



# 2017 Cultural Competency Plan

San Francisco Department of Public Health  
Behavioral Health Services  
Cultural Competency

San Francisco Behavioral Health Services (BHS) is at the forefront of the Department of Public Health's (DPH) commitment to providing quality, integrated care that is culturally and linguistically appropriate for its diverse population of clients, patients, and family members. The Behavioral Health System (BHS) is comprised of integrated Mental Health and Substance Use services. On an annual basis, BHS provides services to over 28,000 unduplicated children, youth, transitional aged youth, adults and older adults each year. BHS integrated services are offered through civil service clinics and are also contracted out to approximately 200 programs through Community Based Organizations.

BHS provides integrated Mental Health and Substance Use services to one of the most diverse client populations in the country. The **City and County of San Francisco**, is the cultural, commercial, and financial center of Northern California and is the only consolidated city-county in California. San Francisco encompasses a land area of about 46.9 square miles (121 km<sup>2</sup>) on the northern end of the San Francisco Peninsula, which makes it the smallest county in the state. It has a density of about 18,451 people per square mile (7,124 people per km<sup>2</sup>), making it the most densely settled large city (population greater than 200,000) in the state of California and the second most densely populated major city in the United States after New York City. San Francisco is the fourth-most populous city in California, after Los Angeles, San Diego, and San Jose, and the 13th-most populous city in the United States—with a Census-estimated 2015 population of 850,282. The city and its surrounding areas are known as the San Francisco Bay Area, and are a part of the larger OMB-designated San Jose-San Francisco-Oakland combined statistical area, the fifth most populous in the nation with an estimated population of 8.7 million. (Amer. Comm. Survey, 2016)

Based on the 2016 American Community Survey, the ethnic makeup and population of San Francisco included: 444,597 Whites (52.3%), 313,526 Asians (36.9%), 55,486 African Americans (6.5%), 8,873 Native Americans (1%), 6,360 Pacific Islanders (0.7%), 59,686 from other races (7%), and 41,697 from two or more races (4.9%). There were 129,898 Hispanics or Latinos of any race (15.3%) (Amer. Comm. Survey, 2016).

San Francisco has a minority-majority population, as non-Hispanic whites comprise less than half of the population, 41.2%, down from 92.5% in 1940.<sup>[9]</sup> The principal Hispanic group in the city was those of Mexican decent (7.7%). The Hispanic population is most heavily concentrated in the Mission District, Tenderloin District and Excelsior District.<sup>[10]</sup> San Francisco's African American population has declined in recent decades,<sup>[9]</sup> from 13.4% of the population in 1970 to 5.1%.<sup>[11]</sup> The current percentage of African Americans in San Francisco is similar to that of the state of California;<sup>[11]</sup> conversely, the city's percentage of Hispanic residents is less than half of that of the state. The majority of the city's African American population reside within the neighborhoods of Bayview-Hunters Point, Visitation Valley in southeastern San Francisco and in the Fillmore District in the northeastern part of the city. (US Census 2010)

In 2010, residents of Chinese ethnicity constituted the largest single ethnic minority group in San Francisco at 21.2% of the population; the other Asian groups are Filipinos (4.4%), Vietnamese (1.7%), Japanese (1.3%), Asian Indians (1.9%), Koreans (1.2%), along with smaller populations of Thais, Burmese, Cambodians and Indonesians, among others. The population of Chinese ancestry is most heavily concentrated in Chinatown, Sunset District, and Richmond District, whereas Filipinos are most concentrated in the Crocker-Amazon (which is contiguous

with the Filipino community of Daly City, which has one of the highest concentrations of Filipinos in North America), as well as in South of Market. (US Census 2010)

After declining in the 1970s and 1980s, the Filipino community in the city has experienced a significant resurgence. The San Francisco Bay Area is home to over 382,950 Filipino Americans, one of the largest communities of Filipinos outside of the Philippines. The Tenderloin District is home to a large portion of the city's Vietnamese population as well as businesses and restaurants, which is known as the city's Little Saigon. Koreans and Japanese have a large presence in the Western Addition, which is where the city's Japantown is located. The Pacific Islander population is 0.4% (0.7% including those with partial ancestry). Over half of the Pacific Islander population is of Samoan descent, with residence in the Bayview-Hunters Point and Visitation Valley areas; Pacific Islanders make up more than three percent of the population in both communities. (US Census Bureau 2010)

Native-born Californians form a relatively small percentage of the city's population: only 37.7% of its residents were born in California, while 25.2% were born in a different U.S. state. More than a third of city residents (35.6%) were born outside the United States (US Census 2010)

With this great level of diversity of race, ethnicity, culture and language, the City and County of San Francisco has a history of commitment to providing care for all residents in need of health services, particularly in the most efficient and cultural competent manner possible. In order to avoid a public health crisis, the City and County has committed to re-structuring health planning and service delivery so that there is a reduction in health disparities that adversely affect neighborhoods, communities, families and individuals. There is also a recognition by DPH Leadership that it is equally important to allocate support for culturally and linguistically appropriate services that are respectful and responsive to the cultural and linguistic needs of all individuals.

BHS recognizes the need to serve an increasingly global population of residents. Many of these clients are impacted by mental health, substance use and addiction, primary care and a myriad of social challenges. The Behavioral Health System must be responsive and respectful to language, cultural and historical differences, in order to effectively meet the dynamic needs of individuals and population groups. Culturally and linguistically appropriate services are increasingly recognized as foundational requirements for improving the quality of care and services, thus possibly improving overall outcomes.

