explained: "*If leadership isn't committed, DEIB becomes another project instead of becoming part of how the organization operates.*" Another noted: "*Our employees know immediately whether leadership actually believes in this work or whether we're simply checking a box.*" A senior executive observed: "*The tone is established from the top. Leaders decide what gets funded, what gets measured, and ultimately what gets sustained.*" Participants emphasized that authentic commitment requires executive sponsorship, visible modeling, psychological safety, and continuous engagement rather than short-term initiatives (Table 3).

Table 3
Major Themes and Illustrative Participant Quotations.

Theme	**Illustrative Quotation**	**Interpretation**
Leadership commitment	*"Leadership sets the tone for everything."*	Executive commitment shapes organizational priorities
Systems integration	*"Equity belongs in every department."*	DEIB must be embedded throughout organizational systems
Community engagement	*"Communities should help design solutions."*	Equity requires authentic partnerships
Accountability	*"If you don't measure it, you can't improve it."*	Sustainable DEIB depends on measurable outcomes
Organizational resilience	*"The language changes, but the work remains."*	Equity initiatives must survive political and organizational shifts

Theme 2: DEIB Must Be Embedded Within Organizational Systems

Participants consistently asserted that meaningful DEIB must extend beyond recruitment and workforce demographics to encompass the entire operational architecture of an agency. Rather than delegating equity to an isolated diversity office, successful organizations integrate equity principles into recruitment, onboarding, promotion, procurement, budgeting, strategic planning, and quality improvement. As one participant remarked: "*Equity isn't something our equity office owns. Every department owns it." Another stated: "If HR is doing one thing, operations another, and leadership something else, the system won't change.*"

Theme 3: Authentic Community Engagement Builds Equity and Trust

Participants emphasized that organizational equity internal to the workforce must be paired with authentic, sustained relationships with the external communities served. Community engagement was conceptualized not as one-way consultation after policies are finalized, but as a continuous partnership in program design and evaluation. One participant reinforced this: "*Communities should never simply receive services. They should help design them.*" Another stated: "*Trust isn't built during emergencies. It's built over years of showing up consistently.*" Reflecting on lessons from the COVID-19 pandemic, public health leaders noted that agencies with pre-existing community trust, language accessibility, and advisory boards were far better equipped to deliver equitable emergency responses.

Theme 4: Meaningful DEIB Requires Accountability and Continuous Evaluation

A major gap identified across agencies was the lack of comprehensive evaluation metrics. While most organizations tracked demographic representation and training attendance, few systematically evaluated organizational culture, employee psychological safety, or clinical health outcomes. As one participant stated: "*We count participation because it's easy. Measuring belonging is much harder.*" Another commented: "*You can't improve what you never measure.*" Participants advocated for data-driven equity dashboards combining workforce metrics, retention rates, promotion disaggregation, and community trust indicators to drive transparent accountability.

Theme 5: The Future of DEIB Depends on Organizational Resilience

In evaluating the future of equity initiatives amid shifting political and regulatory environments, participants clearly separated changing external vocabulary from core organizational values. One executive explained: "*The terminology may change, but fairness never goes out of style.*" Another reflected: "*Whatever we call it – health equity, inclusion, justice, accessibility – the work remains.*" Participants anticipated that resilient organizations would sustain equity work by embedding its principles directly into quality improvement, population health management, patient safety, and administrative policy.

Cross-Cutting Implementation Challenges

While participants overwhelmingly endorsed the strategic necessity of DEIB, their narratives revealed that moving from organizational intent to sustained operational execution is hindered by deeply ingrained structural, financial, and environmental obstacles. Rather than existing in isolation, these implementation barriers operate across public sector and non-profit agencies alike, affecting both executive decision-makers and frontline DEIB facilitators. Analysis of participant accounts revealed six interconnected challenges that routinely impede the institutionalization of equity initiatives, underscoring the complex operational realities and systemic frictions that leaders must navigate within public-serving health systems (Table 4):

Table 4
Cross-Cutting Challenges to DEIB Implementation.

