

San Francisco

Department of Public Health

2016-2017

Cultural Competency Report

2017 Tri-Annual Audit
San Francisco Department of Public Health
Behavioral Health Services- Cultural Competency
Cultural Competency Unit

At a Glance

The San Francisco Behavioral Health System (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 km²) 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 km²), 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 864,816. 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. (Wikipedia, 2016)

As of the 2010 census, the ethnic makeup and population of San Francisco included: 390,387 Whites (48.1%), 267,915 Asians (33.3%), 48,870 African Americans (6.1%), 4,024 Native Americans (0.5%), 3,359 Pacific Islanders (0.4%), 53,021 from other races (6.6%), and 37,659 from two or more races (4.7%). There were 121,744 Hispanics or Latinos of any race (15.1%) (US Census 2010).

San Francisco has a minority-majority population, as non-Hispanic whites comprise less than half of the population, 41.9%, down from 92.5% in 1940.^[9] The principal Hispanic groups in the city were those of Mexican (7.4%), Salvadoran (2.0%), Nicaraguan (0.9%), Guatemalan (0.8%), and Puerto Rican (0.5%), ancestry. The Hispanic population is most heavily concentrated in the Mission District, Tenderloin District and Excelsior District.^[10] San Francisco's African American population has declined in recent decades,^[9] from 13.4% of the population in 1970 to 6.1%.^[11] The current percentage of African Americans in San Francisco is similar to that of the state of California;^[11] 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 21.4% of the population; the other Asian groups are Filipinos (4.5%), Vietnamese (1.6%), Japanese (1.3%), Asian Indians (1.2%), Koreans (1.2%), Thais (0.3%),

Burmese (0.2%), Cambodians (0.2%), and Indonesians, Laotians, and Mongolians make up less than 0.1% of the city's population.^[12] 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% (0.8% 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.

The Behavioral Health System 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 the SF Behavioral Health System is currently providing culturally and linguistically competent care. Secondly, the report outlines what the future priorities for the City and County Behavioral Health Plan are.

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) 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 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 to provide technical assistance and Trainings in 2014-2015. **Please see Appendix A and Appendix B for Cultural Competence Informational Report- Focus Group and Community Forum**

Date	Name: CLAS Standard 13 Development- Cultural Competence Report- Focus Group & Community Forum
22-July-14	Cultural Competence Report: Technical Assistance Training
27-Aug-14	Cultural Competence Report: Technical Assistance Training
03-Sep-14	Cultural Competence Report: Technical Assistance Training

With BHS's 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. Please see Appendix C for the training presentation and initial template. The training provided a structure for collaborative efforts through Community Advisory Boards (CABs). CC Staff developed a training to instruct and support both Facilitators and Participants in how to effectively develop and implement meetings that provide recommendations for clinic and program practice improvement. **Please see Appendices D & E.**