The Cultural Competence Plan is first a report about the current landscape of how BHS is currently providing culturally and linguistically competent care and secondly, outlines what the future priorities for the City and County Behavioral Health Plan are going forward.

The Plan includes information on the eight criteria set by the State as indicators of Cultural Competence:

1. Commitment to Cultural Competence
2. Updated Assessment of Service Needs
3. Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Mental Health Disparities

4. Client/Family Member/Community Committee: Integration of the Committee within the County Mental Health System
5. Culturally Competent Training Activities
6. County's Commitment to Growing a Multicultural Workforce: Hiring and Retaining Culturally and linguistically Competent Staff
7. Language Capacity
8. Adaptation of Services

Behavioral Health Services (BHS) Executive leadership and the general BHS workforce recognize that the enhanced CLAS Standards' emphasis on cultural identity is a key attribute that encompasses race, ethnicity or languages spoken. With this lens for health care, BHS is committed to offering culturally competent care essentially by providing client-centered care. One strategy for addressing diversity or disparity needs stemming from education, health literacy, age, gender, income, sexual orientation, religion, disability status, socioeconomic class and access to care, among others is to use the directives noted in the CLAS.

Although the enhanced National CLAS Standards do not represent statutory requirements, failure of a recipient of Federal financial assistance to provide services consistent with Standards 5 through 8 could result in a violation of Title VI of the Civil Rights Act of 1964 implementing regulation (See 42 USC 2000d et. Seq. and 45 CFR Part 80). Therefore, although Standards 5 through 8 do not represent legal requirements in all cases, implementation of these goals will help ensure that BHS clinics and its individual provider network serve persons of diverse backgrounds in a culturally and linguistically appropriate manner and in accordance with the law.

### **1. Commitment to Cultural Competence**

The County of San Francisco has long had a commitment to not just quality health care provision, but specifically, culturally competent health care service provision. Therefore, on January 8, 2002 the San Francisco Health Commission unanimously passed a resolution adopting the culturally and linguistically Appropriate Services (CLAS) Standards, established by the Federal Office of Minority Health, as guidelines to provide a uniform framework for developing and monitoring culturally and linguistically appropriate services.

The SF Health Commission is the governing body of the Health Department, establishing policies governing service planning and delivery in clinics, programs and hospitals. The Commission develops guiding principles and missions for the provision of public health services. The Commission acknowledges that the enhanced CLAS standards as implemented by DPH are intended to be broadly inclusive of diverse racial, ethnic, and sexual and other cultural and linguistic groups. The Commission also approved the formation a Cultural Competency Task Force to address issues surrounding Cultural Competency and implementation of the policy.

The Cultural Competence commitment is not just for civil service clinics but also for our Contracted Community-Based Organizations. Stipulated by contract, it is the expectation of SFDPH administration that all county and contracted providers are providing culturally competent and culturally responsive services, and are working to continually enhance their current level of cultural competence.

In order to have effective investment and support for Cultural Competency in Health Planning, Development, Implementation and Evaluation, it is critical for San Francisco to have such Health Commission and Director of Health Leadership commitment and investment. Overall, the Commission is required by City & County Charter to manage and control 1) City and County hospitals, to monitor and regulate emergency medical services, and 2) monitor and manage clinic and community-based organization in all matters pertaining to the preservation, promotion and protection of the lives, health and mental health of San Francisco residents.

With the Health Commission's adoption of the enhanced CLAS Standards as the guiding framework for Behavioral Health Services and other Departments, this is the guiding structure for implementing culturally and linguistically appropriate services. The enhanced CLAS standards are utilized to improve BHS' ability to address access to and quality of care and address health care disparities across the various client and patient groups seeking care from SF DPH. By providing a structure to implement culturally and linguistically appropriate services, the enhanced National CLAS Standards will improve an organization's ability to improve health care disparities.

In addition, under Title VI of the Civil Rights Act of 1964, as implemented by Executive Order 13166, BHS acknowledges that federal funds are received, thus the organization strongly recommends that Civil Service Clinics and its CBO providers take reasonable steps to provide meaningful access to their programs for individuals with limited English proficiency. The recommendation assist BHS to incorporate cultural and linguistic competency into the health services they provide.

BHS is also beginning to plan to work with one of the Department of Public Health's hospitals, Zuckerberg General Hospital. This partnership positions BHS to align its efforts and leverage resources with a hospital that receives its accreditation from the Joint Commission and the National Committee for Quality Assurance. These alignment efforts ensure that BHS is moving in the direction of strengthening standards that target the improvement of communication, cultural competency, patient-centered care and the provision of language assistance services (Briefer French, Schiff, Han, & Weinick, 2008; Wilson-Stronks & Galvez, 2007).

### **CLAS Standards to Enhanced CLAS Standards**

The first CLAS Standards were published by the OMH in 2000. They provided a framework for all health care organizations to best serve the nation's increasingly diverse communities. The Health Commission's 2002 Adoption of the CLAS Standards set the standards for the BHS Leadership to begin using the CLAS Standards to plan for improvement of service planning and delivery

From 2010 to 2013, the CLAS Standards underwent an Enhancement Initiative to incorporate the past decade's advancements, expand their scope and improve their clarity to ensure understanding and implementation. BHS Leadership used these revisions to ensure that they continue as the cornerstone for advancing health equity through culturally and linguistically appropriate services with a stronger focus on the culture, audience, health and recipients

The enhanced CLAS Standards were officially launched April 24, 2013. The expanded work is composed of 15 Standards that provide individuals and organizations with a guide for successfully implementing and maintaining culturally and linguistically appropriate services. BHS recognizes that all 15 Standards are necessary to advance health equity, improve quality and help eliminate health care disparities in the SF Behavioral Health community and the larger DPH system of care. Each individual Standard is important and the exclusion of any Standard diminishes an organizations' ability to provide health care in a culturally and linguistically appropriate manner. Thus, BHS Executive leadership, the Cultural Competency Unit and the Cultural Competency Taskforce strongly recommends that each of the 15 Standards be implemented in the Civil Service Clinics and the Community Based Organizations.