Challenge	Representative Participant Perspective	Organizational Implication(s)
Inconsistent leadership commitment	*"Leadership determines whether equity becomes part of the organization or remains another project."*	Limits organizational sustainability and accountability
Resource limitations	*"The work keeps growing, but resources don't."*	Restricts staffing, programming, and long-term planning
Political polarization	*"The terminology changes, but the mission shouldn't."*	Requires adaptive organizational communication
Limited evaluation	*"We're measuring activity more than impact."*	Makes it difficult to demonstrate effectiveness
Organizational resistance	*"Culture changes slower than policy."*	Slows implementation and workforce engagement
Operational integration	*"Policies say one thing, daily practice says another."*	Weakens organizational credibility and outcomes

1. **Inconsistent Leadership Commitment and Prioritization**: Vulnerability to executive turnover and budget shifts was frequently cited. As one participant explained: "*If the CEO believes in the work, everything moves faster. If leadership changes, sometimes the entire strategy changes.*" Another observed: "*Some organizations say equity is important, but when difficult budget decisions come, equity is often the first thing to disappear.*"
2. **Limited Resources and Financial Sustainability**: Dependence on temporary grants creates staffing instability. One participant remarked: "*The work expands every year, but staffing rarely does.*" Another stated: "*Everyone wants equity until they have to budget for it.*"
3. **Political Polarization**: Navigating external opposition requires strategic communication. One participant noted: "*The language has become politicized, but fairness hasn't.*" Another explained: "*Sometimes we're changing the words, not because the work changed, but because people react differently to certain terms.*"
4. **Difficulty Measuring Meaningful Outcomes**: Overreliance on process outputs obscures long-term impact. One participant commented: "*We know how many people attended the training. We don't know whether behaviors changed.*" Another observed: "*Belonging is probably the hardest thing to measure*."
5. **Organizational Resistance to Change**: Misconceptions and zero-sum thinking generate friction during policy updates. One participant explained: "*People hear diversity and immediately think someone is losing something.*" Another stated: "*Changing culture is much harder than changing policy.*"
6. **Translating Aspirations into Practice**: Disconnects persist between mission statements and daily workflows. One executive summarized: "*It's easy to write equity into a mission statement. It's much harder to operationalize it.*"

Future Priorities for DEIB

When evaluating the long-term trajectory of organizational equity, participants outlined a strategic roadmap aimed at overcoming current implementation barriers and moving beyond episodic, activity-based initiatives. Rather than expressing cynicism in the face of political, financial, or regulatory headwinds, leaders articulated a forward-looking vision grounded in organizational transformation. They emphasized that sustaining equity requires shifting from passive demographic representation to building deep institutional capabilities. To achieve this, participants identified six interconnected priorities necessary to embed belonging into core operations, distribute leadership accountability across all administrative tiers, strengthen community power-sharing, and ensure that DEIB principles remain resilient across leadership transitions and shifting external environments (Table 5):

Table 5
Participants' Vision for the Future of DEIB.

Future Priority	Illustrative Participant Perspective	Intended Organizational Outcome
Institutionalize DEIB	"*Every department should own equity.*"	Sustainable organizational integration
Develop inclusive leaders	"*Leadership exists at every level.*"	Stronger organizational culture
Strengthen community partnerships	"*Communities should co-create solutions.*"	Increased trust and responsiveness
Improve accountability	"*Measure outcomes, not activities.*"	Evidence-informed decision making
Increase organizational resilience	"*The mission stays even when the language changes.*"	Long-term sustainability
Transform organizational culture	"*Belonging should become normal.*"	Inclusive and equitable workplaces