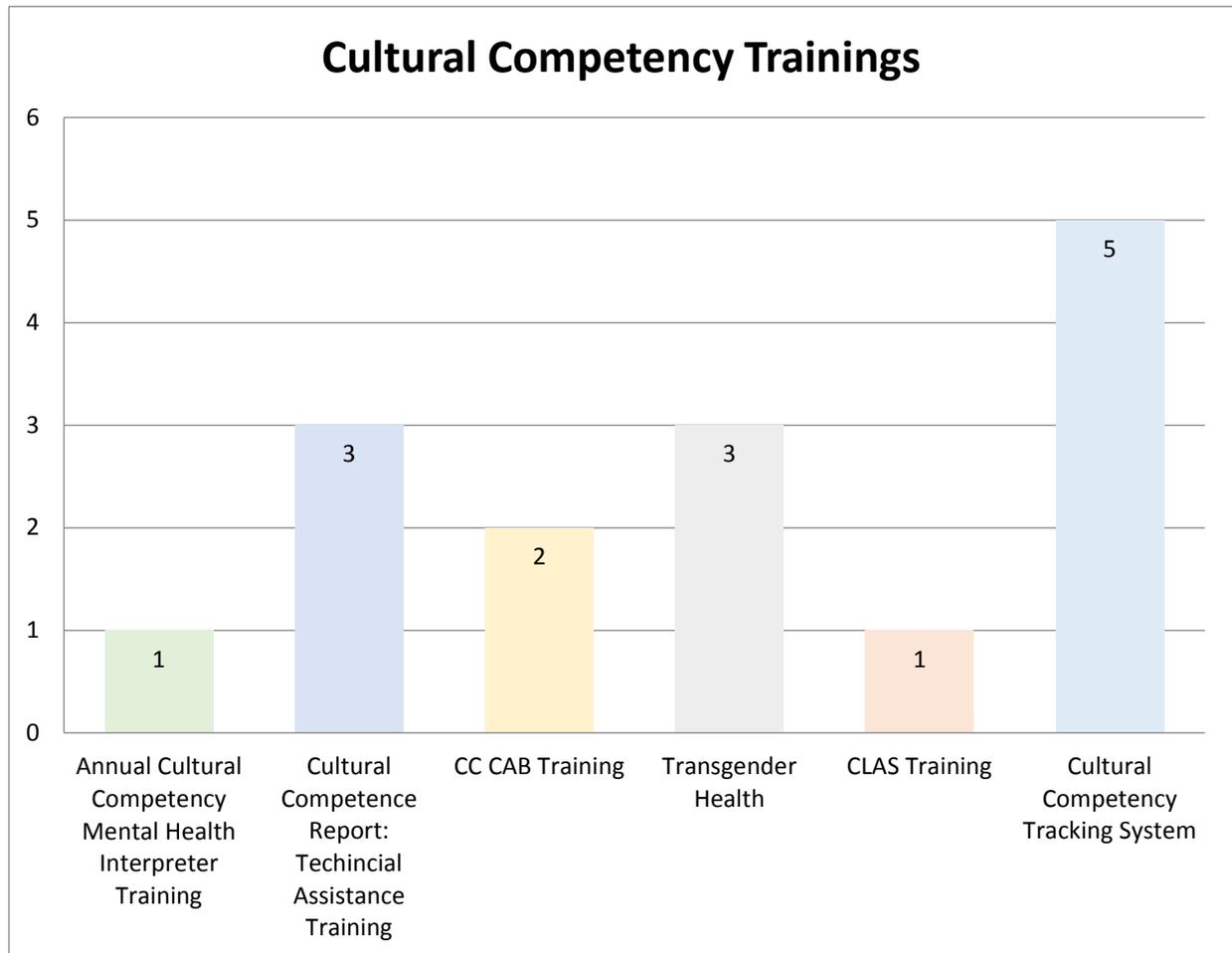
Date	Name: CLAS Standard 13 Presentation and Template Training
26-Aug-15	Cultural Competence Report: Technical Assistance Training
14-Sep-15	Cultural Competence Report: Technical Assistance Training
21-Sep-15	Cultural Competence Report: Technical Assistance Training

Date	Name: CC Community Advisory Board (CAB)
3-Nov-15	CC CAB Training
17-Dec-15	CC CAB Training

As discussed, Trainings and Technical Assistance Development activities are developed by BHS Cultural Competence staff, in consultation with Cultural Competency Taskforce Members. Participants in this advisory group are from BHS clinical staff, CBO programs and consumer groups. Meetings are scheduled on a monthly or bi-monthly calendar. An example of the meeting schedule is found below:

Date	Name: Cultural Competency Taskforce Meetings
02-Feb-16	Cultural Competency Taskforce
03-Mar-16	Cultural Competency Taskforce
05-May-16	Cultural Competency Taskforce
06-Jul-16	Cultural Competency Taskforce
09-Aug-16	Cultural Competency Taskforce