BHS Executive leadership supports culturally and linguistically appropriate health care and services that are respectful of and responsive to the cultural and linguistic needs of all individuals. BHS, in alignment of larger DPH priorities, are increasingly working towards reducing disparities and improving health care quality among its client and family service population. In order to support the BHS workforce with cultural competency and enhanced CLAS Standards core competency learning opportunities, training staff worked with the Cultural Competency Taskforce to identify enhanced CLAS Standard 13 as the first Standard to introduce to and operationalize for the BHS Workforce. Focus Groups and/or Community Forums were used to begin the relationship and collaboration building within and between clinics, programs, and community groups to identify and plan for practice improvements. CC Staff and the Training Section began providing technical assistance and Trainings in FY 14-15.

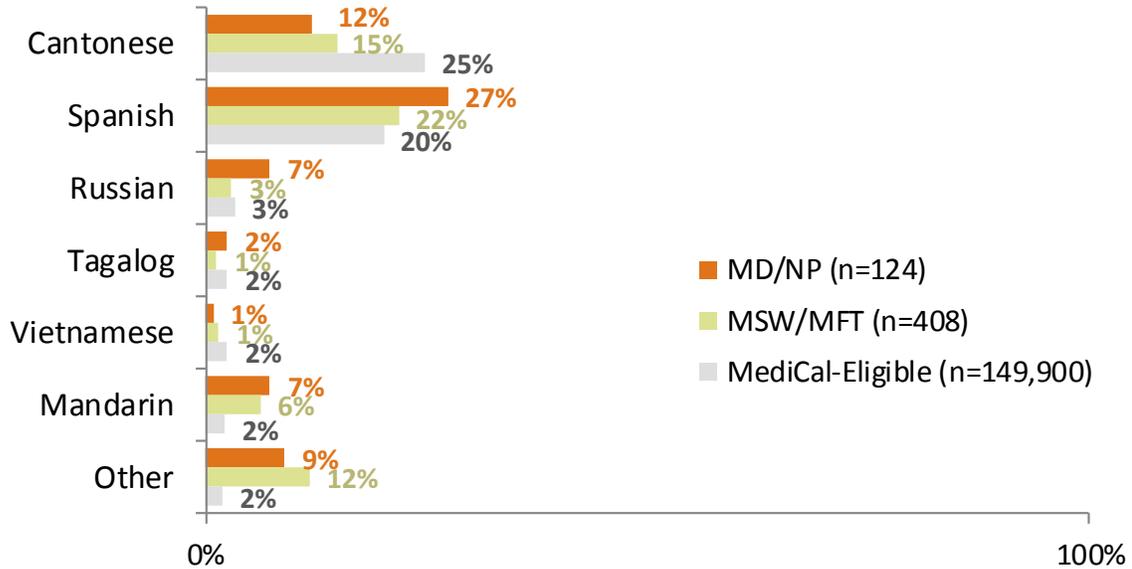
With BHS' commitment to providing cultural competent services, BHS provides technical assistance and training for clinic staff and community based organization staff to plan for and implement documentation of Cultural Competence, with an initial focus on CLAS Standard 13. Trainings were designed to begin planning for how to implement, document and track Organizational Cultural Competency efforts, with the initial focus on CLAS Standard 13 implementation in behavioral health clinical and program settings.

## **2. Updated Assessment of Service Needs**

MHSA Workforce staff contracted with an external Consulting group to conduct a BHS Staff Demographic Assessment by Race/Ethnicity by Licensure compared to the Client Demographic Assessment, with a particular focus on serving/accessing the Medical population. In support of MHSA efforts, Cultural Competency attended planning meetings and provided critical feedback, as needed. The findings are as follows:

Among San Franciscans eligible for MediCal, 57% speak a primary language other than English. The most commonly-spoken languages are Cantonese (25% of the MediCal-eligible population, and 44% of those speaking a primary language other than English, speak Cantonese) and Spanish (20% of the MediCal-eligible population, and 35% of those speaking a primary language other than English, speak Spanish). Exhibit 1 shows the capacity of providers in San Francisco's combined civil service and contractor public mental health workforce to serve MediCal-eligible community members in their primary languages.

**Exhibit 1: Racial and Ethnic Composition of Masters-level CBHS Civil Service and Contractor Providers Compared to Medicaid-eligible Population**



As this chart shows, the San Francisco public mental health workforce is fairly well equipped to serve the MediCal-eligible population in their primary language, with provider capacity mirroring or exceeding the language needs in the community. A notable exception is in the case of Cantonese speakers, where approximately half the proportion of providers speak Cantonese compared to the population in need. About 85% of all Chinese individuals in the MediCal-eligible population in San Francisco speak Cantonese as their primary language, with only 6% speaking English.

In addition to the workforce needs assessment, BHS is now in the process of conducting a community needs assessment from January 2017 through March 2017. MHSA staff has and will continue to conduct its Community Planning Process/Stakeholder Engagement Series, where we inform CBOs and community members about MHSA work and ask them for their feedback on needed mental health supports and services that they see/observe in their communities.