1. **Institutionalize DEIB as a Core Function**: Moving beyond standalone departments toward universal integration. One participant reflected: "*The goal is that eventually we won't have an equity office because every office will be doing equity.*" Another said: "*If equity depends on one person or one department, we've already limited its impact.*"
2. **Develop Inclusive Leaders at Every Level**: Preparing middle managers and supervisors to cultivate everyday belonging. One executive noted: "*Every manager influences belonging.*" Another explained: "*Leadership isn't just positional authority. It's the ability to create environments where people feel valued.*"
3. **Strengthen Community Partnerships Through Shared Leadership**: Transitioning from outreach to shared governance. One participant remarked: "*Communities should be partners, not simply recipients of services.*" Another said: "*The people closest to the problems usually understand the solutions.*"
4. **Build Robust Accountability Frameworks**: Moving toward disaggregated outcome tracking. One participant observed: "*The next phase isn't doing more work. It's understanding whether the work actually changes people's experiences.*"
5. **Promote Adaptability and Sustainability**: Embedding equity into core infrastructure to survive political or financial shifts. One participant explained: "*The words may change, but inclusion, fairness, and respect aren't going anywhere.*" Another reflected: "*Organizations that survive will be those that make equity part of how they operate, not something they talk about.*"
6. **Shift from Representation to Transformation**: Prioritizing psychological safety and structural change over headcount. One participant summarized: "*Representation gets people into the room. Inclusion allows them to speak. Belonging allows them to stay and lead.*"

From Performative to Restorative DEIB

A central narrative thread across all interviews was the imperative to transition from performative gestures to restorative organizational transformation. Participants criticized symbolic actions – such as public statements, awareness events, or isolated committees – that generate public visibility without altering internal power dynamics, resource allocation, or employee experiences. As one participant said: "*Anyone can issue a statement. The harder work begins after the statement.*" Another pondered: "*The real question isn't whether you have a DEIB committee. It's whether people experience fairness every day.*" Participants positioned restorative DEIB as an active, structural process of repairing historical inequities, rebuilding trust, ensuring psychological safety, and embedding fairness into daily administrative operations (Table 6).

Table 6
Participants' Perspectives on Performative and Restorative DEIB.

Dimension	Performative DEIB	Restorative DEIB
Leadership	Symbolic endorsement	Visible, sustained leadership commitment
Purpose	Organizational image	Organizational transformation
Focus	Activities and compliance	Systems change and equity outcomes
Workforce	Representation	Inclusion, psychological safety, belonging
Community	Consultation	Partnership and shared leadership
Accountability	Limited evaluation	Continuous measurement and improvement
Resources	Temporary funding	Long-term organizational investment
Sustainability	Vulnerable to leadership changes	Embedded in organizational systems
Success indicator	Number of initiatives	Measurable organizational and community impact

Conceptual Framework

Figure 1 synthesizes our empirical findings into an integrative conceptual model. The framework demonstrates how sustained executive leadership commitment initiates systems-level integration, authentic community partnership, robust evaluation, and organizational resilience. By actively navigating implementation barriers and transitioning from symbolic, performative activities toward restorative practices, organizations build mature equity capabilities that foster lasting workforce belonging, institutional trust, and health equity outcomes.

Discussion

This qualitative study demonstrates that achieving meaningful DEIB requires moving beyond superficial demographic representation toward embedded systems change, psychological safety, and sustained institutional belonging. While workforce representation merely indicates who is present within an organization, belonging reflects whether individuals experience sustained acceptance, shared decision-making influence, and psychological safety in their daily professional environments. Grounded in Inclusive Leadership Theory, our findings demonstrate that inclusive leaders must actively model equity-minded behaviors, facilitate difficult organizational conversations, and establish shared governance structures where staff feel empowered to voice concerns without fear of administrative retaliation [23]. Furthermore, our results extend existing literature [2, 3, 6] by bridging internal employee psychological safety with external community trust, positioning belonging not merely as an internal workforce management metric, but as a critical institutional condition that directly governs patient satisfaction, community engagement, and overall health system legitimacy.