06-Oct-16	Cultural Competency Taskforce
01-Dec-16	Cultural Competency Taskforce

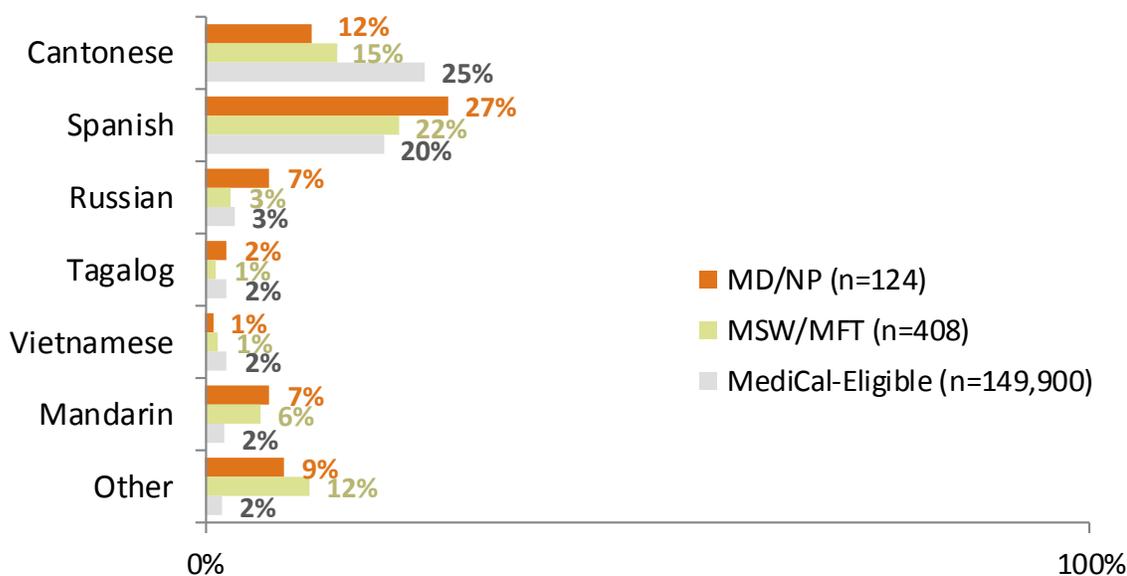


2. Updated Assessment of Service Needs

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 12 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-

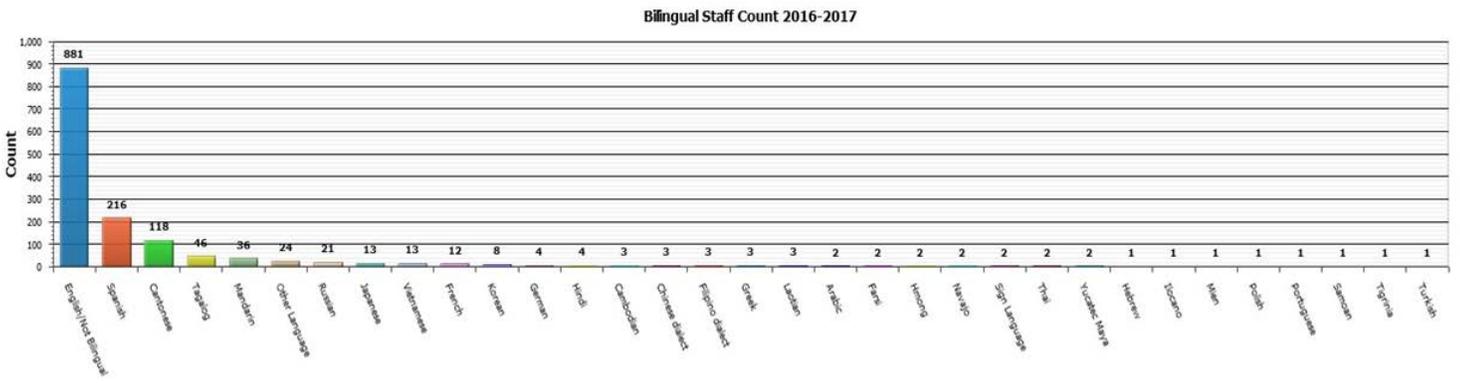
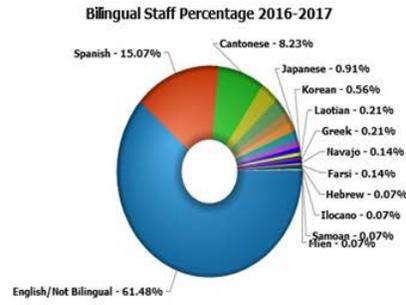
Throughout the year, trainings are held to educate providers on issues such as Culturally Comp. Mental Health Interpretation, Cultural Dynamics in Clinical Settings, Language Access Principles and how to use the Cultural Competency Tracking System. Providers are informed of the inherent barriers that may prevent those in need of mental health services from seeking support. **See Appendix F for a listing of Cultural Competency support trainings for last fiscal year.**

Building on the Cultural Competence Tracking System (CCTS), which was developed in 2015, the CCTS underwent an upgrade in 2017. After receiving input from providers and tracking recurring areas of concern, some changes were made to enhance usage of the database, making it easier to navigate and organize information for both users and admins.

The upgrades to CCTS system include the following:

- Tool for uploading Cultural Competency Reports and ADA compliance documents
- Enhanced and streamlined user interface which provides users with much simpler data entry, updates, queries and other capabilities
- Data charts consolidated onto a single page to make the homepage easier to read **(See Exhibit 2 on the following page)**
- Revised user/admin guides, with updated Powerpoint materials to use for training staff through presentations
- Cleanup of technical issues that address functionality areas for administrators
- Creation of a “guest user” level of access for those solely looking for staff language availability/capacity information

Exhibit 2: Staff Bilingual Capacity Rpt.