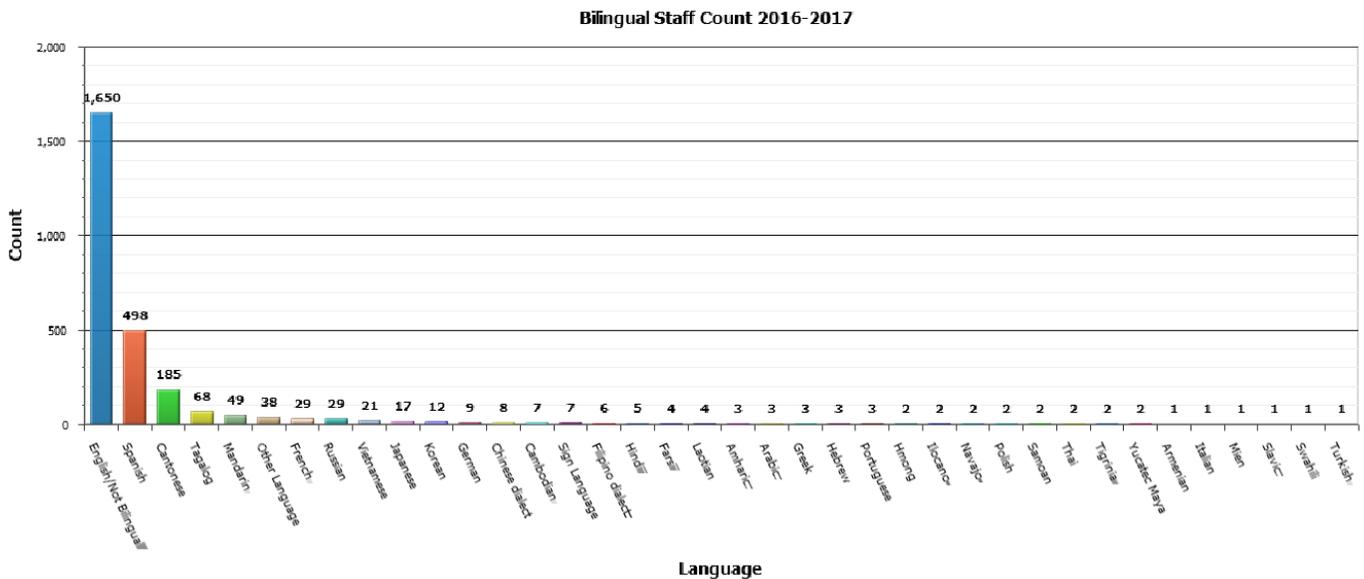
**3. Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Mental Health Disparities-**

Last year, Civil Service and Community Based Organization staff were trained and granted access to the Cultural Competence Tracking System (CCTS). The CCTS replaced the legacy maintenance tracking system that was originally developed in Microsoft Access. By designing, testing and deploying the CCTS, the Cultural Competence Office has improved its capabilities in maintenance management, tracking, and reporting- language capacity for client services and staff demographics and licensure requirement. In Spring 2017, the OCC worked with a contractor to

add features to the system and improve the user interface, making it easier to navigate. The intention of these changes were to make the system more of a “one-stop-shop,” where users/programs could submit all of the documents regularly required of them by the OCC or the Business Office of Contract Compliance (BoCC).

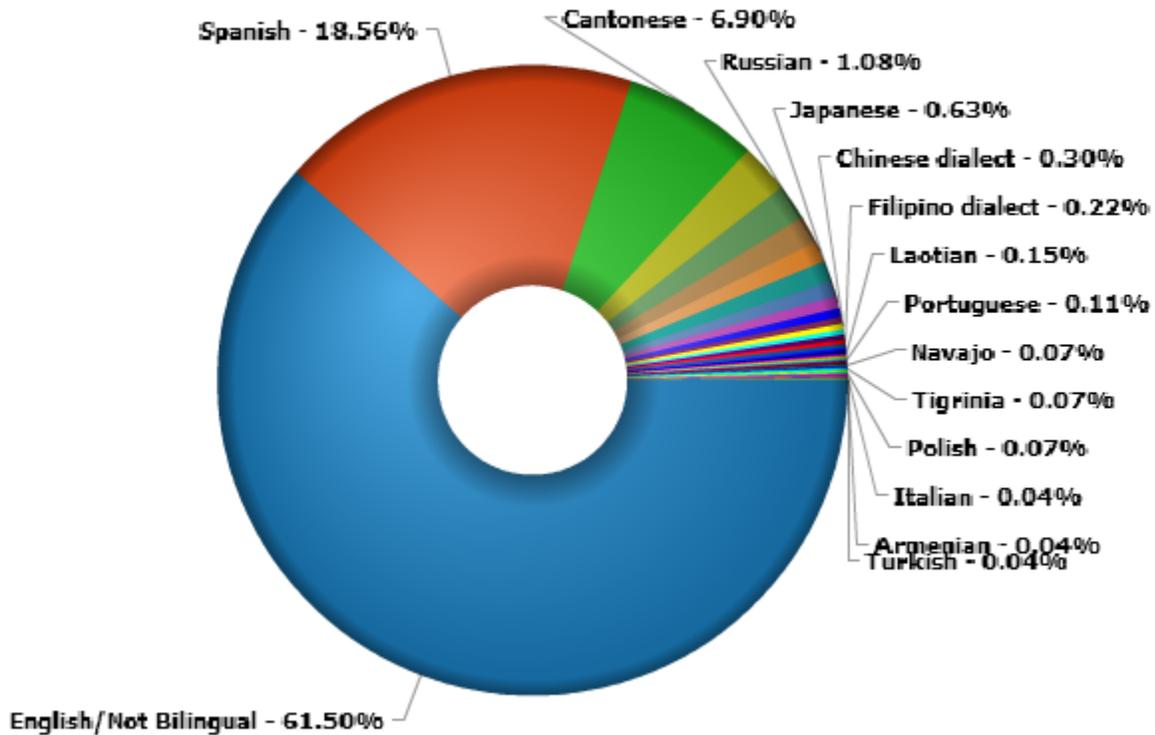
The new CCTS system provides the following capabilities:

- Public-facing and can be accessed from any computer with Internet Explorer
- System secured by user authentication and authorization
- Tool for uploading Cultural Competency Reports and other required documents
- Enhanced and streamlined user interface which provides users with much simpler data entry, updates, queries and other capabilities
- Data export capabilities which allow users to export data to various software tools for simplified reporting and presentation capability
- Google Maps integration and JavaScript Charts/Graphs displaying language capacity (See Exhibit 2 on the following page)
- Revised user guide and updated materials for training staff



**Exhibit 2: Staff Bilingual Capacity Rpt.**

**Bilingual Staff Percentage 2016-2017**



**4. Client/Family Member/Community Committee: Integration of the Committee within the County Mental Health System**

The Cultural Competency Task Force (CCTF) was formed to address issues surrounding Cultural Competency and implementation of the enhanced CLAS Standards amongst both civil service clinics and community-based organizations (CBO's). The CCTF serves as an advisory board and provides input, recommendations and reviews of policies, procedures and inclusions of cultural and linguistic objectives in all funding contracts. Some of the areas that Cultural Competence is committed to improving for Civil Service and CBO programs are:

- Language Access – maximizing access amongst non-English speakers
- Community Partnership – to increase penetration rates amongst underserved populations
- Cultural Competency Database - revamped interface/user guide to enhance utilization
- Cultural Competency Health Literacy Training – minimizing knowledge gaps
- Cultural Competency Micro Aggression Training – addressing trauma in clinical settings
- Immigrant/Illegal Youth Training – offering guidance in a politically unstable environment
- Bay Area Refugee Training for Health Service Providers
- Data and Research on Shifting San Francisco Population Trends
- Community Advisory Boards (CABs) - for partner, consumer and provider input

The CC Task Force continuously strives to strengthen the impact of Community Advisory Boards (CAB) on increasing client satisfaction. Engagement from providers, clients and community partners better captures the degree of need in the service area. This dialogue informs providers on how to tailor programs to address culture-specific mental health issues. Task force meetings are usually held every other month to ensure that providers are kept up-to-date on policy developments where it concerns MHS. However, given the shifting of roles within the division leadership, the Task Force has not been able to meet according to the normal schedule. Below are the list of Task Force meetings that were held in 2017.

Date	Name
09-Feb-17	Cultural Competency Taskforce
11-May -17	Cultural Competency Taskforce
27-Jul-17	Cultural Competency Taskforce
02-Nov-17	Cultural Competency Taskforce

**Table 2: CC Task Force Members**

Last Name	First Name	Job Class	Program Name
Austin	Francine	HPC III: Program Manager	CDTA
Bassiri	Kavoos Ghane	Director	SFDPH - BHS
Di Martino	Angela	Project Coordinator	Curry Senior Center-DPH
Fleming	Teresa	Clinic Director	BAART Programs - Turk St. Clinic
Hammerle	Ellen	Director	Catholic Charities
Houston	Felicia	Program Director	A Woman's Place/ Community Awareness & Treatment Services, Inc.
Lam	Mary	Director	Chinatown North Beach MH- DPH
Larson	Fancher	Mental Health Patients' Rights Advocate	San Francisco Mental Health Clients Rights Advocates
Shea	Christina	Deputy Chief/Clinical Director	RAMS, Inc. (Richmond Area Multi-Services, Inc.
Uribe	Anthony	CATS HR Director	Community Awareness & Treatment Services, Inc.

Going forward, the Task Force will be doing a self-evaluation, developing ways to not only increase membership but to also achieve greater internal diversity. As currently comprised, the CCTF is lacking the level of diversity that it desires, one that truly reflects the communities that are being served by BHS. With this in mind, a new membership application will be created by current members; one that takes into account both diversity and the likelihood of continued participation. Furthermore, better record keeping will be used to monitor participation and devise ways to ensure member retention.

## **5. Culturally Competent Training Activities**

Since 2014, the Office of Cultural Competence has provided trainings to Civil Service Staff, CBO staff and BHS Leadership on critical areas such as CAB recruitment, development and maintenance. Other trainings include those on the latest updates in the CLAS Standards, gender assessments, transgender 101, trauma-informed services training among others. Such trainings equip care providers with the knowledge, and more importantly, the perspective that is needed to handle the City's diverse clientele. In September, following the pattern of previous years, a site Director's Training session was held to instruct program heads on how to best use the Cultural Competence Tracking System, as well as how to complete a new form that was introduced to address CAB activities within agencies.

Throughout 2017, the CCTF has been having discussions on what areas and topics should be covered in upcoming trainings. Potential trainings for the coming year include language-specific sessions, conducted in a given language for all staff/clinicians who qualify as having bilingual status. The general consensus is that there should be a shift from standard ethnic/cultural-specific trainings to ones that take a more robust outlook at mental health from a cultural perspective.