Leadership commitment emerged as the primary implementation mechanism determining whether DEIB initiatives achieve structural transformation or deteriorate into symbolic, ad hoc gestures. Crucially, our study emphasizes that equity implementation cannot be delegated solely to a chief diversity officer, health equity director, or isolated DEIB facilitator. Aligning with empirical findings by Hogan et al. [24] and Esparza et al. [25], dedicated equity personnel frequently face a severe structural mismatch between expansive institutional expectations and inadequate authority, staffing, or sustained financial backing. To prevent facilitator burnout, role overload, and institutional stagnation, DEIB must be operationalized as a systems-level practice distributed across executive leadership, human resources, procurement, finance, clinical operations, and community-facing divisions [24, 25]. Embedding equity into routine operational workflows and supervisory performance metrics ensures that DEIB practices remain resilient against leadership turnover and competing organizational priorities.

A central theoretical contribution of this study is the explicit conceptual distinction drawn by participants between performative and restorative DEIB. Performative approaches rely on highly visible, symbolic activities – such as public commitments, awareness campaigns, cultural celebrations, or mandatory standalone trainings – that satisfy external pressure but leave underlying power dynamics, resource allocations, and administrative policies unchanged [24, 25]. In contrast, we propose restorative DEIB as a transformative, systems-level framework focused on actively identifying and repairing historical institutional inequities, redistributing decision-making authority, and rebuilding organizational trust. Restorative DEIB shifts the overarching organizational objective from passive regulatory compliance to active structural repair, ensuring that equity principles are deeply institutionalized across governance, policy development, strategic budgeting, and daily operational practices [2, 3, 6].

Transitioning from performative to restorative DEIB necessitates a fundamental overhaul of organizational evaluation and accountability frameworks. Consistent with systematic reviews by Fremont et al. [26] and Gichane et al. [27], health systems frequently rely on easily tracked process outputs – such as training completion rates or event attendance – rather than evaluating long-term workforce retention, promotion equity, or clinical health disparities. While process metrics provide baseline administrative data, organizations must transition toward disaggregated, outcome-oriented indicators that evaluate psychological safety, equitable career advancement, service access, and community trust [26–28]. Furthermore, addressing workforce resistance and zero-sum assumptions requires moving beyond mandatory implicit bias training toward transparent policy alignment, clear managerial accountability, and safe, structured channels for employee voice that demonstrate consistent alignment between stated values and administrative actions.

Advancing sustainable DEIB also requires reframing community engagement from episodic consultation into an authentic redistribution of decision-making power [24, 27]. Restorative partnerships engage community members, local health workers, and advisory bodies directly in defining organizational priorities, co-designing clinical or public health programs, and interpreting evaluation metrics. This deep systems-level integration also serves as a critical mechanism for safeguarding equity initiatives within politically contested or changing regulatory environments [26, 29]. By embedding equity directly into core, non-discretionary operational infrastructure — such as patient safety protocols, clinical quality improvement, civil rights compliance, language access services, and institutional strategic planning – organizations create resilient structures that preserve fair representation, equitable service delivery, and community trust regardless of political shifts or executive leadership transitions [29].

In practice, healthcare, public health, and non-profit executive teams must treat DEIB as core operational infrastructure rather than an auxiliary or discretionary program. Executive leaders must establish shared accountability across all operating units, equip equity personnel with direct budget authority and dedicated staffing, transition from activity counts to multidimensional outcome tracking, and foster inclusive leadership capabilities among middle managers and supervisors who shape daily organizational culture. Ultimately, embedding equity into continuous quality improvement, leadership evaluations, and strategic resource allocation provides health-serving organizations with a sustainable pathway for fostering workforce inclusion, repairing community trust, and advancing health equity over time.