March 2016 of Cultural Competency Tracking System Trainings

Date	Name: CC Tracking System Trainings
28-Mar-16	Cultural Competency Tracking System
30-Mar-16	Cultural Competency Tracking System – Session 1
30-Mar-16	Cultural Competency Tracking System – Session 2
31-Mar-16	Cultural Competency Tracking System – Session 1
31-Mar-16	Cultural Competency Tracking System – Session 2

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
- Cultural Competency Narrative Report – provider resource for self-evaluation

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 held every other month to ensure that providers are kept up-to-date on policy developments where it concerns MHS.

Date	Name
02-Feb-16	Cultural Competency Taskforce
03-Mar-16	Cultural Competency Taskforce
05-May-16	Cultural Competency Taskforce

06-Jul-16	Cultural Competency Taskforce
09-Aug-16	Cultural Competency Taskforce
06-Oct-16	Cultural Competency Taskforce
01-Dec-16	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	President & Chief Executive Officer	RAMS, Inc. (Richmond Area Multi-Services, Inc.
Di Martino	Angela	Project Coordinator	Curry Senior Center
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.
Larson	Fancher	Mental Health Patients' Rights Advocate (SF County)	San Francisco Mental Health Clients Rights Advocates
Okakpu	Osinachi	Workforce Development Coordinator	Office of Workforce Development
Rucker	Toni	Chief Cultural Competency and Workforce Development Officer	Ambulatory Care - Cultural Competency
Velez	Elissa	Substance Use Services Program Coordinator	BHS- System of Care Substance Use Disorder
Uribe	Anthony	CATS HR Director	Community Awareness & Treatment Services, Inc.

5. Culturally Competent Training Activities

The Office of Cultural Competence provides 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.

Implementation of the National enhanced CLAS Standards will vary from organization to organization. Therefore, organizations should identify the best implementation methods appropriate to their size, mission, scope and type of services offered. It is also important to develop measures to examine the effectiveness of the programs being implemented, identify areas for improvement and identify next steps. Many of these measures and evaluation strategies may already be in place throughout an organization, for the purposes of accreditation and grant

management. Health and human service providers, emergency responders, community-based organizations and health care delivery sites (e.g., hospitals, clinics, and community health centers) will have different goals and expectations for the National CLAS Standards. Therefore, their strategies for implementation may differ widely.

The enhanced National CLAS Standards and The Blueprint include specific implementation strategies to further the establishment or expansion of culturally and linguistically appropriate services. Prior to implementation, it is important to have a vision of what culturally and linguistically appropriate services would look like within the organization and to identify available and required resources (e.g., structure, funding, and personnel) to ensure success.

Responsibilities associated with implementing the enhanced National CLAS Standards should be distributed throughout the organization to ensure comprehensive engagement and effectiveness so that no single individual or department bears the responsibility for the entire organization. For example, some organizations find it helpful to establish an interdisciplinary or cross-departmental committee that will help identify, implement and sustain the elements of a well-developed CLAS plan.

Please See Appendix F for List of Trainings from FY 14-15 to FY 16-17

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.

Date	Name: How to Apply for DPH Entry Level Positions	# of Participants
16-Mar-16	Applying for Health Worker Workshop	64
23-Mar-16	Applying for Health Worker Workshop	87
20-April-16	SFSU Workforce Recruitment	
09-Sept-16	Applying –Hiring Technical Assistance	

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 is currently collaborating with a local Expert to provide an Annual Interpreter Training to provide training for staff who are interested in expanding their clinical role to also include bi-lingual interpretation services to clients, as needed. The training is provided, and interested staff are linked to City-approved vendors for both oral and written testing. If approved, they are utilized by their clinic to provide language access needs, as requested by patients and family members.

The Cultural Competency Office also provides City approved interpretation and translation services to DPH clinics. 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 by the last three years of examination results see in Exhibit 3.