## **6. County's Commitment to Growing a Multicultural Workforce: Hiring and Retaining Culturally and Linguistically Competent Staff**

The mission of the San Francisco Department of Public Health (SFDPH) is to protect and promote the health of all San Franciscans. The SFDPH strives to assess and research the health of the community, provide comprehensive, quality, and culturally competent health care services, educate the public and train health care providers to ensure equal access to all. One of the strengths for achieving these goals are through a diverse workforce. The SFDPH leadership has made a commitment to the Black and African American residents in San Francisco by making their health a priority through the Black and African American Health Initiative (BAAHI).

SFDPH has recognized that in order to adequately address and make a significant impact on the health disparities among the Black/African American population in San Francisco, a focused and deliberate process is prioritized across the Department. With BAAHI leadership, there is a clear strategy to ensure that there is appropriate staffing and resources that can be assigned to the following key strategic activities: 1) Percent of Blacks/African American with heart disease, 2) Mortality rate of Black/African American women with breast cancer, 3) Rates of chlamydia among young Black/African American women, and 4) Mortality rates among Black/African American men due to alcohol. The Collective Impact Model provides the framework for the work underway with the key activities in BAAHI.

Behavioral Health is playing a key role with all of the key activities. Through the integration of behavioral health and primary care and through partnerships with community providers, the SFDPH is addressing the mental well-being among Black males and developing strategies to decrease the misuse and abuse of alcohol. BHS is capitalizing on this partnership by cross training its workforce to address the behavioral health and primary care needs of its patients, with the lens of race and equity shaping the care planning and delivery of care.

In addition, BAAHI provides key partnerships with Human Resources to ensure that diverse and culturally appropriate staff are hired and retained in Behavioral Health and throughout DPH.

With the Director of Health, the Health Commission, and Behavioral Health leadership, DPH Human Resources has re-organized itself and added staffing for the Department of Diversity & Inclusion. HR has added two Sections that work directly with BHS, Workforce Development and Career Coaching. There are also two new Recruiters that have been hired to address the language and diversity needs of San Francisco clients accessing the Behavioral Health system.

Cultural Competency Staff also recognized the need for targeted recruiting and hiring for diverse population members into the Behavioral Health workforce. Cultural Competency staff developed and implemented two workshops that focused on informing and training community members from impacted communities on how to apply for entry-level positions in the BHS Workforce. Cultural Competency staff also identified key academic partners from San Francisco State University Health Education to develop an outline for an undergraduate and graduate pipeline plan for student internship and employment into the BHS workforce.

## **7. Language Capacity**

Language Access refers to ensuring that persons who have limited or no English language proficiency (LEP) are able to access information, programs and services at a level equal to that of English-proficient individuals. Language-access services, including professional oral interpretation and written translation, should be provided at no cost to the individual receiving services. Family members, friends and minors should not be used to provide language services.

Culturally and linguistically appropriate services can also help health and health care professionals and organizations gain a competitive edge in the market place. Although the implementation of culturally and linguistically appropriate services certainly requires resources, there are numerous business-related advantages to investing in these resources. By implementing culturally and linguistically appropriate services – including the provision of communication and language assistance, as well as partnerships with the community – an organization can develop a positive reputation in the service area and therefore expand its market share. The provision of effective, equitable, understandable and respectful quality care and services helps cultivate a loyal consumer base, which then solidifies this market share (AMA, 2006).

As the American Medical Association notes, “a loyal consumer base helps organizations avoid costly problems, such as high turnover, low utilization rates, and unused capacity” (AMA, 2006, p. 112). In addition, culturally and linguistically appropriate services, such as assessments of community health assets and needs, help organizations tailor their services, making the services more cost-effective (e.g., Hornberger, Itakura, & Wilson, 1997).

The Office of Cultural Competency and BHS leadership have had ongoing conversations with the Interpreter Services Unit at Zuckerberg SF General Hospital (ZSFG) to strategize ways of leveraging language access resources. Just recently, ZSFG started using video interpretation in cases where onsite staff couldn't meet the language needs of a client. While telephone interpretation is available over the phone through vendor Language Line, use of this method isn't ideal, based on studies indicating that this method is lacking in terms of quality, comfortability of the consumer, and familiarity of the interpreter with the subject matter being discussed. The advantage of the video interpreter is that it at least puts a face to the person the consumer is speaking to, often one with whom s/he can identify with. In the coming months, after establishing the wireless internet infrastructure needed for connectivity of mobile devices, BHS

will conduct trial runs of video interpretation at two MH facilities. At the conclusion of these trials, decisions will be made on whether to further pursue this method for long-term use.

The Cultural Competency Office continues to provide interpretation and translation services to DPH clinics through City-approved vendors. If there is a presenting need at a clinic, staff contact the Office, make the formal request, and the Cultural Competency Analyst will work with City- approved vendors to meet the need for language access. DPH Human Resources can also provide interpreter or translation services for DPH Administration language access needs. Staff who are designated as bilingual must undergo testing to ensure that they meet proficiency standards mandated by the Department, as shown below by recent examination results. One of the concerns often brought up at the CCTF is the need for standardization of bilingual testing methods among different units of DPH. Traditionally, the testing was tailored towards issues related to primary care. Of course, this isn't necessarily sufficient for behavioral health, as there are different terminology and techniques employed within mental health settings. BHS leadership brought this issue up with the Department of Human Resources, and there is now a bilingual certification exam that is specifically for mental health providers.