Directions for Future Research

Future research should utilize longitudinal, mixed-methods, and multi-sector comparative designs to evaluate the durability of DEIB practices across shifting leadership, funding, and political environments. Studies must also incorporate the perspectives of frontline workers, patients, and community partners – particularly those experiencing intersecting forms of marginalization, as systematic evidence remains disproportionately focused on race, ethnicity, and sex while underrepresenting disability, sexual orientation, gender identity, immigration status, and socioeconomic position [26]. Finally, additional work is needed to develop and validate multidimensional measurement frameworks that move beyond basic representation to evaluate psychological safety, organizational belonging, authority distribution, career progression, community power sharing, and health equity outcomes.

Strengths and Limitations

Key strengths of this study include its multi-organizational scope, its comparative design examining both executive leadership and operational implementation perspectives, and its methodological rigor. Trustworthiness was established through semi-structured interviews, reflexive journaling, audit trails, member checking, and investigator triangulation.

Several limitations should nevertheless be considered. As the study focused on public and non-profit organizations in Southern California, findings may not fully transfer to private healthcare systems, other geographic regions, or differing regulatory environments. Furthermore, relying on cross-sectional, self-reported data from leaders and DEIB facilitators introduces potential social desirability bias and excludes the direct perspectives of frontline employees, patients, and community members.

Future research should combine leadership insights with longitudinal organizational performance metrics, policy reviews, and direct assessments from frontline workforce and community stakeholders.

Conclusions

This study demonstrates that meaningful DEIB must extend beyond symbolic declarations and superficial representation to become deeply embedded within healthcare and public-serving organizational governance, policy, and daily decision-making. A central conceptual contribution of this work is the distinction between performative DEIB – characterized by public statements and isolated initiatives that leave underlying power structures intact – and restorative DEIB. We propose restorative DEIB as a transformative organizational framework centered on actively repairing structural inequities, rebuilding institutional trust, fostering psychological safety, and establishing equity as an ongoing operational capability rather than an auxiliary compliance obligation.

Practically, health-serving organizations must transition from tracking process activities toward holistic evaluation frameworks that measure workforce belonging, community trust, service accessibility, and health equity outcomes. Executives must operationalize DEIB as core infrastructure by integrating equity across strategic planning, budgeting, procurement, workforce development, and continuous quality improvement. Future research should validate measures of restorative organizational capacity and evaluate its long-term impacts on organizational performance and patient outcomes. Ultimately, advancing from performative to restorative DEIB offers healthcare organization leaders a sustainable pathway for institutionalizing belonging and achieving lasting systemic transformation.

Declarations

Ethics approval and consent to participate:

The study was conducted in accordance with the Declaration of Helsinki and approved by the American College of Education IRB (notification dated 14 November 2024; ACE IRB-FY2024 2207119555). Informed written consent was obtained from all subjects involved in the study prior to their participation.

Consent for publication:

Not applicable as the manuscript does not contain any individual person's data in any form. All information was de-identified, and all direct quotes are anonymized.

Competing interests:

The authors declare that they have no competing interests.

Note

Participant identifiers were removed to preserve confidentiality.

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Author Contribution

Conceptualization, PO-O; Methodology, PO-O and OOO; Software, PO-O and OOO; Validation, AFG, JAR, AWT-R and SDT-R; Formal analysis, PO-O and OOO; Investigation, PO-O; Resources, PO-O and OOO; Data curation, PO-O and OOO; Writing – original draft, PO-O.; Writing – review and editing, All authors.; Visualization, PO-O and OOO; Supervision, AJG and SDT-R; Project administration, PO-O. All authors read and approved the final manuscript.

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Data Availability

All data supporting the findings of this study are available from the corresponding author on reasonable request.