See Appendix G for Winter 2016-17 Log of Translation/Interpreter Requests

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		
	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

Exhibit 4: April 2016 ASL Interpreter Request Log

DATE	TIME	LOCATION	PATIENT'S NAME	SERVICE REQUESTER'S NAME & PHONE NUMBER
4/1/2016	4:00 pm - 5:30 pm	Family Home: 1390 9th Ave, SF	Emily L and Euni J	Kitty McCarthy 415-517-7749
4/1/2016	9:00 am - 11am	1 South Van Ness (2nd floor Atrium)	Keith Clark	Edwin Batongbacal/NinadaSilva/ Cultural competency cultural.competency@sfdph.org
4/4/2016	9:00 am - 11am	1 South Van Ness (2nd floor Atrium)	Keith Clark	Edwin Batongbacal/NinadaSilva/ Cultural competency cultural.competency@sfdph.org
4/11/2016	4:00 pm - 5:30 pm	Family Home: 1390 9th Ave, SF	Emily L and Euni J	Kitty McCarthy 415-517-7749
4/18/2016	4:00 pm - 5:30 pm	Family Home: 1390 9th Ave, SF	Emily L and Euni J	Kitty McCarthy 415-517-7749
4/25/2016	4:00 pm - 5:30 pm	Family Home: 1390 9th Ave, SF	Emily L and Euni J	Kitty McCarthy 415-517-7749

The Office of Cultural Competency is also working with a consultant and local Subject Matter Expert, in order to initiate a project that will analyze the language capabilities and capacities of the CBO partners that work with BHS. A survey has been developed by the Consultant and will be distributed to all of the providers contracted with BHS. It will collect data on their staffs' language capacities, along with their input on the linguistic areas they feel are lacking. This will inform the Office of Cultural Competency of how to better support these partners going forward. 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. (see also Strat. Planning-Data & Research)

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 a lower quality of overall health care and higher health costs for these patients.

See Appendix H for complete survey

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.

See Appendix A and I for CLAS Standards List Training Presentation

Strategic Planning – Goals and Updates

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**
The Cultural Competency Task Force had identified Health Literacy, for staff and community members, as an area to address for improved communication and adherence to treatment plans. In the winter of '16-'17, OCC met with the leadership at Chinatown/North Beach Mental Health Services to better understand how the clinic has developed and strengthened partnerships at the neighborhood level (Galileo High School/Chinatown-based CBOs) and local colleges and universities (UCSF) to increase language access capabilities at their facility. The meeting clearly highlighted the importance of utilizing and leverage learning and innovation at every level of education. The meeting reinforced and outlined the benefits for partnerships between students and the Behavioral Health workforce. The meeting laid a foundation for the Task Force to continue to meet and identify how learning and information exchange can be beneficial for staff, clients, and community members. This type of Health/Education partnership will be on the planning agenda for the Task Force so that health literacy initiatives can be implemented at clinic and program levels.

Aside from the Health Literacy Planning, the development and implementation of Community Advisory Boards (CABs) is an ongoing point of emphasis for the OCC at meetings and trainings.

- **Access to Care for at Risk Population Groups**
OCC has provided support for increased outreach at community events such as Sunday Streets to broaden the audience it strives to reach. Demographic-specific events like Homeless Connect and interfaith meetings with congregations (i.e. Bayview churches) have sought to reach those groups that are less likely to seek out mental health services.
- **Cultural Competency Training for Leadership**

The CC Task Force meets on a bi-monthly basis to discuss the most pressing needs and issues where it concerns cultural competency. CCTF members report on the developments occurring at their sites and the surrounding community. The OCC uses this information to tailor upcoming trainings and policies. Trainings conducted by the OCC work to build CABs and the capacity of CBO leaders to promote and sustain them.

- **Services**

The OCC continues to assist with the coordination of translation and interpretation services, working with vendors, civil service clinics and other BHS units to ensure that consumers have access to mental health resources.

- **Training and Education for Staff Development**

Throughout the year, the OCC has conducted trainings on relevant CC issues, plus trainings on the tools of the OCC that are meant to increase the flow of information and overall language access. These include trainings on the CC Narrative Reports (with emphasis on CAB development) and the Cultural Competency Tracking System (database), which is meant to provide up to date information on the language capacities of staff at both civil service clinics and CBOs.

- **Data and Research**

In 2017, the OCC began work with a consultant to initiate a survey tracking language access capabilities, resources and needs BHS' CBO partners. The survey was distributed in March and the consultant will track and analyze the data to create a report with recommendations on the standards by which language access should be measured and how to achieve them.

Conclusion:

The Office of Cultural Competency continues to empower both consumers and service providers by supporting efforts to increase access. Through innovation of processes and systems, language access information is being shared at ever increasing rates, helping BHS account for trends and populations for which there were previously gaps and unknowns. Furthermore, the OCC will retain its integral role as a facilitator of relationship building to maximize the coverage of mental health services in the city.