**Exhibit 3:**

**Dept. of Human Resources Bilingual Proficiency Exam Results of Last Three Fiscal Years**

Bilingual Proficiency Exam Results: FY '13-'16						
Language	FY '13 - '14		FY '14 - '15		FY '15 - '16	
	DPH Central Office		DPH Central Office		DPH Total	DPH Central Office
<i>Chinese</i>	47/86	72/74			67/86	27/36
<i>Filipino</i>	0/1	32/32			11/11	2/2
<i>Russian</i>	0/1	0/1			2/2	2/2
<i>Spanish</i>	30/35	72/79			109/127	33/33
<i>Vietnamese</i>	0/2	2/5			0/2	0/2

The Office of Cultural Competency worked with a consultant in order to initiate a survey project that analyzed the opportunities to improve language access and service capabilities of the CBO partners that work with BHS. A survey was developed by the Consultant and distributed to a select number of providers contracted with BHS. It collected data on their staffs' language capacities, along with qualitative input on the linguistic areas they felt were lacking or in need of improvement. As such, areas of deficiency included the lack of a standardized, reliable language skill assessment for those seeking bilingual status and insufficient training resources for CBO staff, among others. The final report offered these, as well as policy recommendations for the department going forward. As evidenced by the previously mentioned mental health-specific bilingual exam that was just approved, steps are being taken to ensure that the Consultant's findings are being applied to operational and planning decisions.

OCC has also met with Clinical Staff from Civil Service clinics in order to draw on their experiences serving specific communities and the partnerships and tools they have successfully used to increase language capacity in their respective clinics. The lack of language access services in a health care setting can create communication challenges and barriers to quality health care. Often this leads to less service penetration in communities that need it, lower quality of overall health care and higher health costs for these patients.

## **8. Adaptation of Services**

While the primary purpose of the CLAS standards is to benefit the client or patient population being served, there are also enormous benefits to the implementing organization. CLAS is promoted by Cultural Competency to benefit BHS Clinics and Programs in the following ways:

The need to provide integrated mental health and substance use services and other health services to persons from many diverse cultures has been acknowledged throughout all parts of the San Francisco Department of Public Health, particularly the City & County's Behavioral Health System for persons receiving Medi-Cal and low-income residents. The Behavioral Health System has aligned its planning and implementation, collaborating with MHSa for a ten-year plan to align County services to promote integrated mental health and substance use with physical health, in collaboration with community partners and businesses. The goals are to build an improved, integrated health system that is committed to 1) Eliminate harm to patients and staff, 2) Improve the health of the people we serve, 3) Provide the best health care experience, 4) Create an environment that values and respects people, 5) Provide financially sustainable health care services, and 6) Eliminate health disparities. Behavioral Health Services supports and is committed to wellness and recovery, integrated behavioral health and substance use services, providing right information, every time, anywhere to clients in need. The ultimate goal is to support clients with skills and supports for healthy choices and pursue policy changes for a healthy environment. Commitment to Enhanced CLAS Standards assures that there is patient, family, and community collaboration in service planning and delivery, thus supporting the improvement of services for the Medi-Cal population in BHS.

### **1. It's the Law**

Complies with Federal Anti-Discrimination Law Title VI of the Civil Rights Act of 1964  
Any organization receiving federal funds must comply with the CLAS Standards

### **2. Healthier, More Satisfied Clients**

Increase Communication through Cultural Awareness  
Reflect Cultural Backgrounds  
Improve Client Understanding and Consent  
Provide Improved Primary and Preventative Care

### **3. Improve Business**

Use Funds Effectively & Efficiently  
Reduce Errors and Decrease Cost  
Improve Effectiveness of Treatment Plans and Create more Timely Recovery  
Avoid Legal and Regulatory Risks

Increase Competency and Satisfaction Levels of Staff  
Have Higher Employee Morale and Retention  
Improve Client Loyalty and Retention

#### **4. Improve Quality**

Culturally and linguistically appropriate services and related education initiatives affect several aspects of BHS' continuous quality improvement initiatives. Research has shown that after implementation of CLAS initiatives in health settings, there are substantial increases in provider knowledge and skill acquisition and improvements in provider attitudes toward culturally and linguistically diverse patient populations (Beach et al., 2004). Studies also indicate that patient satisfaction increases when culturally and linguistically appropriate services are delivered (Beach et al., 2004). BHS is working with its Quality Improvement Section to track Client Satisfaction and changes in key indicators for impacted community groups.

At the organizational level, hospitals and clinics that support effective communication by addressing CLAS have been shown to have higher patient-reported quality of care and more trust in the organization (Wynia, Johnson, McCoy, Passmore Griffin, & Osborn, 2010). Preliminary research has shown a positive impact of CLAS on patient outcomes (Lie, Lee-Rey, Gomez, Bereknyel, & Braddock, 2010), and a growing body of evidence illustrates the effectiveness of culturally and linguistically appropriate services in improving the quality of care and services received by individuals (Beach et al., 2004; Goode et al., 2006).

Cultural competence should be thoroughly integrated into the core of an organization and not be limited to just policies, rules and strategies that address culturally and linguistically appropriate services. The following are some general tips and rationale for integrating CLAS Standards into your organization.

#### **Cultural Competence & CLAS**

The enhanced CLAS Standards emphasize cultural identity as a key attribute that encompasses and exceeds race, ethnicity or languages spoken. Offering culturally competent care essentially means providing client-centered care. This can be achieved by meeting diversity or disparity needs stemming from education, health literacy, age, gender, income, sexual orientation, religion, disability status, socioeconomic class and access to care, among others.