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Figures

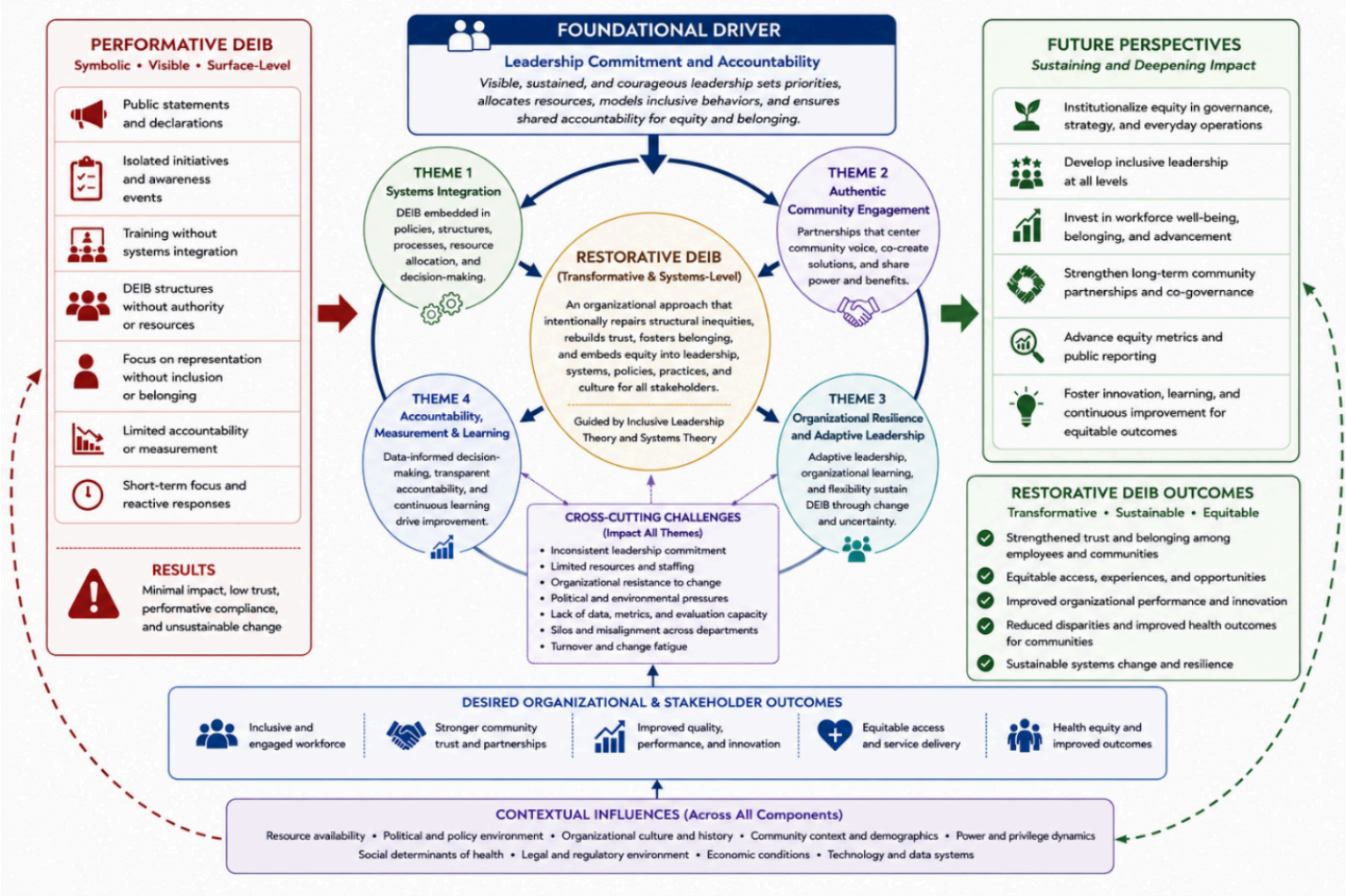


Figure 1

Conceptual Framework: Advancing Organizational Transformation Through Inclusive Leadership and Systems Change *(developed using ChatGPT)*

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