The CLAS Standards with the enhanced emphasis on cultural competence provide an excellent framework for improving cultural competence.

#### **Three Critical Steps in Gaining Cultural Competence**

1. Unlearning: identifying and correcting learned biases
2. Learning: gaining new information, knowledge and wisdom
3. Diversification: increased collective capacity of organizations

On January 8, 2002 the San Francisco Health Commission unanimously passed a resolution adopting the culturally and linguistically Appropriate Services (CLAS) Standards, established by

the Federal Office of Minority Health, as guidelines to provide a uniform framework for developing and monitoring culturally and linguistically appropriate services.

The Commission acknowledges that the CLAS standards as implemented by DPH are intended to be broadly inclusive of diverse racial, ethnic, and sexual and other cultural and linguistic groups. The Commission also approved the formation of a Cultural Competency Task Force to address issues surrounding Cultural Competency and implementation of the policy.

Contract Requirement: Stipulated by contract, it is the expectation of SFDPH administration that all county and contracted providers are providing culturally competent and culturally responsive services, and are working to continually enhance their current level of cultural competence.

### **Strategic Planning – Goals and Objectives**

The SFDPH Cultural and Linguistic Competency Task Force provided the following guidance and critical recommendation in reviewing and developing the following key areas of cultural competence focus and goals for the Department.

- Community Partnership
- Access to Care for at Risk Population Groups
- Cultural Competency Training for Leadership
- Services
- Training and Education for Staff Development
- Data and Research

The SFDPH Cultural and Linguistic Competency Task Force also provided strategic planning for civil service clinics and all Community Based Organizations (CBOs) to not only focus on Community Advisory Board (CAB) implementation, but also support staff development for cultural competent care planning and service delivery.

Last year, the Cultural Competency Task Force identified the following overarching objectives and all have been achieved:

1. Improve the capacity of CAB Program Leads and CAB Participants to efficiently implement and support CAB meetings.
2. Improve networking, relationship building, and health enrollment opportunities with African American community in San Francisco.
3. Improve Behavioral Health Services and DPH's Language Access Services by submitting recommendations for Language Proficiency reviews for translation services and written materials.
4. Develop on-line, Cultural Competency 101 Training for new staff as they On-Board into DPH or for when existing staff would benefit from booster support Cultural Competency trainings.
5. Improve Leadership Understanding of how race and power impact staff and patient experience, hiring, and supervision.
6. Increase the number of general Cultural Competency trainings that address the need for improved engagement of and outcomes for high priority, impacted population groups in San Francisco.

## **CC Task Force as a BHS Network Forum**

Since its formation several years ago, the Task Force (CCTF) has taken on a leadership role for Behavioral Health Services, serving as somewhat of a network-level forum for the City's civil service and CBO programs in addressing issues around cultural competence and the implementation of policies on the matter. This being said, due to the scale and who organizes it, the CCTF should **not be confused for the CAB**, which is specific to a single agency/program and its consumers, while the former represents the network as a whole.

Whereas the typical CAB is comprised of an agency's clients, the clients' families, staff and community members, the Task Force primarily centers around those on the provider side of the equation. This includes staff from BHS and other units of DPH, as well as representatives and leadership from several of the key Community-based Organizations (CBOs) that work with DPH to provide mental health services. The CCTF meets every other month to discuss trends that are being seen within the network, share ideas on staff development and propose policy recommendations that will allow DPH to better assist CBOs in their work. It has the list of objectives that directly support the Cultural Competence Plan and the criteria set by the State, as seen above. In fact, CAB development and facilitation is one of the primary issues that is discussed at each session. The idea of the CAB Questionnaire (discussed later) was first proposed and discussed among Task Force members when Kavoods Bassiri, new BHS Director, began facilitating the sessions.

Membership in the CCTF is essentially open to anyone who is interested, though discussions are more relevant to program management/staff in a position to propose or implement policy. In the past, one would have to apply in order to participate. As of 2017 this has not changed, though heading into 2018 the CCTF intends to review the application process in order to meet the following two goals:

1. Ensure a high degree of participation, meaning higher rates of attendance at bimonthly sessions and a buy-in to the overall mission of the group
2. Diversify the makeup of the group. Since the CCTF is primarily management-level staff, some demographics are under-represented, leaving a gap that falls short of a true representation of the populations being served. Doing outreach needed to educate more groups on the purpose and work of the CCTF will enhance the degree to which communities get their needs met.

With these goals in place, the CCTF seeks to improve itself and live up to the missions that it promotes for the CABs in order to help improve the quality of services provided by the greater BHS network.

## **Progress Towards 2018**

In July 2017, BHS leadership and the CCTF developed a Community Advisory Board Questionnaire that provides BHS with insight into the progress different agencies were making with regards to developing/implementing their CABs. At 8-pages in length, this document is qualitative in nature and streamlines the reporting that was formerly provided through the submission of the longer Cultural Competence Report, which has since been phased out. It was

determined that this format would be more efficient for the staff at agencies who were responsible for doing the annual reporting. Questions focus on the structure of the CABs, the methodology behind their development and retention of membership, as well as the challenges there are to these processes. The reports are submitted either to the CC Analyst or directly onto the CCTS. From the submissions that have already been received, many of the programs have been very candid about the successes, benefits and even the shortcomings of the CABs. Like the Language Access Survey mentioned previously, the perspective and insight gained from this information will go a long way in guiding future decisions on training needs and how BHS can work with providers, both internal and CBOs, to improve the reach and quality of mental health services for the community.